

**DDS HOME AND COMMUNITY-BASED SERVICES ADULT
WAIVER PROGRAM REQUEST FORM**

Name of applicant: _____

(Print Clearly)

Address of applicant: _____

Date of birth: (mm/dd/yyyy): ____/____/____ Social Security Number: ____/____/____

Has applicant been determined by DDS to be an eligible person with intellectual disability? ____Y ____N

Name of Guardian (if any): _____

Whom to contact: _____

Relationship to applicant: _____

Telephone of contact: (_____) _____ - _____

PLEASE CHECK ONE OF THE FOLLOWING FOUR OPTIONS: (see reverse side for program descriptions)

1. () I am **applying for any of the three DDS Adult Waiver Programs**.
 - I understand that if I choose this option, I will first be assessed for the Adult Supports Waiver Program and if I am found eligible for the Adult Supports Waiver Program, I will not be considered for any other DDS waiver program.
 - If I am not found eligible for the Adult Supports Waiver Program I will be assessed for the Community Living Waiver Program. If I am found eligible for the Community Living Waiver Program, I will not be considered for any other DDS waiver program.
 - If I am found ineligible for the Community Living Waiver Program, I will be assessed for Intensive Supports Waiver Program.
2. () I am **applying only for the Adult Supports Waiver Program** because I live at home, or on my own, or in another home and I need at least one waiver service. I will not be considered for any other waiver program.
3. () I am **applying only for the Community Living Waiver Program** because I need a moderate level of supports in order to live in my own, or my family's home or the home of another, but I do not require 24 hour supervision. I will not be considered for any other waiver program.
4. () I am **applying only for the Intensive Supports Waiver Program** because I require 24 hour supervision. I will not be considered for any other waiver program.

CHOICE STATEMENT:

I _____ (Applicant or guardian) choose to apply for the Home and Community-Based Services Adult Waiver Programs and live and receive my services in the community rather than in an ICF/ID.

SIGNATURE: _____

DATE: (mm/dd/yyyy): ____/____/____

**Complete this form and mail it
to:**

**Department of Developmental Services
Waiver Management Unit
1000 Washington Street
Boston, MA 02118
www.mass.gov/dds**



**MASSACHUSETTS DEPARTMENT OF
DEVELOPMENTAL SERVICES**

**Executive Office of Health and Human Services
Kathleen E. Walsh, Secretary
Department of Developmental Services
Jane F. Ryder, Commissioner**

***DDS HOME AND COMMUNITY-BASED SERVICES ADULT
WAIVER APPLICATION***

To be eligible for the DDS Adult Waiver Programs you must:

Be a person with intellectual disability as determined by DDS;
Meet Medicaid eligibility requirements;
Be at least 22 years of age or older;
Meet federal requirements for waiver services including eligibility for admission to an Intermediate Care Facility for people with Intellectual Disabilities (ICF/ID — in Massachusetts, an ICF/ID is a large institution);
Choose to receive your services in the community rather than in an institution; and
Be assessed to need one or more waiver services.

There are three different DDS Adult Waiver Programs:

The **Adult Supports Waiver Program** is for individuals who can live in their own home or family home due to a combination of strong natural/informal, generic and Medicaid services.

The **Community Living Waiver Program** is for individuals who can live in their family home or home of someone else, and do not need supervision 24 hours a day, seven days a week due to the combination of natural, generic, and Medicaid services.

The **Intensive Waiver Program** is for individuals who need supervision and support 24 hours a day, seven days a week, outside of their own or family's home due to significant behavioral, medical, and/or physical support needs and the absence of available, natural, generic and Medicaid Services.

DDS REGIONAL OFFICES

***Northeast* : Hogan Regional Center, P0 Box A, Hathorne, MA 01937**

Kelly Lawless, Regional Director (978) 774-5000

***Central West*: 140 High Street, Suite 301, Springfield, MA 01105**

Anthony Keane, Regional Director (413) 205-0800

***Metro*: 465 Waverley Oaks Rd., Suite 120, Waltham, MA 02452**

Gail Gillespie, Regional Director (781) 314-7500

***Southeast*: 151 Campanelli Drive, Suite B, Middleboro, Ma 02346**

Richard O'Meara, Regional Director (508) 866-5000