



DDA: Navigating the System

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Agenda



- 1) What is DDA
- 2) Why is it important?
- 3) Who can access DDA?
- 4) How does a person become “DDA eligible”?
- 5) What is a waiver?
- 6) How does a person enroll on a waiver?
- 7) What is respite care and how do you get it?
- 8) What is personal care and how do you get it?
- 9) What can you expect from you Case Manager?
- 10) Where do you go for help?

What is the Developmental Disabilities Administration (DDA)?



- ❖ The portion of our **state government**, within DSHS, responsible for providing support and care to people with intellectual and developmental disabilities across their lifespan.
- ❖ Where people with developmental disabilities go to get help for in-home, out-of-home, and community-based services
- ❖ For those who will require long-term services and support, DDA will play a critical role.
- ❖ Formerly called DDD

Examples of DDA services

Short Term Services

- Overnight Planned Respite (age 18 and older)
- Emergency respite
- Behavior Support Team (Ages 3-17)

Long Term Services

- Personal Care
- Respite Care
- Supported Employment
- Behavior Support
- Supported Living
- Waivers

Other Perks to being a DDA Client

- School to Work
- Housing or Rental Assistance
- Developmental Disabilities Life Enrichment Trust (DDLLOT)
- Parkview Homebuyers Program
- South Mental Health DD Chemical Dependency program



[For a complete list and description of available DDA services](#)

Why is DDA important?



- ❖ Long-term care is costly, and most people, even those with financial resources, can't afford to pay for it on their own.
- ❖ Although DDA is not a crisis agency, having them available during an unexpected crisis is a critical safety net.
- ❖ Being DDA eligible enables the state to more accurately count how many people with disabilities live in Washington in order to better prepare and serve them.

**WELCOME TO THE DEVELOPMENTAL
DISABILITIES ADMINISTRATION (DDA)**

Supported Employment



**Personal
Care**

Who can access DDA services?

❖ Anyone who has a developmental disability **as defined by Washington State.**

- Children receiving ESIT services
- Not dependent on income
- Exception: Immigration Status

❖ The disability must:

- Have originated before you turned eighteen
- Continue or can be expected to continue indefinitely
- Result in substantial limitations

❖ Your diagnosis must be one of the following:

- Developmental Delays (only until age 9)
- Intellectual Disability
- Cerebral Palsy
- Epilepsy
- Autism (NOT Autism 1)
- Another neurological condition

❖ [A medical diagnosis is not enough.](#)





DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
Eligible Conditions With Age and Type of Evidence

All disability conditions must originate prior to age 18, be expected to continue indefinitely, and result in substantial limitation in adaptive functioning per WAC 388-823.

Eligible Conditions Specific to Age			
Condition	0 - 3	4 - 19	20 and older
Developmental Delays	X	X	
Intellectual Disability (ID)		X	X
Cerebral Palsy		X	X
Epilepsy		X	X
Autism		X	X
Another neurological or other condition similar to Intellectual Disability		X	X

Tests Accepted as Evidence of Substantial Limitation	
Cognitive Tests	Adaptive Assessments
<ul style="list-style-type: none"> Stanford-Binet Wechsler Intelligence Scales (WISC) Differential Abilities Scale (DAS) Kaufman Assessment Battery for Children (K-ABC) Das-Naglieri Cognitive Assessment System (CAS) Woodcock Johnson Test of Cognitive Abilities (WJ) Reynolds Intellectual Assessment Scales, 2nd Edition (RIAS 2) <p>If you have a hearing impairment, English is not your primary language or you are non-verbal, your FSIQ may be estimated using one of the tests below:</p> <ul style="list-style-type: none"> Leiter International Performance Scale-Revised (Leiter-R) Wechsler Intelligence Scales (WISC, WAIS, WNV) Comprehensive Test of Nonverbal Intelligence (C-TONI) Kaufman Assessment Battery for Children (K-ABC) Nonverbal scale index 	<ul style="list-style-type: none"> Vineland Adaptive Behavior Scales (VABS) Scales of Independent Behavior-Revised (SIB-R) Inventory for Client and Agency Planning (ICAP) Adaptive Behavior Assessment System (ABAS)

