East Central Kansas Aging and Disability Resource Center
CDDO serving Coffey, Osage and Franklin Counties

2024

APPLICATION FOR INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITY WAIVER SERVICES

Please completely fill out this application. Do not leave any spaces blank. If you have a question about the question or the section, please contact Vicki Seems at the CDDO: 785-242-7200. Please submit the following **mandatory** documentation with this application, as the application **will not** be processed without these documents:

- Copy of Social Security Card
- Copy of Birth Certificate
- Copy of Adoption Papers (if applicable)
- Cody of Medicaid card (if you do not have a Medicaid card, you will need to apply for one)
- Copy of Guardianship papers (if applicable)
- School Records (IEP, School Psychological evaluation, IQ testing/assessments, Early Childhood Records)
- Diagnostic Records: Documentation MUST be given by a professional who is licensed to give a DSM intellectual disability diagnosis. This includes any psychological evaluation, any diagnostic testing for specific disabilities for I/DD (Intellectual and/or Developmental Disabilities)

Name:_____ Date:_____

Maiden name:_____Phone:_____

Date of Birth:_____ Age:_____ Gender: Male Female

Street Address:_____ P.O. Box:_____

City/State/Zip:_____ email address:_____

Medicaid card number: _____Social Security #:_____

Financial Resources: SSI SSDI Vision Card Payee: yes no

Payee contact information if yes (name, address, phone number):_____

Legal Guardian: yes no Name of Legal guardian:_____

Guardian address:_____

Guardian phone number:_____

Marital status: ☐Single ☐Married ☐Widowed ☐Divorced

Gender: ☐Female ☐Male

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date received:_____Processor:_____
3 page form

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I am interested in the following services (please check as many as apply):

☐In-Home Supports ☐Adult Day Service/Alternative ☐Adult Residential Service

☐Employment/Job Coaching ☐Children's Residential ☐ Sleep Cycle Supports

☐Specialized Medical Supports ☐Targeted Case Manager ☐Independent Living Skills Assistance

County Where Services are Needed:

☐Franklin ☐Osage ☐Coffey

MEDICAL/PSYCHOLOGICAL INFORMATION

Diagnosis: _____

Age of onset of disability: _____

History of Seizures (in the past 5 years): Yes No

List any physical impairments/medical concerns:_____

_____

_____

History of Mental Health Services/Hospitals: (include name of treatment facility, city and state)

1. Place name:_____ Date :_____
2. Place name:_____ Date:_____

Evaluations from Diagnostic Centers:

1. Place name:_____Date:_____
2. Place name:_____Date:_____

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Placement in other I/DD Facilities:

1. Place name:_____Date:_____
2. Place name:_____Date:_____

Education Background:

Name of current or last school attended:_____

City/State: _____Highest Grade Level Achieved:_____

Attended Special Education Classes: YES NO Date of graduation: _____

Current Medications:

Current Medication	Reason for Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signatures:

By signing your name below, you agree that the information given in this application is accurate and truthful, to the best of your knowledge and belief.

Applicant signature:_____date:_____

Parent/Guardian signature:_____date:_____

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