Developmental Disabilities Administration (DDA)

Low Intensity Support Services (LISS) Program, Services Eligibility Application

APPLICANT INFORMATION (The applicant is the individual with a developmental or intellectual disability)

First Name: Susan	**Middle Name:** B.	**Last Name:** Miller
Mailing Address: (Address, City, State and Zip Code) 310 Old Freeland Rd, Freeland, MD 21053		
Social Security #: 123-45-6789	**Date of Birth:** 08/01/2014	**Telephone #:** 887-282-8202

SERVICE INFORMATION-Please do not write "see attached". This section must be completed.

1. Service/Item Request	2. Name & Address of Vendor/Service Provider	3. Licensed Professional's Name & License # (for licensed service providers)	4. Telephone # of Vendor/Service Provider	5. Total Amount Requested for Service/Item	6. Date(s) of Service (Dates must be within the current fiscal year)	7. Daily/Hourly Rate Amount of days/hours
Respite	Carol Smith 123 Assist Ln Baltimore, MD 21202	N/A	443-555-1212	$300.00	7/1/25- 6/30/26	$15.00/hour 20 hours
Reason for the above service/item Place reason here I am a full time working parent and at times I need a break for myself. This will allow me time to run errands and go to appointments with peace of mind knowing Susan will be well cared for.				☐ Reimbursement	☑ LISS Pay Vendor/Purchase	
Assistive Technology iPad	Apple online	N/A	N/A	$528.94	N/A	N/A
Reason for the above service/item Place reason here Susan is non-verbal and this tablet will help her communicate with us and in the community.				☐ Reimbursement	☑ LISS Pay Vendor/Purchase	
Speech Therapy	ABC Speech Therapy 111 East Apple Way Baltimore, MD 21202	Sarah King SLP 01234	410-555-1212	$250.00	7/1/25- 6/30/26	$25 Co-Pay Per Visit
Reason for the above service/item Place reason here Susan goes to speech therapy twice a week and we pay a $25 co-pay per visit.				☑ Reimbursement	☐ LISS Pay Vendor/Purchase	

Please Read Before Signing

By signing this application, I hereby attest that the information provided is accurate to the best of my knowledge. I understand LISS funding is not an entitlement program. Receipt of LISS funding is contingent upon DDA's LISS eligibility criteria for the applicant, the service/item, and/or the provider verification of the above information. If you are an authorized representative or completing the request for a child, please sign your name for the applicant. Please check off ☑ I acknowledge that I have received and read the Low Intensity Support Services-FY 2026

Signature of Applicant: _____ **Date:** _____

Signature of Parent/ Legal Guardian (if applicant is under 18): Angela Miller **Date:** 10/1/25

Person designated to receive letters, emails and phone calls. Print Name: Angela Miller **E-Mail:** amiller@gmail.com

Address (if different than above): _____ **Phone Number:** 887-282-8202

Please Select One. I wish to receive correspondence by: ☑ **Email Only** ☐ **Mail Only** ☐ **Both Email and Mail**