Shawnee County
Community Developmental Disabilities Organization
"Your resource for connecting our community"

2701 SW Randolph Ave
Topeka KS 66611
(785) 232-5083
(785) 235-8041 *fax*
www.sncddo.org

Thank you for your interest in applying for I/DD Services. Currently there is a waiting list for the funding of these services. The sooner eligibility is determined the sooner you can be added to the waitlist.

The second page of this letter provides you with a check off list of all documents needed to determine Eligibility. Eligibility will be determined after ALL documents have been accurately completed and received. *(Allow up to 5 business days to process your application once all documentation is returned).*

If the person seeking services does not have a diagnosis and you need assistance with obtaining one, please contact me and I can provide you with a list of providers who can determine diagnosis.

If additional information is needed to determine eligibility, you will be notified. If the additional information is not received within 90 days, your file will be placed in an inactive status. If you choose to pursue services again after that point, you can contact us to begin the eligibility process again.

At any point if you need my assistance please contact me. I can be reached tkrentz@sncddo.org or 785.506.8677. The packet can be delivered, mailed, scanned or faxed to me.

Sincerely,

Tiffanie Krentz

Tiffanie Krentz
Shawnee County CDDO Liaison
2701 SW Randolph Avenue
Topeka KS 66611
Ph: 785.506.8677
Fax: 785.235.8041

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Checklist for All Documents Needed to Determine Eligibility

_____**Application for Services**: This form should be completed about the person seeking the services. It must be signed by the person seeking services and the guardian if there is one. If your child is under 18 then the parent should sign it. Must be signed in order to be considered for eligibility.

_____**Referral for I/DD Services**: The information is about the person seeking the services. Contact person is who you want me to contact if I have questions or need additional information.

_____**Authorization for Release of Information**: This is a release that allows me to contact providers about the person seeking services. Please list the school that they attended in the USD box, under Medical you need to list the current primary doctor and any specialist that sees that person. In the Other box, please list any mental health providers or those who have provided services about the individual applying.

_____**Social Security Administration Release**: This release is only needed if the person seeking services receives benefits from SSA.

_____**Diagnostic Records:** Documentation of your diagnosis as determined by licensed professionals, a psychological evaluation, supporting documentation of test/assessments used to determine the diagnosis that meets criteria for IDD Services (see list included with packet).

_____**School Records to include:** IEP, school psychological evaluation, IQ scores/testing and assessments and early childhood records.

_____**Services records including:** Speech, Occupational/Physical Therapy, Tiny K, and Success by Six and any other therapies

_____**Copy of Social Security Card**

_____**Copy of Birth Certificate**

_____**Copy of Medicaid Card (if applicable)**

Community CDDO
Shawnee County
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Eligibility for Services and Supports

To receive services and supports paid for by federal or state funds from KDADS/MH&DD, persons must meet specific eligibility criteria outlined in this section. It is the responsibility of the CDDO to ensure persons supported by developmental disability funds administered by KDADS/MH&DD meet these criteria; however, the CDDO may also hold each of its affiliates responsible for ensuring this. Use of KDADS/MH&DD administered developmental disability funds to provide services and supports to persons who do not meet the eligibility criteria may result in recoupment of those funds from the CDDO.

Consistent with L. 1995, Chap. 234 (Substitute for H.B. 2458) persons who are intellectually or otherwise developmentally disabled are those whose condition presents an extreme variation in capabilities from the general population which manifests itself in the developmental years resulting in a need of life long interdisciplinary services. This identifies those who, among all person with disabilities, are the most disabled as defined below:

Intellectual/Development Disability means substantial limitations in present functioning that is manifested during the period from birth to age 18 years and is characterized by significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable adaptive skill areas:

1. Communication
2. Self-care
3. Home living
4. Social Skills
5. Community use
6. Self-direction
7. Health and Safety
8. Functional Academics
9. Leisure
10. Work

Other developmental disability means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment (or a condition which has received a dual diagnosis of mental retardation and mental illness) and is evidenced by a severe, chronic disability which:

1. Is attributed to a mental or physical impairment or a combination of mental and physical impairments. **AND**
2. is *manifest* before the age of 22, **AND**
3. is likely to continue indefinitely, **AND**
4. results in *substantial limitations* in any three or more of the following areas of life functioning:
    a. self-care,
    b. understanding and the use of language,
    c. learning and adapting
    d. mobility
    e. self-direction in setting goals and undertaking activities to accomplish those goals

f. living independently
g. economic self-sufficiency, **AND**

To further clarify substantial functional limitations, refer to The Eligibility Determination Instrument (EDI) available from MH&DD. This instrument is designed to assist assessing specific areas in which a person demonstrates substantial functional limitations. There is an EDI for adults and one for children.

