EAST CENTRAL KANSAS (ECK) CDDO APPLICATION FOR INTELLECTUAL AND/OR DEVELOPMENTAL (I/DD) WAIVER SERVICES | 2023-2024

117 S. Main, Ottawa, KS 66067

785-242-7200

APPLICATION GUIDELINES FOR DETERMINING ELIGIBILITY FOR FUNDED WAIVER SERVICES

Thank you for your interest in applying for services on the Intellectual and/or Developmental Disability (I/DD) waiver. These services are paid for through the Medicaid card and are available to people who meet the State-set criteria for this funding. **AT THIS TIME THERE IS A WAITING LIST FOR FUNDING FOR THESE SERVICES.** Please review the list of documents needed to make this determination for eligibility. These documents will have to be given to the CDDO in order to make a determination. Please allow up to 30 days to process your completed application with **all** of its supporting documentation. You will be contacted by the CDDO eligibility staff 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 the East Central KS CDDO (Community Developmental Disability Organization) serving Coffey, Osage, and Franklin Counties. Records will also be accepted from professionals via fax, mail, secure email, regular mail, or hand delivery. Fax line for the CDDO is: 785-242-7202.

The following documents are mandatory (must have them in order to process the application):

- Copy of Social Security Card
- Copy of Birth Certificate (http://vitalrec.com)
- Copy of Adoption papers (if applicant has been adopted)
- Copy of Medicaid card (if you do not have a Medicaid card, you will need to apply for one)
- Copy of Guardianship papers (if applicant has a legal guardian)
- Third Party Liability form plus front/back copy of all insurance covering applicant
- Referral form, application form (included in application packet)
- Release of information: authorizes the CDDO to exchange information with all agencies having information necessary to this application. **This form is vital.**
- School Records (IEPs, School Psychological Evaluation, IQ testing/assessments, early childhood records)
- Services Records: Speech, Occupational Therapy, Physical Therapy, Tiny K, Success by Six and all other therapies related to the application for I/DD waiver services
- Diagnostic Records: Documentation for an intellectual disability MUST be given by a professional who is licensed to give a DSM intellectual disability diagnosis. This is generally **not** a document by a school psychologist. This includes any psychological evaluation, any diagnostic testing for specific disabilities for I/DD.

**If you have not had a psychological evaluation, have not been assessed, have questions about the process, or need more information about this important document, please call your local Mental Health agency (Elizabeth Layton Center for Franklin County, Mental Health Center of East Central Kansas for Coffey County, and Crosswinds for Osage County). If you have any questions about this application or the indicated supporting documents, please call Jacqualynn Branch at: 785-242-7200.

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 Jacqualynn Branch 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

CDDO Section: CDDO Application form rev. 3/1/2020
date received: Processor:

3 page form

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

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:_____

EAST CENTRAL KANSAS COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (ECK CDDO)

APPLICATION STATEMENT FOR INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITY DETERMINATION

I wish to apply for Intellectual and/or Developmental Disability Services: ☐ **YES** ☐ **NO**

Applicant's Name: _____ **Date of Birth:** _____

Community Developmental Disability Organization (CDDO) and Community Service Provider (CSP) Differences

EAST CENTRAL KANSAS, as the Community Developmental Disability Organization (ECK CDDO), serves as the 'gatekeeper' or sole point of entry to community services for individuals with intellectual and/or developmental disabilities in Coffey, Franklin, and Osage Counties. For a person to receive services, it must be determined that they have a primary diagnosis of intellectual disability (ID) and/or developmental disability (DD).

Community Service Providers (CSP) provide services, subject to available funding, to individuals who have been determined eligible for I/DD services by the CDDO. Community Service Providers are affiliates (contracted providers) of the CDDO and must demonstrate their ability to provide quality services pursuant to state and federal regulations.

STATEWIDE WAITLING LIST FOR FUNDING

Individuals who are eligible for I/DD services and waiting for funding are added to the statewide waiting list. **Individuals must wait for funding to become available in order to receive services.** The state will allocate funding, when it is available based on the individual's request date for services. The CDDO must provide priority to eligible individuals who meet the criteria for crisis (for example: a sudden loss of natural supports creating situations of imminent harm) and need immediate support to continue living safely in the community. The waiting list for Home and Community Based Services (HCBS) (through the Medicaid card) is currently ten (10) years long.

If you are determined eligible for I/DD services, the CDDO representative will meet with you to determine the type(s) of service(s) you need to achieve your preferred lifestyle. Your name is added to the statewide waiting list when the CDDO enters the information gathered during the functional assessment, and that assessment is entered, upon tiering between 1-5. Tier 0 clients cannot be added to the wait list and shall be assessed every year until tiering between 1-5. Special circumstances, which may warrant crisis funding, should be discussed with the CDDO representative. While waiting for funding, you may contact the CDDO to request your status on the waiting list.

