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

2019

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 Amber Vogeler 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:_____

Placement in other I/DD Facilities:

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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:_____

Release of Information Form

EAST CENTRAL KANSAS COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (CDDO) SERVING COFFEY, OSAGE, and FRANKLIN COUNTIES

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; _____
- **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