5. reflects a need for a *combination* and *sequence* of special, interdisciplinary or genetic care, treatment or other services which are *lifelong*, or extended in duration and are *individually planned and coordinated*. **AND**
6. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.

For children under the age of six, developmental disability means a *severe, chronic disability* which:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments**, AND**
2. is likely to continue indefinitely, **AND**
3. results in at least three developmental delays as measured by qualified professionals using appropriate diagnostic instruments or procedures, **AND**
4. reflects a need for a *combination* and *sequence* of special, interdisciplinary or generic care, treatment or other services which are *lifelong*, or extended in duration are *individually planned and coordinated*, **AND**
5. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill.

PROCEDURES:

1. The CDDO (Community Developmental Disability Organization) shall assure that all persons receiving state and/or federal funds meet the I/DD eligibility definition.
2. To receive ICF-I/DD or HCBS/I/DD services an individual must meet the eligibility criteria outlined by the State of Kansas per the Developmental Disability Reform Act.
3. If determined ineligible, a person shall have the right to request a reconsideration of eligibility determination by a third party. The request much be made in writing and forwarded to the Shawnee County CDDO Liaison, 2701 SW Randolph Ave., Topeka, KS 66611
4. If upon reconsideration by a third party the person remains ineligible the person shall have the right to an appeal. The appeal must be filed in writing within 30 days of the ineligible notice and sent to:

Administration Hearings Section
1020 S. Kansas Ave.
Topeka, KS 66612

Shawnee County CDDO
Referral for I/DD Services

Name:	**SS#:**
Address:	**Medicaid #:** **MCO:**
City/ST/Zip:	**DOB:**
Telephone #:	**Contact Person:**
Parent/Guardian:	**Contact Person Telephone #:**
Home Telephone #: **Work Telephone #:**	**Person Making Referral:**
Parent/Guardian:	**Reason for Referral:**
Home Telephone #: **Work Telephone #**	**School/Teacher**
Emergency Contact: **Telephone #:**	**School/Teacher Telephone #:**

Office Use Only

Information Provided: ☐ **HIPAA** ☐ **Affiliate List** ☐ **TCM Choice Form** ☐ **Release of Information**	**Initial Meeting Date: _____** **Basis Date: _____** **CDDO Representative _____**
Follow Up Completed:	**Comments:**

Date Received: _____

CDDO Community
Shawnee County
Community Developmental Disabilities Organization
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Application for Services

Date: _____

General Information:

Legal Name: _____ Preferred **Name:** _____

Street Address: _____

City: _____ **State:** _____ Zip **Code:** _____

Phone home: _____ Work**:** _____ **Cell:** _____

Referred by: _____ **Phone:** _____

Address: _____

Family Information:

Names of Parents and/or Interested Persons:

Name: _____ **Relationship:** _____

Home Address: _____ **Phone:** _____

Business Address: _____ **Phone:** _____

Court Appointed Guardian and/or Conservator: Yes ☐ **No** ☐
(If "yes" attach Guardianship and/or Conservator documentation)

Address: _____

Phone: _____ **County of Court Order:** _____

Emergency Contact if parents or guardian cannot be reached:

Name: _____

Home Address: _____ Phone**:** _____

In DCF (Dept of Children's and Family) Custody: **Yes** ☐ **No** ☐
(If "yes" provide name and telephone number of contact person and documentation of custody)

Services Requested (Mark All That Apply):

Day Services (Including Sheltered Workshop, Supported Employment, Adult Life Skills): _____

Residential Services (Including Group Living, Supported Living, Semi-Independent Living): _____

Target Case Management: _____

In-Home Supports (Supportive Home Care, Respite, and Night Support: _____

Medical Information:

Age of Onset of Disability: _____ **Physical Condition: Good** ☐ **Fair** ☐ **Poor** ☐

Physician: _____

Address: _____ **Phone:** _____

Other Medical Specialists (Eye Doctor, Neurologist etc.)