If the funding for service(s) you are requesting is offered, will you accept that funding? ☐ **YES** ☐ **NO**

RELEASE OF REFERRAL INFORMATION and STATEMENT OF RESPONSIBILITY OF INFORMED CHOICE

Do you authorize ECK CDDO to release information including, but not limited to, your name and type(s) of service(s) you are requesting to Community Service Providers who may inquire about individuals on the service access list?

☐ **YES** ☐ **NO**

While I am waiting to receive funding for services I request, I understand that I should contact Community Service Providers and complete their application if I wish to seek services from that provider when funding is available.

☐ **YES** ☐ **NO**

SIGNATURE OF ACKNOWLEDGEMENT

By signing below, I acknowledge that this application does not guarantee eligibility for I/DD services, nor does it guarantee funding for services if I am determined eligible for I/DD services.

_____ _____

Applicant Signature Date

_____ _____

Guardian/Responsible Party Signature Date

East Central Kansas
Area Agency On Aging
Serving - Anderson - Coffey - Franklin - Linn - Miami - Osage

the CDDO of Coffey, Osage & Franklin Counties

117 South Main - Ottawa, Ks 66067 • (785) 242-7200 • (800) 633-5621 • www.eckaaa.org

Release of Information Form

Name: _____ Date of Birth: _____

Medicaid Number: _____ Phone Number: _____

Address: _____ City/State/Zip Code: _____

I authorize East Central Kansas Area Aging on Aging, **Community Developmental Disability Organization (CDDO) of Coffey, Osage and Franklin Counties**: 117 S. Main, Ottawa, KS 66067; to obtain or disclose information with the individuals and agencies listed below:

- **Medical/MCO**: _____
- **Relatives/Non Guardian/Friends**: _____
- **School/Vocational Rehabilitation/Transition Services**: _____
- **Psychological** (IQ testing, psych evaluations, etc): _____
- **CDDO**: ECK CDDO; _____
- **DCF/KDADS/SRS/Foster Care Agency**: KDADS; KDHE Clearinghouse; Department of Children & Families: Disability Rights Center
- **Law Enforcement/Legal**: _____

****Service Provider**: _____

Specific description of the information to be used or disclosed:

☒ IQ testing which indicates a full-scale IQ and tests related to adaptive skills
☒ Diagnosed Developmental Disabilities and areas of substantial functional limitations such as:
self-care, understanding and use of language, learning and adapting, self direction in goal setting, mobility, living independently, economic self-sufficiency

☒ Individualized Education Plan/Individualized Family Support Plan
☒ Current Funding and Service information
☐ Other: _____

The information may be used or disclosed for each of the following purposes:

☒ Eligibility Determination for I/DD services ☒ Communication
☒ Referral to services ☒ Crisis-Exception services ☐ Other: _____

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. I understand that I may revoke this authorization by notifying the Executive Director, 117 S. Main, Ottawa, KS 66067 in writing of my desire to revoke it. I understand revoking this authorization will not have any affect on actions taken by the East Central Kansas (ECK) CDDO, in reliance on this authorization. I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

☒ This authorization will expire ***One Year from Date of Signature*** **Or** on the occurrence of the following: _____

_____ _____
Witness Signature Individual's Signature/Date

_____
Designated Representative Signature/Date

_____
Legal Guardian Signature/Date

the CDDO of Coffey, Osage & Franklin Counties

EAST CENTRAL KANSAS COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (ECK CDDO)
Coffey, Osage, and Franklin Counties

THIRD PARTY LIABILITY FORM

Return this form to the CDDO along with a copy of all insurance cards

Name: _____ Medicaid #_____

☐ **Individual has Medicaid only** (*Proceed to Consent and Notifications Section*)

Primary Insurance Policy Information (includes Medicare)

Name of Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip _____

Insurance Company Phone number _____

Name of Insured _____

Policyholder name _____

Relationship to beneficiary _____

Policyholder Address _____

City _____ State _____ Zip _____

Policyholder Date of Birth _____ Policyholder Social Security# _____

Policy group number _____ Policy Number _____

A copy of your insurance card(s) (front and back) must be presented annually.

Consent and Notifications

In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event your insurance coverage changes, you will be required to submit the new information.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance carrier. This constitutes advance notice to you, the beneficiary, that if all program requirements are met (by the provider) and payment is not made by your insurance and/or Medicaid, you may be responsible for the charges if services are not covered (by your insurance and/or Medicaid).

Acknowledgement:
I have read and understand the above statement and agree to all provisions outlined herein.

Consent:
I authorize the release of any medical or other information necessary to process a claim. I hereby give my consent to the provider(s) listed above to bill my insurance and/or Medicaid and receive payment for services rendered.

