Harvey-Marion County CDDO

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

Dear Applicant,

Thank you for contacting the Harvey-Marion County CDDO regarding services and supports for persons with intellectual and other developmental disabilities.

Enclosed you will find the following items:

- Your copy of the Harvey-Marion County CDDO Notice of Privacy Practices
- Your copy of the definition of eligibility for services for persons with developmental disabilities funded by State of Kansas
- A resource list for obtaining a psychological evaluation and a medical examination
- An application for eligibility determination
- A medical examination form
- Psychological evaluation guidelines
- Release of information forms
- Acknowledgment of Receipt of Notice of Privacy Practices form

Your application will be considered complete when we have received all of the following items:

- ☐ Completed, signed Acknowledgment of Receipt of Notice of Privacy Practices
- ☐ Completed, signed application form
- ☐ Completed, signed release forms
- ☐ A psychological evaluation
- ☐ A medical examination
- ☐ A copy of current health insurance (KanCare, Medicare, other health insurance plan)
- ☐ If applicable: Letters of Guardianship, or Durable Power of Attorney documents, or Child In Need of Care Journal Entry signed by Judge and Case Plan

We will keep your application status open for *up to six months* while you gather the necessary items. After six months, if your application is still incomplete, we will consider your application inactive and closed out. A new application will be necessary.

If you have any questions, or it you need help with any part of this process, feel free to call our office at (316)-283-7997 and ask for Kevin.

Sincerely,

Kevin Gaeddert
Executive Director

Harvey-Marion County CDDO

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

General Information

Name:	Address:
City:	State: Zip:
County:	Phone:
What county do you consider to be your home:	Marital Status: ☐Married ☐Single
Birth Date:	Sex: ☐Male ☐Female
Social Security #:	Medicaid #:
Email:	

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 any and 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:	

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 a guardian has not been appointed, is one needed? _____Yes _____No

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, or Topeka? _____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

Primary Physician:
Specialist(s):
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

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Harvey-Marion County CDDO

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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:	
Individual's Signature:	
Date:	

Harvey-Marion County CDDO

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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

HARVEY-MARION COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

REVISION DATE: 5-21-18 FAX#: 316-283-7969

PHYSICAL EXAMINATION FORM

PART 1: COMPLETED BY APPLICANT (DOCTOR: PLEASE VERIFY)

NAME: ____ **BIRTH DATE:**__________________________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CHECK):

- ❑ FREQUENT HEADACHES
- ❑ DIFFICULTY WITH VISION
- ❑ DIFFICULTY WITH HEARING
- ❑ CONVULSIONS OR SEIZURES (FREQUENCY_____________)
- ❑ UNUSUAL IRRITABILITY
- ❑ DIFFICULTY WITH MEMORY
- ❑ CHOKING ON FOOD/FLUID
- ❑ FAINTING
- ❑ UNUSUAL WEIGHT GAIN/LOSS
- ❑ DIARRHEA OR CONSTIPATION
- ❑ LOSS OF APPETITE
- ❑ HEMORRHOIDS
- ❑ FREQUENT INDIGESTION
- ❑ HERNIA OR "RUPTURES"
- ❑ VARICOSE VEINS OR LEG ULCERS
- ❑ FEVER OR NIGHT SWEATS
- ❑ COUGH PRODUCING BLOOD
- ❑ PERSISTENT COUGHING
- ❑ TUBERCULOSIS
- ❑ EXCESSIVE FATIGUE
- ❑ PAIN IN CHEST
- ❑ SHORTNESS OF BREAT
- ❑ ASTHMA OR HAY FEVER
- ❑ SWOLLEN ANKLES
- ❑ PAIN IN CHEST
- ❑ SHORTNESS OF BREATH
- ❑ ASTHMA OR HAY FEVER
- ❑ SWOLLEN ANKLES
- ❑ ARTHRITIS/SWOLLEN JOINTS
- ❑ PERSISTENT/ RECURRING SKIN RASHES/LESIONS
- ❑ BURNING UPON URINATION
- ❑ BLOOD IN URINE
- ❑ NERVOUS BREAKDOWN
- ❑ HEART ATTACK
- ❑ STROKE
- ❑ SEXUALLY TRANSMITTED DISEASES
- ❑ DIABETES
- ❑ HYPOGLYCEMIA
- ❑ HEPATITIS
- ❑ BED WETTING
- ❑ PMS
- ❑ FRACTURES (DESCRIBE/DATE)____________
- ❑ OPERATIONS (DESCRIBE/DATE)
- ❑ OTHER HOSPITALIZATIONS (DESCRIBE/DATE)
- ❑ SERIOUS INJURIES (DESCRIBE/DATE)_______
- ❑ FOOD ALLERGIES (SPECIFY)_______________
- ❑ DRUG ALLERGIES (SPECIFY)_______________

PART 2. COMPLETED BY PHYSICIAN.
LAB/IMMUNIZATION RECORD (GIVE LAST DATE FOR EACH, ATTACH LAB WORK WHEN POSSIBLE):