Physician: _____

Address: _____ **Phone:** _____

Physician: _____

Address: _____ **Phone:** _____

Current Medications:	**Prescribed by:**	**Dosage:**	**Purpose:**

Seizures: Yes ☐ **No** ☐ **Are they controlled? Yes** ☐ **No** ☐

Type of Seizure: _____ **Frequency:** _____

Physical limitations and/or other medical problems:

_____

_____

_____

_____

Insurance Information:

Medical Insurance: Yes ☐ **No** ☐ **Name of Policy Holder:** _____

Policy Number: _____ **Company:** _____

Mailing Address: _____

Medical Card: **Yes** ☐ **No** ☐ **Card Number:** _____

Other: _____

Educational Information:

Name and address of current/last school attended: _____

_____

Highest Grade Completed: _____ **Special Education Classes:** **Yes** ☐ **No** ☐

Work History:

Place:	**Job Description:**	**Dates:**	**Reason for Leaving**
_____	_____	_____to____	_____
_____	_____	_____to____	_____
_____	_____	_____to____	_____
_____	_____	_____to____	_____
_____	_____	_____to____	_____

History: List in chronological order placements, evaluations, examinations in facilities such as hospitals, diagnostic centers, mental health clinics, institutions, work training programs, etc.

Date: _____to____ Facility: _____

Address: _____

Date: _____to____ Facility: _____

Address: _____

Date: _____to____ Facility: _____

Address: _____

Date: _____to____ Facility: _____

Address: _____

Date: _____to____ Facility: _____

Address: _____

Date: _____to____ Facility: _____

Address: _____

Applicant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Authorization for Release of Information

I, _____hereby authorize Shawnee County CDDO to disclose information to, obtain information from, and exchange information with:

☐ Kansas Rehabilitation Services
☐ KDADS/DCF/KDHE
☐ USD _____, Local Education Agency
☐ CSP _____
☐ CSP _____
☐ CSP _____

☐ Medical _____
_____
_____
☐ Other _____
_____
_____

Regarding: _____ DOB: _____ SS#: _____

The written, verbal and electronic information to be disclosed, obtained or exchanged is:

☐ Referral Information
☐ Release of Records
☐ Social History
☐ Services Rendered
☐ Medical
☐ Other _____ (Specify)
☐ Psychological
☐ Education Records

Information is to be used for eligibility determination and continuity of care.

This consent shall remain effective from the date signed unless revoked and/or changed below.
I understand that I may revoke this request in writing at any time except for action already taken. Revocation should be made in writing to: TARC/SNCDDO 2701 SW Randolph, Topeka, KS 66611.

Specify date, event, or condition upon which the consent will expire: _____

_____ I received the CDDO Resource Guide and Affiliated Provider List.
_____ I have been informed of the content in the CDDO Resource Guide, and am aware of choice options; and I declined a copy of the guide.
_____ I consent for my name and address to be shared with all licensed community service providers who request the name and address of persons waiting for services.

This consent authorizes a copy to be considered as valid as the original.

THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON THE REVERSE SIDE

- I understand that under state and federal confidentiality provisions only the information specified can be released to only the specified person or agency.
- I also understand that Shawnee County CDDO cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released.
- I also understand that this authorization is voluntary. I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan or is not otherwise covered under the federal privacy laws and the disclosure may no longer be protected by the federal rules of confidentiality or HIPAA (Health Insurance Portability and Accountability Act). I understand that certain persons or organizations may not re-disclose substance abuse treatment information.
- I also understand that this release will remain valid unless revoked and/or changed.
- I also understand that if I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until:
    - There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.
    - Other time when authorization can be revoked: _____
- I verify that I have asked and received answers to all questions.
- I authorize the use or disclosure of the records/information described. I have read and understand this form.

  I am the person receiving services or the guardian authorized to act on behalf of the person receiving services.
- I understand the photo is part of the CDDOs permanent record to be utilized in the event of an emergency.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian (if appropriate) Date

AGENCY USE ONLY:

Date Information Released: _____ By Whom: _____

Check One: ___By Phone ___By mail ___In Person ___Electronic ___Fax ___Other

PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES, 42 CFR PART 2. THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FUTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR, PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN $500 IN THE CASE OF A FIRST OFFENSE AND NOT MORE THAN $5000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
SN CO. CDDO	2701 SW Randolph Ave. Topeka, KS 66611

***I want this information released because:** Eligibility Determination

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Psychiatric Evaluation

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:**	***Date:**
****Address:**	****Daytime Phone:**
Relationship (if not the subject of the record):	****Daytime Phone:**

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

FAMILY SERVICE & GUIDANCE CENTER

Authorization for Use and Disclosure of Protected Health I

_____ Process Release
_____ Process Obtain
_____ File

Client Last Name	Client First Name	MI	DOB	SSN

I authorize the exchange of information with the following person / agency: SHAWNEE COUNTY CDDO

I authorize Family Service and Guidance Center, Inc. to release or obtain the following written documents via:

☒ **Mail** **A**ddress: 2701 SW Randolph Ave **City**: Topeka **State:** KS **Zip:** 66611
☒ **Electronic - E-mail Address:** tkrentz@sncddo.org
☒ **Fax #:** (785) 235-8041 ☐ **Other:** _____

Release	Obtain	(Please check each applicable entry)
☒	☐	Admission Evaluation Report
☒	☐	Diagnosis Only Report
☒	☐	Treatment Plan(s) Report
☒	☐	Psychiatric Consultation Report
☒	☐	Psychological Evaluation Report
☒	☐	Discharge Summary Report
☐	☐	Medical Report
☐	☐	Hospitalization Screening Report
☐	☐	Progress Review(s) Report
☒	NA	Learning Disorder Reports

Release	Obtain	(Please check each applicable entry)
☐	☐	Progress Notes
Type: _____ Date Range: _____ _____		
Type: _____ Date Range: _____ _____		
☐	☐	Alcohol and Drug Information
☐	☐	Other: _____
NA	☐	____IEP, ____Grades, ____Attendance

☐ **FSGC Clinical Contact Information to School**

COMMUNICATION
I authorize the following form(s) of communication in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding client's treatment including diagnosis.
☒ **Mail (Letter)** ☒ **Electronic (Email)** ☒ **Verbal (Face/Face or Telephone)**

THE PURPOSE OR NEED FOR THE DISCLOSURE (Check all that apply) ☐ **Evaluation / Treatment Planning**
☐ **Case Coordination** ☐ **Legal Proceedings** ☐ **School Placement** ☒ **Other I/DD Eligibility Determination**

I understand this authorization will expire: (Check One)
☒ **90 Days Post Discharge** ☐ **On the following date:** _____ (MM/DD/YY)
☐ **Upon the following specific event**, (Please describe.) _____
I understand that it is my responsibility to inform the FSGC Medical Records Clerk when the noted event is past.

READ CAREFULLY: I understand that under state and federal confidentiality provisions only the information specified can be released to the specified person or agency. (CFR – 42, part 2, KAR 30-60-47(b) (5), AAPS guidelines, Chapter 7). * I understand that FSGC cannot ensure that the recipient will maintain confidentiality of this authorized release of information. * I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of the authorization. * I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations**. *** I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notice of revocation to **FSGC. *** I understand that Protected Health Information provided on portable electronic media will not be encrypted and may be at risk for inadvertent disclosure if lost or stolen. By requesting the use of portable electronic media, I accept this risk. * I understand that fees may be charged for preparing and sending copies of records. * I understand that if I wish to restrict the release of documents or communication I should request the Request to Restrict Uses and Disclosures of Protected Health Information Form.

Parent/Legal Guardian Signature	Printed Name	Relationship to Client	Signature Date

Client Signature if at Least 14 years of Age	Signature Date

FSGC or Agency Staff Witness to Signature	Signature Date

ROI..111218.011419.012519