Community Developmental Disabilities Organization
Serving Chase, Lyon, Morris & Wabaunsee Counties
PO Box 2204
Emporia, KS 66801

~APPLICATION GUIDELINES FOR ELIGIBILITY DETERMINATION~

Congratulations you have taken the first step to see if you and/or your child are eligible for Home and Community Based Services through the waiver for individuals with Intellectual and/or a Developmental Disability (I/DD). Hetlinger Community Developmental Disabilities Organization (CDDO) is the single point of entry for services for individuals who reside in the following counties: Chase, Lyon, Morris and Wabaunsee. Now that you have contacted the CDDO we can begin the eligibility process. At this time there is a waiting list for those services. Please review the list below and complete the forms as indicated. Eligibility will be determined after ALL documents have been received. (Allow up to 45 days to process your application.) You will be contacted by CDDO personnel after eligibility has been determined.

IT IS THE APPLICANT'S RESPONSIBILITY TO ENSURE THAT THE FOLLOWING DOCUMENTS ARE DELIVERED TO THE CDDO.

Documents can be mailed, faxed or hand delivered to Hetlinger CDDO. Faxed records will also be accepted from professionals. Fax: (620) 342-0558.

☐ Copy of Social Security Card
☐ Copy of Birth Certificate
☐ Copy of Adoption Papers (if applicable)
☐ Copy of Guardianship Papers (if you have a guardian)
☐ Copy of Military DD 214 Form, TriCare verification, & proof of Ks. residence (if applicable)
☐ Copy of Medicaid Card (if applicable)
☐ Eligibility Application – completed and signed
☐ Release(s) of Information that authorize CDDO to exchange information with any agencies & professionals you are or have been involved with including schools which you are or have attended.

TOP PORTION OF RELEASE MUST BE COMPLETED AND LOWER PORTION MUST BE SIGNED & DATED

☐ School Records to Include: IEP, school psychological evaluations, IQ scores/testing and assessments and early childhood records
☐ Services Records to Include: Speech Occupational and Physical Therapy, Tiny K and other therapies.
☐ Diagnostic Records: Documentation of your diagnosis as determined by a licensed professional, a psychological evaluation, supporting documentation of test/assessments used to determine the diagnosis that meets criteria for I/DD Services. Eligibility Requirements are listed on the next page.

Intellectual Disability

Intellectual Disability means substantial limitations in present functioning that is manifested during the period from birth to age 18 years and is existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable adaptive skill areas:

Communication	Self-care	Home living	Social Skills	Community Use
Self-direction	Functional Academics	Health and Safety	Leisure	Work

This diagnosis must be made by a healthcare professional that is licensed to make DSM IV-TR diagnosis. Some examples of healthcare professionals in Kansas who can make this diagnosis are Licensed Psychologists (LP); Licensed Specialist Clinical Social Worker (LSCSW); Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Psychotherapist (LCP); and Licensed Clinical Marriage and Family Therapist (LCMFT).

Developmental Disabilities

Other developmental disabilities means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairments (or condition which has received a dual diagnosis of intellectual disability and mental illness) and is evidenced by a severe, chronic disability which:

1. Is attributable to a mental or physical impairment or a combination of mental and physical impairments; AND
2. Is manifest before the age of 22, AND
3. Is likely to continue indefinitely, AND
4. Results in substantial functional limitations in any three or more of the following areas of life functioning:

Self-care	Learning and adapting	Mobility	Self-direction
Living Independently	Economic self-sufficiency	Receptive & Expressive Communication	

5. Reflects a need for or a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated.
6. Does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of the infirmities of aging.

Children with a Developmental Disability

1. is attributable to a mental or physical impairment or combination of mental and physical impairments, AND
2. Is likely to continue indefinitely, AND
3. Results in at least three (3) developmental delays as measured by qualified professionals using appropriate diagnostic instruments and procedures, AND
4. Reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated.
5. Does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill.

Step 4 – Third Party Reconsideration

1. Applicant and/or guardian may request a third party reconsideration of eligibility determination by sending a written request to the following address:

   Hetlinger CDDO – Eligibility Redetermination
   PO Box 2204
   Emporia, KS 66801
2. If the determination remains the same after documentation has been reviewed by a neutral third party who is qualified to determine eligibility for I/DD services, the individual will be mailed a second denial letter notifying them of their right to administrative appeal.
3. If after the information is reviewed and the person is found eligible the person will be mailed a letter of eligibility and the BASIS screener will contact them to complete the DDP assessment.

Step 5 – Administrative Appeal

1. Written requests for administrative appeal should be mailed to the following address within 30 days of the date of your denial letter.

