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

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Thank you for your interest in the CDDO and I/DD services! You will find enclosed in this packet, several different forms that need to be completed as well as a checklist of documents needed. Please see the comments listed below about each document and if you have additional questions feel free to reach out to me.

- **Application Guidelines for Eligibility Determination**: this is a checklist of all the documents that are required before eligibility can be determined. If you need assistance in obtaining those documents please contact me directly.
- **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. If a medical provider diagnosed the person with a qualifying diagnosis, please list their name. In the Other box, please list any mental health providers. If the person seeking services receives benefits from Social Security, do not put SSA on this release as they have their own release (also included). This release must be signed on the back or it cannot be used.
- **Social Security Administration Release**: This release is only needed if the person seeking services receives benefits from SSA. Complete this for the person seeking services and sign it. If a person is their own guardian then they can sign the form, if not then the guardian needs to sign it.

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.

At any point if you need my assistance please contact me. I can be reached @ 506.8677 or jreling@sncddo.org.
The packet can be delivered, mailed, scanned or faxed to me.

Thank you!

Jess Reling, Liaison
2701 SW Randolph Avenue
Topeka KS 66611
Ph: 785.506.8677
Fax: 785.235.8041
jreling@sncddo.org

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2701 SW Randolph Ave.
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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 your 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**.**
- ◯ **The *Notice of Privacy Practices* form – completed and signed**
- ◯ **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.
- ◯ **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.
Records can be faxed to Jess Reling at (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 Jess Reling at (785) 232-5083.

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 #: 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: ______________________________

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: ____

<u>Educational Information:</u>

Name and address of current/last school attended: ___________________________________

____

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

<u>Work History:</u>

Place:	Job Description:	Dates:	Reason for Leaving
________________________	__________________	______to_____	__________________
________________________	__________________	______to_____	__________________
________________________	__________________	______to_____	__________________
________________________	__________________	______to_____	__________________
________________________	__________________	______to_____	__________________

<u>History:</u> 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: ____

Applicant Signature: ____ Date: __________

Parent/Guardian Signature: ______________________________________ Date: __________

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).*

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:** SN CO. CDDO

***ADDRESS OF PERSON OR ORGANIZATION:** 2701 SW Randolph Avenue
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:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ 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 **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   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 any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain 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:** ______________________________

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)