IDAHO DEPARTMENT OF HEALTH & WELFARE

:Date to IAP:_____

CHILDREN'S DEVELOPMENTAL DISABILITIES SERVICES APPLICATION UPDATE R 1_1_2015

Date: _____

Child's Name:_____ Date of Birth: _____

Is the child currently enrolled in Medicaid? ☐Yes ☐ No MID#_____

Parent(s)/Legal Guardian Name(s):_____

Primary language spoken in household:_____ Do you need a translator?_____

Physical Address: _____

Mailing address if different:_____

Telephone (1): _____Telephone (2): _____

Email: _____

Physician Name:_____Telephone:_____

Physician Address:_____

Diagnosis_____

Name of School, if applicable: _____Name of Primary Teacher:_____

By signing this application update, your signature provides consent for the Department to gather, use and disclose information as needed for the individual to receive Department benefits or services.

Parent/Legal Guardian Signature: _____ Relationship to Applicant:_____

16.05.01.050.When individuals, legal representatives or informal representatives sign an application, they consent for the Department to gather, use and disclose information as needed for an individual to receive Department benefits or services. If none of these individuals provides a consent on an application, service may be denied. An informal representative may only consent to the disclosure of confidential information when permitted by these rules.