TB TEST: / / ☐ NEGATIVE ☐ POSITIVE		BLOOD WORK: / / ☐ CBC ☐ SMAC ☐ VDRL	
CHEST X-RAY (NECESSARY ONLY FOR POSITIVE TB OR THOSE UNABLE TO TAKE TB TEST) ☐ NEGATIVE ☐ POSITIVE		HEPATITIS B: / / ☐ NEGATIVE ☐ POSITIVE	
TETANUS:	MUMPS:	MEASLES:	RUBELLA:
POLIO:	DPT/DT:	U/A:	OTHER:

IS PATIENT NOW UNDER YOUR CARE OR ANY OTHER PHYSICIAN? ☐ YES ☐ NO

IF YES, GIVE NATURE OF CONDITION AND PLAN FOR TREATMENT:

PHYSICAL EXAMINATION (DEVIATIONS FROM NORM SHOULD BE DESCRIBED:)

HEIGHT: ____ ft. ____ in. WEIGHT: _____lbs.	TEMPERATURE: _____ f
BLOOD PRESSURE:	PULSE:
VISION: _____ right _____ left OTHER FINDINGS:	

HEARING: _____ right _____ left	OTHER FINDINGS:
NOSE:	THROAT:
MOUTH:	NECK:
LYMPHATIC SYSTEMS:	BREASTS:
LUNGS: _________ right _________ left	CARDIOVASCULAR SYSTEM:
ABDOMEN:	HERNIA:
GENITO-URINARY:	ANO-RECTAL:
NERVOUS SYSTEM:	SKIN:
FEET:	VARICOSE VEINS:

DIAGNOSIS	**ICD CODE**
1___	1___
2___	2___
3___	3___
4___	4___
5___	5___

DO YOU HAVE KNOWLEDGE OF SUBSTANCE ABUSE BY THIS INDIVIDUAL? ☐ YES ☐ NO

PROGNOSIS:

IS THE PATIENT'S CONDITION EXPECTED TO EXHIBIT DETERIORATION OR IMPROVEMENT? EXPLAIN:___

ACTIVITIES TO BE AVOIDED:	WEIGHT RESTRICTIONS:

ADAPTIVE DEVICES: WHAT DEVICES ARE USED AND WHEN ARE THEY NEEDED? ___

LIST ALL MEDICATIONS, NON-PRESCRIPTION AND PRESCRIPTION, CURRENTLY BEING TAKEN BY THIS PERSON

MEDICATION	PRESCRIBING DR.	PURPOSE	DOSAGE	FREQUENCY
1___	1___	1___	1___	1___
2___	2___	2___	2___	2___
3___	3___	3___	3___	3___
4___	4___	4___	4___	4___
5___	5___	5___	5___	5___
6___	6___	6___	6___	6___

RECOMMENDATIONS/COMMENTS:

PHYSICIAN'S SIGNATURE: ___ DATE:___
PHYSICIAN'S PRINTED NAME: ___
PHYSICIAN'S ADDRESS AND PHONE NUMBER: ___

Name:______________________________________

Prairie View Case Number:______________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Printed Name: ________________________________

Address: ________________________________

____

Date of Birth: ________________________________

Purpose of Disclosure:

___ to coordinate treatment

___ at the request of the patient

___ other:____________________________

I authorize

Prairie View
1901 East First Street
PO Box 467
Newton, KS 67114

___ to exchange information with:

___ to disclose information to:

___ to obtain information from:

Name:____________________________________

Address:__________________________________

____

____

Phone: (home)____________________________

(cell)____________________________________

(business/work)_______________________

Fax:______________________________________

Check appropriate blanks:

_____ **Hospital Inpatient** – psychiatric assessment, history & physical, lab, psychological testing report, discharge summary

_____ **Addictions Inpatient** – psychiatric assessment, substance abuse assessment, history & physical, lab, psychological testing report, progress reports, discharge summary

_____ **Partial Hospital** – psychiatric assessment, discharge summary

_____ **Psychiatric Residential Treatment Facility** – psychiatric assessment, psychological testing report, discharge summary

_____ **Outpatient** – admission assessment, list of medications

_____ **School records** – school progress notes, school intake evaluation, grades, attendance, IEP

_____ **Treatment plan**

_____ **Psychiatric Assessment**

_____ **Psychological testing report**

_____ **Substance abuse assessment**

_____ **Sex offender assessment**

_____ **Therapy notes** (last 6 months)

_____ **Medication checks** (last 6 months)

_____ **Lab reports** (last 6 months)

_____ **Entire** record – including correspondence and fee information

_____ **Other**:____

Expiration Date:______________________ (one year from date signed if not otherwise specified)

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to revoke the authorization, except to the extent action has been taken or it has been relied on, by putting my revocation in writing and delivering it to Prairie View. I understand that information disclosed under the authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy rules. I understand that I will receive a copy of this authorization.

____
Printed Name of Patient

____
Signature of Patient

Date:__________________ Time:________________

OR

____
Printed Name of Representative

____
Signature of Representative

____
Description of Representative's Authority
(i.e. Legal Guardian or Durable Power of Attorney)

____
Address Line 1

____
Address Line 2

Phone:__________________________

Date:____________________ Time:______________

____
Prairie View Representative

Date:__________________ Time:________________