

## Developmental Disabilities Administration Low Intensity Support Services (LISS) Request Form

APPLICANT INFORMATION				
Last Name:	First:	Middle:	Marital Status (circle one) Single Married Div Sep Widow	
Address:	City:	State:	Zip Code:	Home Phone #:
Social Security #:	Date of Birth: / /	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Individual's Annual Income:		Household Annual Income:		
Primary Disability:		Race(circle one): Black/African American White/Caucasian Asian American Indian/Alaska Native American Pacific Islander/Native Hawaiian		
What is the relationship of the person completing this form to the applicant? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Resource/Service Coordinator <input type="checkbox"/> School Counselor <input type="checkbox"/> Other :				
If not "self", please note name of person completing this form:			Phone #:	
Please check all programs and services the applicant is currently receiving services or resources from:				
DDA <input type="checkbox"/> Resource/Service Coordination <input type="checkbox"/> Day/Supported Employment <input type="checkbox"/> Residential <input type="checkbox"/> CSLA <input type="checkbox"/> Supports <input type="checkbox"/> Autism Waiver <input type="checkbox"/> REM(Rare & Expensive Case Management) <input type="checkbox"/> Model <input type="checkbox"/> Living at Home <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Special Education <input type="checkbox"/> In-Home Aid Service (IHAS) <input type="checkbox"/> Attendant Care Program <input type="checkbox"/> MAPC <input type="checkbox"/> Older Adults Waiver <input type="checkbox"/> Division of Rehabilitative Services (DORS) <input type="checkbox"/> Social Services <input type="checkbox"/> Energy Assistance (MEAP) <input type="checkbox"/> Food Bank <input type="checkbox"/> Housing <input type="checkbox"/> Transportation <input type="checkbox"/> Medical Assistance/Medicaid <input type="checkbox"/> Other:				
Resource/Service Coordinator/Case Manager Name:			Phone #:	
			Email:	
Note: Applicants are required to submit appropriate documentation including a copy of their social security card, proof of Maryland residency, and proof of disability in order for eligibility to be considered.				
Service/Item Request				
Please note the service or item request and description or details (if applicable):				
Service/Item Cost:			Applicant Contribution (if applicable):	
Resource/Service Request have been made to (if applicable) and Status (i.e. application pending, denied, funded amount)				
1				
2				
3				
Service Vendor Name (if known:)				
Address:			City:	State:
			Zip Code:	Phone #:
Applicant Declaration				
By signing this application, I hereby attest that the information provided to process the Low Intensity Support Services (LISS) funding request is accurate to the best of my knowledge. I understand that receipt of LISS funding is contingent upon DDA's LISS eligibility criteria, verification of the above information, and funding availability.				
Signature:			Date:	
Name (print):				
Form Effective 12/10/09				