September 8, 2016

Regarding the referral for Child for ID/DD (Intellectual disability/Developmental Disability) services. Enclosed in your packet is an Application for Services, Guidelines for Eligibility Determination, HIPPA and consents. **All paperwork must be completed in full and returned to me in 30 working days from the date above.**

Please complete consents forms to medical professional who can make the following diagnosis you must Initial and make sure to have a witness sign.

Qualification for the I/DD waiver include having an Intellectual disability that was diagnosis before the age of 18 or a developmental disability diagnosed before the age of 22.

In order to be diagnosed with an Intellectual disability, an individual must be evaluated by a person trained and licensed to make such a diagnosis. This would include a Psychological evaluation with a Full Scale IQ and a DSM-5 of Intellectual Disabled. I cannot except a psychological evaluation completed by a school psychologist unless they are licensed.

If it is a developmental disability I must have documentation from medical person who made the diagnosis before the age of 22 and the person must have at least 3 functional limitations on the Eligibility Determination Instrument that I will complete to qualify for the I/DD waiver.

Please feel to contact me at 620-605-1383.

Lori Hinman

CDDO Coordinator
CDDO of Southeast Kansas
P.O. Box 266
Columbus Ks, 66725
620-605-1383
Fax 620-717-4168

CDDO of SEK

P.O. Box 266/1200 Merle Evans Dr. Columbus, KS 66725
Cherokee, Crawford, Labette & Montgomery Counties

-Application Guidelines for Eligibility Determination-

Thank you for your interest in applying for services and funding for I/DD Services. At this time, there is a waiting list for funding for 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 30 days to process your application.*) You will be contacted by the CDDO Coordinator after eligibility has been determined.

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

Documents can be mailed, faxed or hand delivered to CDDO of SEK. Faxed records will also be accepted from professionals. Fax: (620) 717-4168

- ☐ Copy of **Social Security Card**
- ☐ Copy of **Birth Certificate** (http://www.vitalrec.com)
- ☐ Copy of **Adoption Papers** (if applicable)
- ☐ Copy of **Guardianship Papers** (if you have a legal guardian)
- ☐ Copy of **Military DD 214 form, Tricare verification, & proof of KS residence** (if applicable)
- ☐ Copy of **Medicaid Card** (if you have Medicaid)
- ☐ Copy of **Insurance Card(s)**
- ☐ **Eligibility Application** – completed and signed
- ☐ **Releases of Information** that authorize the CDDO to exchange information with any agencies & professionals you are or have been involved with, including schools which you are or have attended.

  Top portion of Releases must be completed & Lower portion must be Initialed Signed & Dated

- ☐ **Receipt Page for Privacy Policies** - completed and signed

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, please contact Lori Hinman at (620) 605-1383 or Fax (620) 717-4168.

CDDO of SEK

A Community Developmental Disability Organization for Cherokee, Crawford, Labette and Montgomery counties

Application for Intellectual/Developmental Disability (I/DD) Services
All areas must be completed

General Information

Name:			
Date of Birth:	Social Security #:	Medicaid #:	
Address:	City:	State:	Zip Code:
County of Residence:	Home County:	Phone:	
Gender: ☐ Male ☐ Female	Marital Status:	Email:	
MCO: ☐ Amerigroup ☐ Sunflower ☐ United Health Care			
Active Military or Military Dependent & TriCare Echo Eligible? ☐ Yes ☐ No			

Legal Status/Guardianship Information/Contacts

Please check all that apply:

☐ Applicant has a legal guardian appointed by the court
☐ Applicant is over 18 years of age and does **not** have a guardian appointed by the court
☐ Applicant is a ward of the State
☐ Applicant is under the age of 18 years old

Parent Contact Information *(for applicants under 18 years old)*

Parent's Name:	Address:	
City:	State:	Zip:
Phone:	Email:	

Legal Guardian Contact Information *(for applicants 18 years & older or child in custody)*

Guardian's Name:	Address:	
City:	State:	Zip:
Phone:	Email:	
Location of Hearing for Guardianship:		

Other Contact Person Information *(if applicable)*

Name:		Address:	
City:		State:	Zip:
Phone:	Email:	Relationship to Applicant:	

Financial Information

What are your financial resources?

☐ None ☐ Supplemental Security Income (SSI) ☐ Social Security
☐ Employment ☐ Support from family ☐ Other
☐ Medicaid ☐ Private Insurance

Disability / Medical / Psychological Information

List any Diagnoses / Physical Impairments / Medical Concerns:

_____

NOTE: *In order for the CDDO to determine if you meet eligibility requirements, it will be necessary to request supporting documentation. Include the name of the facility where the above diagnoses were made in the section below and please remember to complete a* ***Release of Information****, which is included, for each facility as well.*

Age of onset of Disability: _____ History of Seizures (in the last 5 years): ☐ Yes ☐ No

☐ Evaluations from Medical Hospitals / Diagnostic Centers: (Include Name of City & State)

1. Hospital/Facility Name: _____ Date: (Mo./Yr.)_____
2. Hospital/Facility Name: _____ Date: (Mo./Yr.)_____

☐ History of Mental Health Services / Hospitals: (Include Name of City & State)

1. Hospital/Facility Name: _____ Date: (Mo./Yr.)_____
2. Hospital/Facility Name: _____ Date: (Mo./Yr.)_____

☐ Placement in other I/DD Facilities: (Include Name of City & State)

1. Facility Name: _____ Date: (Mo./Yr.)_____
2. Facility Name: _____ Date: (Mo./Yr.)_____

Family Doctor:	Medical Specialist:
Other:	

Education / Employment Information

Name of Current or Last School Attended:		City / State:	
Highest Grade Level Achieved:	Date of Graduation:	Attended Special Education Classes: ☐ Yes ☐ No	
Involved with Vocational Rehabilitation through DCF (Dept. for Children & Family) ☐ Yes ☐ No		Currently Employed: ☐ Yes ☐ No	If Yes, Name of Employer:

Service Information

Services Requested: ☐ Residential ☐ Personal Care Services ☐ Day ☐ Financial Management Services ☐ Case Management
If funding for services were offered, would you accept them? ☐ Yes ☐ No
If found eligible, do you wish for your name and address to be released to community service providers who are affiliated to provide the services identified as needed? ☐ Yes ☐ No

Signatures

By signing below, I agree that the information contained in this application is correct to the best of my knowledge. I understand that falsification of information on this form may be cause for denial or rejection from services and/or supports. I understand this is a preliminary application and does not guarantee eligibility or funding for I/DD services. I authorize inquiries to be made to verify any and all information on this form.

_____ _____ _____ _____

Applicant Signature Date Parent/Guardian Signature Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

CDDO of Southeast Kansas
1200 Merle Evans Drive
P O Box 266
Columbus KS 66725

Phone: (620) 429-8985
FAX: (620) 429-8723

Client Name:_____ Address: _____
Date of Birth: _____ Social Security Number: _____

I HEREBY AUTHORIZE CDDO OF SEK TO OBTAIN FROM

Name of Individual or Agency: _____

Address, City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

THE FOLLOWING INFORMATION: **(Client/legal representative initial appropriate blank)**

_____ Psychiatric evaluation report.

_____ Summary of alcohol/drug treatment.

_____ Medical Records

_____ Other (Specify)_____

_____ Summary of treatment to include dates of contact, Diagnosis, prognosis, treatment plan, intake case Summary, closing summary and recommendations.

_____ Psychological evaluation report.

_____ Summary of inpatient psychiatric treatment.

_____ School report regarding grades and conduct.

THE PURPOSE OR NEED IS TO:

Obtain information for eligibility for the Intellectual /Developmental Disabled waiver.

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES **ONE YEAR FROM THE DATE SIGNED.**

Client Signature: _____ Date: _____

Printed Name of Client: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____ Relationship: _____

Witness Signature: _____ Printed Name: _____
Title: _____ Agency: _____

The above signed acknowledges that he/she is aware that certain information that he/she is consenting to release is confidential and protected by Federal and State Law. The undersigned acknowledges upon signing this consent that they are waiving their rights under these laws and that they are aware of the specific protections they are afforded or they are waiving their right to being informed of the specific provisions of these laws. Statute 42 CFR – Part 2.

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Printed Name of Parent/Guardian:_____ Relationship: _____

Witness Signature: _____ Printed Name: _____
Title:_____ Agency: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

CDDO OF SOUTHEAST KANSAS

This is to acknowledge my receipt of CDDO of Southeast Kansas Notice of Privacy Practices (effective date September 16,2013) on the date stated below.

Name of
Individual:_____

Signature: (Circle one and Sign/Date)

Legal Guardian

Parent of Minor Child

Individual Who is Own Guardian

_____
(Signature of Individual/ Individual's Representative)\

Printed name

_____

Date Signed_____

Name:

Address:

Yours to Keep

COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (CDDO)

CDDO OF SOUTHEAST KANSAS
NOTICE OF PRIVACY PRACTICES
EFFECTIVE SEPTEMBER 16, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice; you may request a copy at any time.

The information in this Notice will be followed by CDDO of Southeast Kansas, and all workforce members (employees, officers, directors, volunteers, and independent contractors), collectively referred to herein as CDDO.

CDDO is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

HOW CDDO MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

CDDO may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to other persons or organizations involved in your treatment, such as other health care providers, family members, and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying CDDO and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. CDDO provides some services through contracts or arrangements with Affiliates/business associates. We require our Affiliates/business associates to appropriately safeguard your information.

Creation of De-Identified Health Information. We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and Disclosures Required By Law. We will use and/or disclose your information when required by law to do so.

Disclosures for Public Health Activities. We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures About Victims of Abuse, Neglect, or Domestic Violence. We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for Judicial and Administrative Proceedings. We may disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for Law Enforcement Purposes. We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures Regarding Victims of a Crime. In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to Avert a Serious Threat to Health or Safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for Specialized Government Functions. We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Disclosures for Fundraising. We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for its benefit. You have a right to opt out of receiving such fundraising communications.

OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this Notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent CDDO has not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by CDDO. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right to Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures and Access Report. You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request an accounting or an access report, you must complete a specific written form providing information we need to process your request.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. CDDO's Privacy Officer is the only person who has the authority to approve such a request. CDDO is not required to honor your request for restrictions, except if (a) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law, and (2) the protected health information pertains solely to a health care item or services for which you or any person (other than a health plan on your behalf) has paid CDDO in full.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. CDDO's Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with CDDO or with the Secretary of the Department of Health and Human Services. To file a complaint with CDDO, please contact the Privacy Officer, **(Cliff Sperry, HIPAA Privacy Officer, CDDO of Southeast Kansas, PO Box 266, Columbus, KS 66725, call 620-429-8985, or email to cliff.sperry@cddosek.org)**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

CDDO reserves the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.