CDDO of SEK

A Community Developmental Disability Organization for Cherokee, Crawford, Labette and Montgomery counties

Application for Intellectual/Developmental Disability (I/DD) Services
All areas must be completed

General Information

Name:			Date of Birth:	
Social Security #:			Medicaid #:	
Address:			City:	State:
Zip Code:	County of Residence:	Home County:	Phone:	
Gender: ☐ Male ☐ Female		Marital Status:	Email:	
MCO: ☐ Aetna ☐ Sunflower ☐ United Health Care				
Active Military or Military Dependent & TriCare Echo Eligible? ☐ Yes ☐ No				

Legal Status/Guardianship Information/Contacts

Please check all that apply:

☐ Applicant has a legal guardian appointed by the court
☐ Applicant is over 18 years of age and does **not** have a guardian appointed by the court
☐ Applicant is a ward of the State
☐ Applicant is under the age of 18 years old

Parent Contact Information *(for applicants under 18 years old)*

Parent's Name:	Address:	
City:	State:	Zip:
Phone:	Email:	

Legal Guardian Contact Information *(for applicants 18 years & older or child in custody)*

Guardian's Name:	Address:	
City:	State:	Zip:
Phone:	Email:	
Location of Hearing for Guardianship:		

Other Contact Person Information *(if applicable)*

Name:		Address:	
City:		State:	Zip:
Phone:	Email:	Relationship to Applicant:	

Financial Information

What are your financial resources?

☐ None ☐ Supplemental Security Income (SSI) ☐ Social Security
☐ Employment ☐ Support from family ☐ Other
☐ Medicaid ☐ Private Insurance

Disability / Medical / Psychological Information

List any Diagnoses / Physical Impairments / Medical Concerns:

____

NOTE: *In order for the CDDO to determine if you meet eligibility requirements, it will be necessary to request supporting documentation. Include the name of the facility where the above diagnoses were made in the section below and please remember to complete a **Release of Information**, which is included, for each facility as well.*

Age of onset of Disability: ____________ **History of Seizures** (in the last 5 years): ☐ Yes ☐ No

☐ **Evaluations from Medical Hospitals / Diagnostic Centers:** (Include Name of City & State)

1. **Hospital/Facility Name:** ________________________________ **Date:** (Mo./Yr.)________
2. **Hospital/Facility Name:** ________________________________ **Date:** (Mo./Yr.)________

☐ **History of Mental Health Services / Hospitals:** (Include Name of City & State)

1. **Hospital/Facility Name:** ________________________________ **Date:** (Mo./Yr.)________
2. **Hospital/Facility Name:** ________________________________ **Date:** (Mo./Yr.)________

☐ **Placement in other I/DD Facilities:** (Include Name of City & State)

1. **Facility Name:** ____ **Date:** (Mo./Yr.)________
2. **Facility Name:** ____ **Date:** (Mo./Yr.)________

Family Doctor:	**Medical Specialist:**
Other:	

Education / Employment Information

Name of Current or Last School Attended:		City / State:	
Highest Grade Level Achieved:	Date of Graduation:	Attended Special Education Classes: ☐ Yes ☐ No	
Involved with Vocational Rehabilitation through DCF (Dept. for Children & Family) ☐ Yes ☐ No		Currently Employed: ☐ Yes ☐ No	If Yes, Name of Employer:

Service Information

Services Requested: ☐ Residential ☐ Personal Care Services ☐ Day ☐ Financial Management Services ☐ Case Management
If funding for services were offered, would you accept them? ☐ Yes ☐ No
If found eligible, do you wish for your name and address to be released to community service providers who are affiliated to provide the services identified as needed? ☐ Yes ☐ No

Signatures

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 services and/or supports. I understand this is a preliminary application and does not guarantee eligibility or funding for I/DD services. I authorize inquiries to be made to verify any and all information on this form.

_______________________ ___________ _____________________ _________

Applicant Signature Date Parent/Guardian Signature Date