   Administrative Hearing Section
   1020 South Kansas Ave
   Topeka, KS 66612-1311

Statewide Waiting List

Beginning with the fiscal year 2006 KDADS/CDDO contract a statewide waiting list for funding was instituted. All individuals across the state will be placed on this statewide waiting list (if eligible) upon completion of the initial DDP assessment.

HETLINGER COMMUNITY DEVELOPMENTAL DISABILITIES ORGANIZATION
P.O. Box 2204/Emporia, Kansas 66801 Phone: 620-342-1087 Fax: 620-342-0558
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client/Patient Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____

I HEREBY AUTHORIZE *HETLINGER COMMUNITY DEVELOPMENTAL DISABILITIES ORGANIZATION* to:

Release Information To:

Agency Name	Address (city, state, zip)	Telephone	Fax

Obtain Information From:

Agency Name	Address (city, state, zip)	Telephone	Fax

THE FOLLOWING INFORMATION:

☐BASIS information (including DDP score/tier)
☐School Records (IEP, Transcripts, Test Scores)
☐Medical Records (health status, restrictions, current medications, diagnosis)
☐Other (Specify)_____
☐Vocational History
☐Psychological Evaluations/Reports
☐Current needs
☐Communication between agencies

THE PURPOSE OR NEED IS TO:

☐To assist in determining eligibility for HCBS I/DD Services

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME UPON WRITTEN REQUEST EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES UPON:
☐Other (Specify):_____

Client Signature:_____ Date:_____
Guardian Signature:_____ Date:_____
Witness Signature:_____ Date:_____

The above signed acknowledges that he/she is aware that certain information he/she is consenting to release is confidential and protected by Federal and State Law. The undersigned acknowledges upon signing this consent that 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 CFR- Part 2

Hetlinger DEVELOPMENTAL SERVICES INC

Community Developmental Disabilities Organization
Service Chase, Lyon, Morris & Wabaunsee Counties

REFFERAL APPLICATION

APPLICANT INFORMATION		
Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
County of Residence:	US Citizen: ☐ Yes ☐ No	Kansas Resident: ☐ Yes ☐ No
KanCare/Medicaid #:	Managed Care Organization:	
Enrolled in Health Home?: ☐ Yes ☐ No	Health Home Partner:	
Gender: ☐ Male ☐ Female		
Active Military or Military Dependent & TriCare Echo eligible? ☐ Yes ☐ No		

PARENT CONTACT INFORMATION (*FOR APPLICANTS UNDER 18 YEARS OLD)*		
Parent's Name:		
Address:		
Home Phone:	Work Phone:	Cell Phone:
Email address:		

LEGAL GUARDIAN CONTACT INFORMATION *(FOR APPLICANTS 18 YEARS & OLDER OR CHILD IN CUSTODY)*		
Guardians Name:		
Address:		
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

OTHER CONTACT PERSON *(IF APPLICABLE)*		
Contact Person:		
Address:		
Home Phone:	Work Phone:	Cell Phone:
Email Address:		
Relationship to Applicant:		

MEDICAL/PSYCHOLOGICAL INFORMATION		
Diagnosis:		
NOTE: 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 (include in Eligibility Packet) for this facility as well.		
Age of Onset of Disability:	**History of Seizures** (in the past 5 years): ☐ Yes ☐ No	
List any Physical Impairments/Medical Concerns:		
Evaluations from Medical Hospitals/Diagnostic Centers: (please include Name of City and State as well)		
Facility Name:	Address:	Date Seen:
History of Mental Health Services/Hospitals: (please include Name of city and state as well)		
Facility Name:	Address:	Date Seen:
Placement in other I/DD Facilities: (Include name of city and state as well)		
Facility Name:	Address:	Date Seen:
BACKGROUND INFORMATION		
Name of current or last school attended:		
Address:		Highest Grade Achieved:
Attended Special Education Classes: ☐ Yes ☐ No		Date of Graduation:
Involved in Vocational Rehabilitation through DCF (Dept. for Children & Family): ☐ Yes ☐ No		
Currently Employed: ☐ Yes ☐ No	Name of Employer:	
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 on this form may be cause for denial or rejection from services and/or supports. ☐ I understand there are eligibility criteria that I must meet and there is no guarantee of services even if I do meet the eligibility criteria. ☐ I understand that my name will be placed on the waiting list for HCBS I/DD Waiver funding at this time unless I can provide verification that my circumstances meet the definition of a crisis as outlined in the KDADS/CDDO contract. ☐ I understand that my name and address will be placed on a local waiting list and may be shared with all affiliated community service providers, unless I ask to be removed. ☐ SHARE MY NAME AND ADDRESS ☐ DO NOT SHARE MY NAME AND ADDRESS		
Signature of applicant:		Date:
Signature of Parent/Guardian:		Date: