LISS Agency Date Stamp

Developmental Disabilities Administration
Low Intensity Support Services (LISS)
Random Selection Application

Applicant Information (for which services are requested)			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	Gender: M / F
Date of Birth:	Social Security Number:	Medical Assistance Number: (If No MA Number, please list the date of application for those over 18)	
Street Address:			
City:	County:	Zip Code:	
E-mail Address:	Telephone Numbers: (Home)	(Cell)	

Applicant Representative Information (optional unless applicant is under 18 years of age or has a legal guardian)		
Name:	Relationship to applicant:	Telephone number:

Applicant Declaration of Intent
By signing this request form, I understand I am requesting to participate in a random selection of applicants identified through documentation as having an eligible diagnosis. I am a resident of the state of Maryland requesting funding for an eligible service as noted on the LISS website at http://dda.dhmh.maryland.gov/SitePages/liss.aspx. I hereby attest that the information provided on this form is accurate to the best of my knowledge. I understand funding through LISS is not an entitlement and, if selected through the random selection process, I will be required to provide documentation verifying my identity, disability, residency, and an identified eligible service/item delivered or provided by an eligible vendor. I also understand that a representative of the LISS agency serving my county will contact me and assist with the LISS process.
Signature of LISS Applicant or Representative if under 18 years of age: _____Date:_____