Shawnee County CDDO
2701 SW Randolph Ave.
Topeka, KS 66611

Application Guidelines for Eligibility Determination

Thank you for your interest in applying for I/DD Services. At this time there is a waiting list for the funding of these services. Please review the list below and complete the forms as indicated. Eligibility will be determined after ALL documents have been received *(Allow up to 5 business days to process your application).*

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.

NOTE:

- ✓ If you are determined eligible, we will notify you in writing of your eligibility and that you need to schedule an appointment with the CDDO to discuss service and support options available to you in Shawnee County.
- ✓ If you are determined ineligible, you will be notified in writing, and we will assist you identifying alternative community options.

IT IS THE APPLICANT'S RESPONSIBILITY TO ENSURE THAT THE FOLLOWING DOCUMENTS ARE DELIVERED TO THE CDDO

- ◯ Copy of your social security card
- ◯ Copy of your birth certificate
- ◯ Copy of you Medicaid card (if applicable)
- ◯ Referral for I/DD Services form
- ◯ Application for Services – completed and signed
- ◯ Release of Information: which authorizes the CDDO to exchange information with any agencies and professionals you are or have been involved with including schools which you are or have attended. The top part of the release must be completed and the lower portion must be signed and dated.
- ◯ 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, Success by Six and any other therapies.
- ◯ 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 MR/DD Services (see list included with packet).

Documents can be mailed or hand-delivered to Shawnee County CDDO.
Faxed records will be accepted from professionals. Fax number (785) 235-8041.

If you have not had a psychological evaluation, have not been assessed, have questions about the process or need more information about what documents are necessary to determine eligibility contact Wendy Gatewood at (785) 232-5083.

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

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 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. Community Developmental Disability Organization shall assure that all persons served with MH&DD funds meet one of the above definitions unless otherwise approved by MH&DD in writing.
2. In order to receive ICF/MR or HCBS/MR services, person must meet additional eligibility criteria outlined in MH&DD Policy HCBS/MR90-1 and the HCBS/MR handbook.
3. If there is a difference of opinion MH&DD/Developmental Disabilities reserves the right to request a third party review.
4. Persons shall have the right to a reconsideration of the eligibility determination by requesting such, in writing, from MH&DD.
5. If upon reconsideration, the determination is unchanged, persons shall have the right to an appeal, which must be filed within 30 days by writing:

Administration Hearings Section
Credit Union One Bldg.
610 W. 10th, 2nd Floor
Topeka, KS 66612

Shawnee County CDDO
Referral for I/DD Services

Name:	**SS#:**
Address:	**Medicaid #:**
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: ☐ **HIPPA** ☐ **Funding Request For Services** ☐ **Case Management Information** ☐ **TCM Choice Form** ☐ **Release of Information**	**Initial Meeting Date:** _____ **Basis Date:** _____ **CDDO Representative** _____
Follow Up Completed:	**Comments:**

Date Received: _____

CDDO Community
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Shawnee County CDDO
Application for Services

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[Ŝ∃l·ƒ bl·YŜY ______________________ **Preferred Name:** ______________________

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City: ______________ **State:** ______________ **Zip:** ______________

Phone home: ______________ **work:** ______________**cell:** ______________

Referred by: ______________________ **Phone:** ______________________

Address: ______________________

Family Information:
Names of Parents and/or Interested Persons:

Name: ______________________ **Relationship:** _____ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

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 SRS 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:**

Seizure: 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: _____ Facility: _____

Address: _____

Date: _____ Facility: _____

Address: _____

Date: _____ Facility: _____

Address: _____

Date: _____ Facility: _____

Address: _____

Date: _____ Facility: _____

Address: _____

Date: _____ 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
☐ 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 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.