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

CONSUMER NAME		GENDER		M		F
DOB		COUNTY				
ADDRESS		CITY/STATE				
KANCARE #		SOCIAL #				

Primary Contact for Updates (Email & Cell): We require the email address and cell phone number for the individual designated to receive application updates and progress reports from the HMCDDO.

CONTACT NAME:		**RELATIONSHIP:**	
EMAIL:		**PHONE:**	

CHECK ALL THAT APPLY: Legal Decision-Making Supports for Applicant

	Child in need of care (DCF Custody)		*Natural Guardian (parent of child under 18)*
	Guardian (Court appointed)		*Personal Representative*
	Conservator (Court appointed)		*Social Security Payee*

If you have checked any of the above, please complete below:

Name		Address	
Email		City	
Phone		State	

If you are Guardian or Conservator, please list County that case was filed in:

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:				

Emergency Contacts

Name		*Relationship*	
Address		*City/State/Zip*	
Email		*Phone*	
Name		*Relationship*	
Address		*City/State/Zip*	
Email		*Phone*	

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Diagnostic Information Section: Programmatic Eligibility Criteria:

Consistent with K.S.A. 39-1803 (f) and (h), individuals who are residents of Kansas and who have an intellectual or developmental disability are those whose condition presents an extreme variation in capabilities from the general population which manifests itself in the developmental years resulting in a need for life long interdisciplinary services.

Intellectual Disability: A diagnosis of intellectual disability shall be made by a healthcare or mental health professional licensed to make a current (at the time of diagnosis) DSM diagnosis. An Intellectual Disability is defined by K.S.A. 39-1803 as: Substantial limitations in present functioning; and is ***manifested during the period from birth to 18 years*** *of age*; and characterized by significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior including related *limitations in two (2) or more of the following applicable adaptive skill areas*: Communication, Self-care, Home living, Social skills, Community use, Self-direction, Health and safety, Functional academics, Leisure, or Work.

Developmental Disability: A diagnosis of a Developmental Disability shall be made by a healthcare or mental health professional licensed to make a current DSM diagnosis. A Developmental Disability is defined as an intellectual disability; or a severe, chronic disability which is attributable to a physical or mental impairment, a combination of mental and physical impairments or a condition which has received a dual diagnosis of intellectual disability and mental illness; *and has* ***manifested before the age of 22*****;** and is likely to continue indefinitely; and results, in the case of a person five (5) years of age or older, in substantial functional *limitations in three (3) or more of the following areas of life functioning*: Communication, Self-care, Home living, Social skills, Community use, Self-direction, Health and safety, Functional academics, Leisure, or Work.

QUALIFYING DIAGNOSTIC INFORMATION

Intellectual Disability:		Mild		Moderate		Severe
****IQ Score from a Doctor/Psychologist:***						
Developmental Disability:		Cerebral Palsy				Autism
	Fetal Alcohol Syndrome		Epilepsy			Down Syndrome
	Muscular Dystrophy		Traumatic Brain Injury (TBI)			Hydrocephalus
	Fragile X		Huntington's Chorea			Other
If "other" is checked above, please list that diagnosis here:						

PHYSICIAN OR PSYCHOLOGIST THAT DIAGNOSED CONDITION

	NAME
PHYSICIAN / PSYCHOLOGIST	
PRIMARY CARE	
SPECIALIST	
SPECIALIST	

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	

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Receipt Notification of the Harvey-Marion CDDO Privacy Practices

My signature/date below verifies that I have received the HMCDDO's Notice of Privacy Practices

(effective date July 1, 2007, Revised January 9, 2012)

Individual Name:	
Address:	
City/State/Zip:	
Individual's Signature:	
Date:	

(If Applicable)

Guardian Name:	
Address:	
City/State/Zip:	
Guardian's Signature:	
Date:	

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AUTHORIZATION TO DISCLOSE INFORMATION

Harvey-Marion County CDDO
500 Main Place, Suite 204, Newton, Kansas 67114
Phone 316-283-7997; FAX 316-283-7969

Individual whose information is to be disclosed:

Name: _____

Address: _____ City/State/Zip_____

Social Security #: _____ Date of Birth: _____

Agency authorized to disclose the information:

Name: _____

Address: _____

City/State/Zip:_____ Phone: _____ Fax: _____

Agency authorized to request and receive the information:
Harvey-Marion County CDDO: 500 N. Main Street, Suite #204; Newton, KS 67114;
Phone 316-283-7997; FAX: 316-283-7969

Purpose for which the information may be used or disclosed: *To determine eligibility for State of Kansas services and funding for individuals with intellectual/developmental disabilities.*

Description of the Information to be used or disclosed: *Medical records, psychiatric records, psychological testing, and/or any assessments and evaluations associated with diagnosis of intellectual and/or developmental disability condition(s) and associated adaptive functioning.*

Expiration Date of this authorization: *180 days from date signed.*

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 Harvey-Marion County CDDO, in writing of my desire to revoke it. However, I understand that if I revoke the authorization, it will not have any effect on actions taken by the Harvey-Marion County CDDO in reliance on this authorization (disclosures prior to my written request to revoke).

_____ _____
Signature of Individual Date Signed

_____ _____
Signature of Legal Representative / Relationship to Individual Date Signed

_____ _____
Signature of Witness if Individual Signs by Mark & has no Legal Representative Date Signed