Diagnosis, Diagnostician, and Required Evidence of Substantial Limitation		
Diagnosis	Diagnostician	Substantial Limitation
Developmental Delay	Not applicable	Developmental Delays
Intellectual Disability	Licensed Psychologist or Certified School Psychologist	Adaptive functioning assessment with a standard score of ≤69, and Psychological assessment with FSIQ of ≤69 or Stanford-Binet IV with FSIQ of ≤67
Cerebral Palsy, or Similar brain damage which causes, quadriplegia, hemiplegia, or diplegia	Licensed Physician	Onset prior to age 3, and Evidence of the need for direct physical assistance in any 2 of the following: toileting, bathing, eating, dressing, mobility or communication
Epilepsy, Seizure Disorder	Board Certified Neurologist	Seizures are uncontrolled and ongoing or recurring, and Adaptive functioning assessment with a standard score of ≤69
Autism, Autistic Disorder (DSM-IV-TR-299.00), or Autism Spectrum disorder (DSM-5)	Board Certified Neurologist; Board Certified Psychiatrist; Licensed Psychologist; Board Certified Developmental and Behavioral Pediatrician; Licensed Physician or ARNP associated with an Autism Center, Developmental Center, or Center of Excellence	Evidence of onset prior to age 5, an adaptive functioning assessment with a standard score of ≤69, and for DSM-5 diagnosis, an FSIQ of ≤84 (or a written statement that your autism prevents you from testing)
Another neurological or other condition similar to Intellectual Disability	Licensed Physician	Adaptive functioning assessment with a standard score of ≤69, and FSIQ of ≤77 or Stanford-Binet IV with FSIQ of ≤75, or if under age 20, scores in both Broad Reading & Broad Math ≤69 can replace FSIQ testing

How do you become DDA eligible?

**The first step to
accessing services from
DDA:**

Become “DDA Eligible”

- ❖ Prove to the state that you meet their definition of developmentally disabled.
- ❖ The application for DDA eligibility takes less than 30 minutes to complete and can now be submitted via email.
- ❖ DDA Eligibility is a yes or no question and is based almost completely on test scores and medical records





The Arc
King County

The DDA Application

Request for DDA Eligibility Determination (14-151)

Consent (14-012)

Notice of Privacy Practices for Client Confidential Information (03-387)

Washington State Voter Registration for applicants aged 18 or older

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
Request for DDA Eligibility Determination

FOR OFFICE USE ONLY
 Initial Reapplication
DDA NUMBER: _____

Applicant Information
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____ BIRTHDATE: _____

GENDER
 Female Male Unknown / Unreported

MARITAL STATUS
 Never Married Married Separated Widowed

APPLICANT'S COMMUNICATION NEEDS
Interpreter Required: Yes No
Speak English: Yes No
Translate Documents: Yes No
Understands English: Yes No
Primary spoken language: _____

TRIBAL ENROLLMENT
 Yes No

SOCIAL SECURITY NUMBER

HIGHEST EDUCATION LEVEL OR TYPE

ETHNIC CODES (CHECK ALL THAT APPLY)
 American or Alaska Native Black or African American Asian Native Hawaiian / Other Pacific Islander White Unreported

MEDICARE
Yes: type: Adult-Licensed Facility Homeless Relative's home
 No Child - foster home Hospital, medical Own Home
Other insurance: Correctional Facility / Jail Hospital, psychiatric Parent's Home
 Nursing Facility Other, describe: _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____ **COUNTY OF RESIDENCE** _____

WASHINGTON IS MILITARY HOME OF RECORD
 Yes No

MAILING ADDRESS (IF DIFFERENT) _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