_____ _____
Signature of Individual or Responsible Party Date

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Printed Name of Client	Maiden Name (If Applicable)	Last 4 digits of SSN	DOB

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency (if individual is listed, identify relationship to client):_____

Address_____City: _____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ **Elizabeth Layton Center - Franklin County**
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

CROSSWINDS
COUNSELING & WELLNESS

1000 Lincoln Emporia, KS 66801 Phone: 800 279-3645 Fax: 620 342-1021

Please select action needed:

☐	Send Records
☐	Request Info
☐	Service Letter
☐	File in Chart
☐	Send release only

Authorization for the Disclosure of Protected Health Information

Including Mental Health Information and/or Alcohol and Drug Records

Client First Name:		Client MI:		Client Last Name:	
Date of Birth:		Address:			
City/State/Zip:		SSN:		Telephone #:	

The information may be released to/obtained from:

Name/Agency:	
Specific Staff/Title:	Email:
Address:	Telephone #:
City/State/Zip:	Fax #:

I agree that the **PURPOSE OR NEED FOR DISCLOSURE** is indicated below: (Please review and select below)

☐ To Coordinate Treatment/Consultation ☐ To Advise the Court/Attorney/CRB ☐ To Transfer Treatment Providers
☐ To Involve Family in Treatment ☐ To testify or participate in court proceedings
☐ Other (specify): _____

I, the undersigned (client or Legal Representative) hereby authorize **CrossWinds Counseling & Wellness:**

(If not completed on computer, boxes will need to be initialed by client/legal representative)

Crosswinds to: **Release**	Crosswinds to: **Obtain**	
☐	☐	Any Mental Health Treatment Records, which are minimally necessary, including the diagnosis and records of any treatment or evaluations rendered to me.
☐	☐	Any Alcohol, Drug or Substance Abuse information.
	☐	Medical/Lab Reports.
	☐	School reports regarding grades and conduct.
☐	☐	Other (Specify):

VERBAL COMMUNICATION

☐ I authorize verbal communication with the entity listed above in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above named client's treatment.

DISCLOSURE LIMITATIONS: The information indicated will be disclosed unless there are specific restrictions noted below:

THIS DOCUMENT IS NOT VALID UNLESS ACCOMPANIED WITH A SIGNATURE PAGE

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

4000 Cambridge Street
Kansas City, Kansas 66160

Do not write in this box

DT4068
Request for Records

Medical Record #: _____

Account #: _____

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

All sections of this authorization form MUST be completed to be considered valid

Applies to The University of Kansas Health System- Kansas City and Great Bend Campus

Patient Last Name: _____ **First Name:** _____ **MI:** _____ **Date of Birth:** ___/___/___
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
E-Mail Address: (Optional) _____ **Phone:** _____

I request my records to be sent to :

Name _____ Phone: _____
Address: _____
City/State _____ Zip Code _____ Fax Number: (Health Care Provider Only) _____
E-Mail Address: _____

I request the following PHI to be released from my medical record(s):

Campus: ☐ Kansas City & surrounding areas ☐ Great Bend Campus (Cleveland St) ☐ St. Rose Medical Pavilion ☐ Great Bend Family Medicine (Polk)
☐ Central KS Orthopedic Group

☐ Pertinent (Inpatient Summary which includes physician reports, lab, radiology and other test results)
☐ Emergency Room Record
☐ Clinic records – specify clinic or physician: _____
☐ Lab Reports ☐ Radiology/Imaging Reports ☐ Discharge Summary ☐ Operative/Pathology Reports ☐ Immunizations
☐ Mental Health Records – Includes Inpatient and/or ambulatory office visit notes.
☐ Complete medical Record
☐ Billing Records
☐ Radiology film/tracing/media
☐ Other/Outside (please specify): _____
☐ Psychotherapy notes There are no psychotherapy notes in inpatient settings, nor most office visits. A separate form requesting only psychotherapy notes must be completed if these notes are requested.)

Covering the period of health care from:

☐ Specific date(s): _____ to _____ OR ☐ All dates of encounters/visits.

Purpose for requesting information:

☐ Continuing Care ☐ Personal
☐ Insurance ☐ Legal
☐ Other: _____

How are we to send the requested information:

Records will be released electronically rather than on paper if possible.
Fee may apply for records in paper format.
☐ Secure E-Mail ☐ Fax (to health care provider only)
☐ CD (electronic format) ☐ Paper

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- Medical record information may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Health Information Management. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____
  If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure on information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I have a right to receive a signed copy of this authorization.

Patient/Authorized Representative Signature* _____ Date _____ Time _____
Printed Name of Authorized Representative: _____ Relationship to Patient: _____
*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID *(required when records are picked up)* Driver's License State: _____ Number: _____

Witness Signature _____ Date _____ Time _____

Send completed form to: The University of Kansas Health System – Health Information Management
4000 Cambridge St, MS 9345 Kansas City, KS 66160
Attach Signed Form to E-Mail: ROI@kumc.edu or Fax: 913-588-2495
https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION