CDDO OF SEK
Community Developmental Disability Organization
Of Southeast Kansas

Serving Cherokee, Crawford, Labette & Montgomery Counites

Application guidelines for (I/DD) Intellectual/Developmental Disability Waiver Eligibility Determination

Thank you for your interest in applying for services. **Currently there is a waiting list for I/DD Waiver funding. All paperwork must be completed in full and will be processed within 30 working days from the date received. Documents will be returned if not completed in full.**

Qualifications for the I/DD waiver include having an intellectual disability that was diagnosed **before the age of 18** or a developmental disability diagnosed **before the age of 22**. To be diagnosed with an intellectual disability, an individual must be evaluated by a person trained and licensed to make such a diagnosis. This would include a psychological evaluation with a Full-Scale IQ and a DSM-5 of Intellectual Disability and can be completed by your local mental health provider. **Psychological evaluations completed by a school psychologist are not accepted unless the person is a licensed psychologist.**

For a developmental disability such as Autism (Autism must include testing), Cerebral Palsy, TBI etc., documentation is needed from a medical professional who made the diagnosis before the age of 22. A developmental disability may require the Eligibility Coordinator to complete an Eligibility Determination Instrument assessment. The person must have at least 3 functional limitations to qualify for the I/DD waiver.

Required documentation that must be included in submission:

- **Application packet** including:
  - Application for Intellectual/Developmental Disability (I/DD) Services (completed in full and signed)
  - Consent for Release of Information authorizing the CDDO to exchange information with medical professionals that can provide eligibility information if needed medical documentation is not enclosed (completed in full and signed)
  - Acknowledgement of Receipt of Revised Notice of Privacy Practices (completed and signed)
- **Documentation of diagnosis** (or Consent for Release of Information if not included)
- **Copy of Social Security Card**
- **Copy of Birth Certificate** (http://www.vitalrec.com)
- **Copy of adoption paperwork** (if applicable)
- **Copy of guardianship paperwork** (if applicable)
- **Copy of Military DD 214 form, TriCare verification, & proof of Kansas residence** (if applicable)
- **Copy of KanCare Medicaid Card** (if applicable)

Where to send the application and required documentation:

- **Email** to lori.hinman@cddosek.org or info@cddosek.org
- **Fax** to 620-717-4168 or 620-414-1018 (Attention: CDDO Eligibility Coordinator)
- **Hand deliver** to 1200 Merle Evans Drive Columbus KS (Attention: CDDO Eligibility Coordinator)
- **Mail** to PO Box 1061, Parsons, KS 67357 or PO Box 187, Columbus, KS 66725 (Attention: CDDO Eligibility Coordinator)

It is the applicant's responsibility to ensure that the following documents are delivered to the CDDO. After all the information is received, you will be contacted about determination of eligibility. Allow up to 30 days to process your application. Please contact Lori Hinman, Eligibility Coordinator, at 620-605-1383 if you have any questions or need assistance in completing the application.

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: United Sunflower Healthy Blue Please select			
Active Military or Military Dependent & TriCare Echo Eligible? ☐ Yes ☐ No			

Intellectual or Developmental Disability

List I/DD Diagnoses: (REQUIRED)

Age of onset of Disability:

If Funding for Services were offered, would you accept them? Yes No Please select

Legal Status/Guardianship Information/Contacts

Please check all that apply: (REQUIRED)

- ☐ 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

Contact Information ☐ Parent ☐ Guardian ☐ Interested Party

Name:		Address:	
City:		State:	Zip:
Phone:		Email:	

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

CONSENT FOR RELEASE OF INFORMATION

CDDO of Southeast Kansas
PO Box 187
Columbus, KS 66725

Phone: (620)429-8985
Fax: (620) 429-8723

Client Name:

Address, City, State, Zip:

Date of Birth: Social Security Number:

I HEREBY AUTHORIZE CDDO OF SEK TO OBTAIN INFORMATION FROM

Name of Individual or Agency:

Address, City, State, Zip:

Telephone Number: Fax Number:

THE FOLLOWING INFORMATION: (Client/legal representative initial appropriate blank)

- ☐ Medical records to include diagnosis of developmental delay
- ☐ Psychological evaluation to include full scale IQ with DSM code
- ☐ Other as requested

THE PURPOSE OR NEED IS TO:
Obtain information for eligibility for the Intellectual/Developmental Disabled waiver.

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES **ONE YEAR FROM THE DATE SIGNED.**

Client Signature: Date:

Printed Name of Client:

Parent/Guardian Signature: Date:

Printed Name of Parent/Guardian: Relationship:

Witness Signature: Printed Name:

Title: Agency:

The above signed acknowledges that he/she is aware that certain information that he/she is consenting to release is confidential and protected by Federal and State law. The undersigned acknowledges upon signing this consent they are waiving their rights under these laws and that they are aware of the specific protections they are afforded, or they are waiving their right to being informed of the specific provisions of these laws, Statute 42 PFR – Part 2.

CONSENT FOR RELEASE OF INFORMATION

CDDO of Southeast Kansas
PO Box 187
Columbus, KS 66725

Phone: (620)429-8985
Fax: (620) 429-8723

Client Name:

Address, City, State, Zip:

Date of Birth: Social Security Number:

I HEREBY AUTHORIZE CDDO OF SEK TO OBTAIN INFORMATION FROM

Name of Individual or Agency:

Address, City, State, Zip:

Telephone Number: Fax Number:

THE FOLLOWING INFORMATION: (Client/legal representative initial appropriate blank)

- ☐ Medical records to include diagnosis of developmental delay
- ☐ Psychological evaluation to include full scale IQ with DSM code
- ☐ Other as requested

THE PURPOSE OR NEED IS TO:
Obtain information for eligibility for the Intellectual/Developmental Disabled waiver.

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES **ONE YEAR FROM THE DATE SIGNED.**

Client Signature: Date:

Printed Name of Client:

Parent/Guardian Signature: Date:

Printed Name of Parent/Guardian: Relationship:

Witness Signature: Printed Name:

Title: Agency:

The above signed acknowledges that he/she is aware that certain information that he/she is consenting to release is confidential and protected by Federal and State law. The undersigned acknowledges upon signing this consent they are waiving their rights under these laws and that they are aware of the specific protections they are afforded, or they are waiving their right to being informed of the specific provisions of these laws, Statute 42 PFR – Part 2.

CONSENT FOR RELEASE OF INFORMATION

CDDO of Southeast Kansas
PO Box 187
Columbus, KS 66725

Phone: (620)429-8985
Fax: (620) 429-8723

Client Name:

Address, City, State, Zip:

Date of Birth: Social Security Number:

I HEREBY AUTHORIZE CDDO OF SEK TO OBTAIN INFORMATION FROM

Name of Individual or Agency:

Address, City, State, Zip:

Telephone Number: Fax Number:

THE FOLLOWING INFORMATION: (Client/legal representative initial appropriate blank)

- ☐ Medical records to include diagnosis of developmental delay
- ☐ Psychological evaluation to include full scale IQ with DSM code
- ☐ Other as requested

THE PURPOSE OR NEED IS TO:
Obtain information for eligibility for the Intellectual/Developmental Disabled waiver.

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON MY **WRITTEN REQUEST** EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES **ONE YEAR FROM THE DATE SIGNED.**

Client Signature: Date:

Printed Name of Client:

Parent/Guardian Signature: Date:

Printed Name of Parent/Guardian: Relationship:

Witness Signature: Printed Name:

Title: Agency:

The above signed acknowledges that he/she is aware that certain information that he/she is consenting to release is confidential and protected by Federal and State law. The undersigned acknowledges upon signing this consent they are waiving their rights under these laws and that they are aware of the specific protections they are afforded, or they are waiving their right to being informed of the specific provisions of these laws, Statute 42 PFR – Part 2.

ACKNOWLEDGEMENT OF
RECEIPT OF REVISED NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of CDDO of Southeast Kansas' Notice of Privacy Practices effective September 16, 2013.

Name of Individual:_____

Signature is (Select appropriate relationship to Individual)

☐ Legal Guardian

☐ Parent of Minor Child

☐ Individual

_____ Date:_____
(Signature of Individual/Individual's Representative)

_____
(Written Name)

COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (CDDO)

CDDO OF SOUTHEAST KANSAS
NOTICE OF PRIVACY PRACTICES
EFFECTIVE SEPTEMBER 16, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice; you may request a copy at any time.

The information in this Notice will be followed by CDDO of Southeast Kansas, and all workforce members (employees, officers, directors, volunteers, and independent contractors), collectively referred to herein as CDDO.

CDDO is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

HOW CDDO MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

CDDO may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to other persons or organizations involved in your treatment, such as other health care providers, family members, and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying CDDO and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. CDDO provides some services through contracts or arrangements with Affiliates/business associates. We require our Affiliates/business associates to appropriately safeguard your information.

Creation of De-Identified Health Information. We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and Disclosures Required By Law. We will use and/or disclose your information when required by law to do so.

***Disclosures for Public Health Activities*.** We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

***Disclosures About Victims of Abuse, Neglect, or Domestic Violence*.** We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

***Disclosures for Judicial and Administrative Proceedings*.** We may disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

***Disclosures for Law Enforcement Purposes*.** We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

***Disclosures Regarding Victims of a Crime*.** In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to Avert a Serious Threat to Health or Safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

***Disclosures for Specialized Government Functions*.** We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Disclosures for Fundraising. We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for its benefit. You have a right to opt out of receiving such fundraising communications.

OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this Notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent CDDO has not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

***Right to Inspect and Copy*.** You have the right to inspect and copy health information maintained by CDDO. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

***Right to Request Amendment*.** If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

***Right to an Accounting of Disclosures and Access Report*.** You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request an accounting or an access report, you must complete a specific written form providing information we need to process your request.

***Right to Request Restrictions*.** You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. CDDO's Privacy Officer is the only person who has the authority to approve such a request. CDDO is not required to honor your request for restrictions, except if (a) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law, and (2) the protected health information pertains solely to a health care item or services for which you or any person (other than a health plan on your behalf) has paid CDDO in full.

***Right to Request Alternative Methods of Communication*.** You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. CDDO's Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with CDDO or with the Secretary of the Department of Health and Human Services. To file a complaint with CDDO, please contact the Privacy Officer, **(Jim Shuler, HIPAA Privacy Officer, CDDO of Southeast Kansas, PO Box 187, Columbus, KS 66725, call 620-429-8985, or email to jim.shuler@cddosek.org)**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

CDDO reserves the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.