PRIMARY PHONE NUMBER CELL HOME WORK OTHER PHONE NUMBER CELL HOME WORK MESSAGE EMAIL ADDRESS _____

LIBRARY SCHOOL DISTRICTS ATTENDED AND DATES

TELL US WHY YOU ARE APPLYING

DEVELOPMENTAL DISABILITY AND THE AGE FIRST OBSERVED
Age first diagnosed: _____
 Autism Epilepsy Intellectual Disability Neurological Condition Chromosomal Condition Developmental Delay

DISABILITY DETERMINATION SERVICE APPLICATION
Has the applicant applied for Social Security Disability Benefits, Supplemental Security Income, or DSHS Non-Grant Medical Assistance in the last year?
 Yes No

Representative Information
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____ PRIMARY LANGUAGE: _____
MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
Interpreter: Yes No
Translation: Yes No

RELATIONSHIP TYPE / ROLE _____ **LEGAL RELATIONSHIP (ATTACH DOCUMENTS)** _____ **LIVES WITH APPLICANT** Yes No

NAME OF OTHER PARENT _____

Signatures
SIGNATURE OF ADULT APPLICANT _____ DATE: _____
SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE _____ DATE: _____ LEGAL RELATIONSHIP: _____

REQUEST FOR DDA ELIGIBILITY DETERMINATION
DDHS 14-151 (REV. 04/2015)

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Consent

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot release you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:
Name: _____ DATE OF BIRTH: _____ IDENTIFICATION NUMBER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
TELEPHONE NUMBER (INCLUDE AREA CODE): _____ OTHER INFORMATION: _____

CONSENT:
I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

Health care providers
 Mental health care providers
 Substance use disorder service providers
 Housing programs
 School districts or colleges
 Department of Corrections
 Employment Security Department and its employment partners
 Social Security Administration or other federal agency
 Law enforcement
 Other: _____

I authorize and consent to sharing the following records and information (check all that apply):
 All my client records Records on attached list
 Only the following records: _____
 Family, social and employment history Health care information Treatment or care plans
 Payment records Individual information School, education, and training
 Other (list): _____

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.
 Mental health HIV/AIDS and STD test results, diagnosis, or treatment Substance Use Disorder (date or event)
- This consent is valid for one year as long as DSHS needs records, or until _____ (date or event).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.
- A copy of this form is valid to give my permission to share records.

SIGNATURE _____ DATE: _____ WITNESS / NOTARY (SIGN AND PRINT NAME, IF APPLICABLE) _____ DATE: _____
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE) _____ TELEPHONE NUMBER (INCLUDE AREA CODE): _____ DATE: _____

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
 Parent Legal Guardian (attach court order) Personal representative Other _____

NOTICE TO SERVICES PROVIDERS AND CONTRACTORS: If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to commonly investigate or prosecute any alcohol or drug abuse patient.

CONSENT
DDHS 14-012 (REV. 04/2015)

DSHS NOTICE OF PRIVACY PRACTICES FOR CONFIDENTIAL INFORMATION
Effective September 23, 2013

Acknowledgement
(Needed when DSHS provides direct health care treatment)

CLIENT NAME: _____ CLIENT DATE OF BIRTH: _____

I have received a copy of the DSHS Privacy Notice and have had a chance to ask questions about how DSHS will use and share my Personal Health Information.

CLIENT OR PERSONAL REPRESENTATIVE SIGNATURE _____ DATE: _____

FOR DSHS USE ONLY
To be completed if unable to obtain signature of client or personal representative.

Describe efforts made to have the client acknowledge receipt of the Notice of Privacy Practices (NPP):

Describe reason why acknowledgement was not obtained:

STAFF MEMBER'S NAME AND TITLE (PLEASE PRINT) _____ ADMINISTRATION/DIVISION: _____
STAFF'S SIGNATURE _____ DATE: _____

DDHS 03-387 (REV. 06/2015)

Instructions
Use this form to register to vote or update your current registration.

