Harvey-Marion County CDDO

Supporting increased independence, integration, inclusion, and productivity in individual homes and communities.

Application for Intellectual/Developmental Disability (I/DD) Services

General Information

Name:	Address:
City:	State: Zip:
County:	Phone: ☐ Cell ☐ Landline
What county do you consider to be your home:	Marital Status: ☐Married ☐Single
Date of Birth:	Sex: ☐Male ☐Female
Social Security #:	KanCare/Medicaid #:
Email (*required*):	

Race (Check One):

☐Native American ☐African American ☐Hispanic

☐Asian/Pacific Islander ☐Caucasian ☐ Other

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 programs/services. I understand this is a preliminary application. I authorize inquiries to be made to verify all information on this form.

Individual/Legal Representative:_____ Date:_____

HMCDDO Representative:_____ Date:_____

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Disabilities	Age at Onset of Disabilities
Primary:	
Other:	
Other:	
Other:	

Legal decision-making Supports for Applicant - Check all that apply:

___1 Child in need of care (DCF custody)
___2 Guardian (Court-appointed)
___3 Conservator (Court-appointed)
___4 Social Security Payee
___ 5 Natural Guardian (parent of child under age 18)
___ 6 Personal Representative
___ 7 Responsible for Self – Age 18+

If you have checked #1,2,3,4,5, or 6, Please fill out the following:

Name:	Phone (Home) Phone (Work)
Address:	City:
State: Zip:	Court Case #:
County of Guardianship/Conservatorship Hearing:	

If under the age of 18, is applicant in foster care? _____Yes _____No

If yes, please give the foster parents name:

Child placement agency caseworkers and phone numbers:

Has applicant ever resided in any of the following state hospitals:

Kansas Neurological Institute, Parsons, Winfield, or Norton? _____Yes_____No

Rainbow (Kansas City), Larned, Osawatomie? _____Yes_____No

Have applicant ever resided in a nursing facility or private ICF? _____Yes_____No
If yes, Where?
_____

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Please list all programs and/or professionals you have worked with: _____ _____ _____

Medical Information

Physician or Psychologist that diagnosed primary condition:
Contact Information of Physician/Psychologist:
Primary Care Physician:
Specialist:
Specialist:
Specialist:
History of seizures: _____Yes _____No Date of last seizure:
Describe type/frequency:

Emergency Contacts

Name:	Relationship:
Address:	Phone:
City:	State: Zip:
Name:	Relationship:
Address:	Phone:
City:	State: Zip:

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Service/Support Information - What are you applying for?

Case Management?	_____Yes _____No
Help with care in the family home?	_____Yes _____No
Adult Day Supports after public school ends?	_____Yes _____No
Adult Supported Employment to get a job?	_____ Yes _____No
Adult Residential Supports outside family home?	_____ Yes _____No