Print all information clearly using black or blue pen. Mail this completed form to your county elections office (address on back).

Deadline
This registration will be in effect for the next election if received by the elections office no later than eight days before Election Day.

Voting
You will receive your ballot in the mail. Contact your county elections office for accessible voting options.

Public Benefits Offices
Your name, address, gender, and date of birth will be public information if you are at least eighteen years of age.

Notice
Knowingly providing false information about yourself or your qualifications for voter registration is a class C felony punishable by imprisonment for up to five years, a fine of up to \$10,000, or both.

Public Benefits Offices
If you received this form from a public benefits office, where you received the form will remain confidential and will be used for voter registration purposes only.

Registering or declining to register will not affect the assistance provided to you by any public benefits office. If you decline to register, your decision will remain confidential.

If you believe someone interfered with your right to register or your right to privacy in deciding whether to register, you may file a complaint with the Washington State Elections Division.

Contact Information
If you would like help with this form, contact the Washington State Elections Division.
web: www.wctowa.gov
call: (800) 448-4881
email: elections@wa.wa.gov
mail: PO Box 40229
Olympia, WA 98504-0229

Washington State Voter Registration Form
Registration at: www.wctowa.gov

1 Personal Information
last first middle suffix
date of birth (mm/dd/yyyy) gender
residential address in Washington apt #
city state ZIP
mailing address, if different
city state and ZIP
phone number (optional) email address (optional)

2 Qualifications
If you answer no, do not complete this form.
 Yes No I am a citizen of the United States of America.
 Yes No I am at least eighteen years old, or at least sixteen years old and will vote only after turn eighteen.

3 Military / Overseas Status
 Yes No I am currently serving in the military. Includes National Guard and Reserve and spouses or dependents away from home due to service.
 Yes No I live outside the United States.

4 Identification - Washington Driver License, Permit, or ID
If you do not have a Washington driver license, permit, or ID, you may use the last four digits of your Social Security number to register.

5 Change of Name or Address
This information will be used to update your current registration, if applicable.
former last name first middle
former residential address city state and ZIP

6 Declaration
I declare that the facts on this voter registration form are true. I am a citizen of the United States. I will have lived at this address in Washington for at least thirty days immediately before the next election at which I vote. I will be at least eighteen years old when I vote. I am not disqualified from voting due to a court order, and I am not under Department of Corrections supervision for a Washington felony conviction.

sign here _____ date here _____

I'm DDA Eligible – Now What?



- ❖ You're now in the front door of the restaurant but not yet seated at a table
- ❖ Must enroll on a waiver to access employment support, caregiving and respite services
- ❖ BeST Behavior Support

What is a Waiver?

- ❖ A package of services that increase in levels of support and services, depending on the individual's level of need.
- ❖ Most families start with the Individual and Family Support (IFS) Waiver and then move up as needed.
- ❖ You must use (or try to use) the services they give you and show that it isn't enough help before they'll give you more.
- ❖ When enrolled on a waiver you become eligible for Medicaid, regardless of income. Medicaid can be used as a secondary insurance, and to access personal care.

Why is it called a Waiver?

It is an agreement to *wave* the option to receive services in an institutional setting and choosing instead to receive the same or similar services in their own home and community.

How do you enroll on a Waiver?

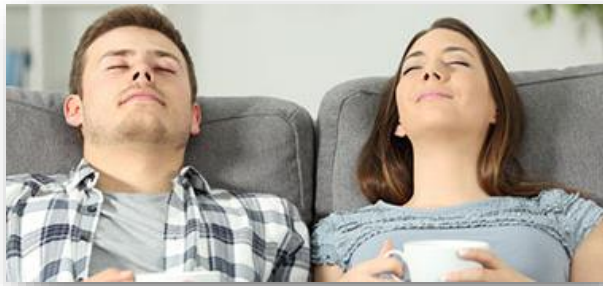
- ❖ “I’d like to request a needs assessment in order to be enrolled on a waiver.”
 - To request services: 1-800-974-4428 or <https://www.dshs.wa.gov/dda/service-and-information-request>
 - Expect a response in ~~1-2 weeks-3-6 months~~ *6-12 months or more*
- ❖ Needs assessment: *TIME TO GET REAL*
- ❖ Waivers are not at capacity but there is an administrative backlog that makes enrolling take a year or more
- ❖ If you are already a Medicaid recipient, you may be eligible for personal care through Community First Choice. Call 206-341-7750 to enroll.
- ❖ If you already have a waiver and would like an increase in services, use ALL the services you already have before requesting more.

If waivers reach capacity: Waivers are awarded based on urgency of need, not first come first serve, and there is no waitlist.

Keep in very close contact with DDA, notifying them of anything new or different including:

- Increase in challenging behaviors
- New diagnosis or medical condition
- New care/support needs
- Pictures and videos are your friends

What is respite care?



Purpose: To allow the primary caregiver a break so that they can continue being the primary care giver, preventing out of home placement.

- ❖ Short-term, intermittent relief for parents/caregivers, where the person with a disability receives care from another person so that the main caregiver can take a break.
- ❖ Respite care is NOT “Child Care” while the parent is at work.
- ❖ The many forms of Respite Care:
 - One-on-One care in your home or the local community for a few hours at a time
 - After-school care, camps, adult day centers, specialized classes, etc. offered by a DDA contracted organization
 - Overnights, weekends, or longer care at a friend/relative’s house or licensed facility
- ❖ To find respite care:
 - Contact your DDA Case Manager
 - Lifespan Respite NW [Respite Vouchers](#)
 - Any social or recreational activity can be respite care!

What is personal care?



Purpose: To provide DIRECT assistance to a person with disabilities with their Activities of Daily Living (ADLs)

What a Personal Care Provider CAN do:

Bathing	Dressing
Toilet Use	Eating
Meal Prep	Essential Shopping
Telephone Use	Personal Hygiene
Bed Mobility	Travel to Medical
Transfer	Ordinary Housework
Wood Supply	Locomotion
Body Care	Meds Management

- ❖ Can't provide childcare, supervision, or skilled nursing
- ❖ Can be provided in the client's home, an Adult Family Home, Assisted Living Facility, or Nursing Home. It can also be provided in the community if it meets the client's care needs.
- ❖ Only parents of clients 18 and over can become paid caregivers.
- ❖ To find a caregiver:
 - Contact your DDA case manager
 - Contact contracted caregiving staffing agencies
 - Carinacare.com
 - Those already providing care can become contracted providers

What to expect from your DDA Case Resource Manager (CRM)



- ❖ CRMs hold caseloads of ~75 people.
- ❖ You have the right to call or email any time. Allow 48 hours for a response. Don't expect the CRM to reach out to you except for the annual assessment. Therefore, if you are having challenges, need more services, or have questions, you must be the one to seek help.
- ❖ If you do not hear back from your CRM or are concerned about their work, contact their supervisor.
 - You can find out who the supervisor is by calling the DDA front desk at **206-568-5700**
- ❖ CRMs should know about the DDA services available to you. They have limited knowledge about non-DDA services.

Where do you go with concerns?

CRMs are doing their best, but DDA is a complicated and ever-changing system so it is easy to make mistakes. If you suspect the information you receive is inaccurate or you are turned down for services, you have a few options:

- ❖ Ask for clarification from the CRM
- ❖ Talk to their supervisor
- ❖ Work your way up the supervisory chain
- ❖ Contact The Arc of King County





Contact Us

The Arc of King County

Information and Family Support

English: 206-829-7053 OR Ask@arcofkingcounty.org

Spanish: 206-829-7030 OR Preguntas@arcofkingcounty.org

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