

**Hetlinger
Community Developmental
Disabilities Organization
Eligibility Process**



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Step 1 – Initial Contact

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 Mental Retardation and/or a Developmental Disability. Hetlinger 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 referral process.

Eligibility criteria for MR/DD services are as follows:

Mental Retardation

Mental Retardation 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:

1. Communication
2. Self-care
3. Home living
4. Social Skills
5. Community Use
6. Self-direction
7. Health and Safety
8. Functional Academics
9. Leisure
10. Work

This diagnosis must be made by a healthcare professional who 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 mental retardation 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:
 - a. Self-care
 - b. Understanding and the use of language
 - c. Learning and adapting
 - d. Mobility
 - e. Self-direction in setting goals and undertaking activities to accomplish those goals
 - f. Living independently
 - g. Economic self-sufficiency, AND
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 2 – Referral Packet

1. Applicant must complete or have someone complete for them the entire Referral Application on pages 6-10 of this packet.
2. Applicant or responsible party must sign the completed Referral Application.
3. Referral Application must be returned to the Director of CDDO Administration.
4. Applicant or designee must complete the Release of Information form located on page 11 of this packet. Applicant or legal guardian must sign release of information. If applicant is over age 18 and no one has been **appointed by the court** as their legal guardian then they must sign this form. If the person has a **court appointed guardian** then a copy of the Letters of Guardianship must be included with the Referral Packet.
5. Signed Release of Information must be returned to the Director of CDDO Administration.
6. If the applicant, applicant's guardian, or designee has in their possession any paperwork which would assist in the eligibility determination it will speed up the process if copies of those items are included when the referral application and release of information are returned.

HETLINGER
COMMUNITY DEVELOPMENTAL DISABILITIES ORGANIZATION
REFERRAL APPLICATION

This application requests certain information that will assist Hetlinger Community Developmental Disabilities Organization (CDDO) in determining the applicant's eligibility to receive services. Please be sure the application is fully completed before forwarding to the address below.

Applicant's Name: _____
Last
First
Middle

Street Address
City
State
County
Zip

() _____ () _____
 Telephone Number – Home Telephone Number – Work

 Social Security Number Kansas Medicaid Number

 Date of Birth

Individual making the referral: _____

 Relationship to Applicant Telephone Number

Types of Service Being Requested:

PLEASE CHECK ALL THAT APPLY

	Supported Employment		Day Service
	In Home Family Supports		Residential Service
	Targeted Case Management		

RETURN COMPLETED APPLICATION TO:

Hetlinger CDDO
 Attn.: Director of CDDO Administration
 PO Box 2204
 Emporia, KS 66801

Personal Identification

Male _____ Female _____

Race _____

United States Citizen Yes _____ NO _____

Language Understood/Spoken: _____

Legal Status

APPLICANT IS

<input type="checkbox"/>	Their own payee	<input type="checkbox"/>	Their own guardian	<input type="checkbox"/>	Has a guardian
<input type="checkbox"/>	Has a conservator	<input type="checkbox"/>	Has a payee	<input type="checkbox"/>	Has a personal representative

If has a guardian is marked above then also complete this section

Guardian's Name: _____

Street Address _____ City _____ State _____ Zip _____

() _____ () _____
Telephone Number – Home Telephone Number – Work

State, county and year guardianship established: _____

COPIES OF LETTERS OF GUARDIANSHIP AND/OR CONSERVATORSHIP MUST ACCOMPANY THIS APPLICATION

Medical Information

Primary Disability: _____

Secondary Disability: _____

Visual Limitations? Yes _____ No _____

Describe: _____

Communication style: (check all that apply)

<input type="checkbox"/>	Verbal	<input type="checkbox"/>	Non-verbal	<input type="checkbox"/>	Uses sounds
<input type="checkbox"/>	Uses gestures	<input type="checkbox"/>	Sign language	<input type="checkbox"/>	Other:

Hearing Impairment? Yes___ No___ Describe:_____

Is applicant able to read? Yes___ No___ Reading Level:_____

Special Diet? Yes___ No___ Describe:_____

Incontinence: Bowel_____ Bladder_____ Day_____ Night_____

Childhood Diseases: Please list

Immunizations:

Allergies:

Does applicant take medication(s) Yes___ No___

MEDICATION	DOSAGE	FREQUENCY	REASON

Does the applicant have seizures Yes___ No___

Seizures are: Controlled___ Uncontrolled___

Describe the type and frequency of seizure activity:

Current Physician:	Address:	Telephone:
Current Psychiatrist:	Address:	Telephone:

Has applicant been hospitalized (physical or psychiatric?) Yes___ No___

Name of Hospital:	Address:	Telephone:
Name of Hospital:	Address:	Telephone:

Educational History

Name of Last School Attended: _____

Street Address _____ City _____ State _____ Zip _____

Regular Ed. _____ Special Ed. _____ Graduation date: _____

Family History

Father's Name: _____

Street Address _____ City _____ State _____ Zip _____

() ()

Telephone Number – Home _____ Telephone Number – Work _____

Mother's Name: _____

Street Address _____ City _____ State _____ Zip _____

() ()

Telephone Number – Home _____ Telephone Number – Work _____

Significant Others (brothers, sisters, step family, grandparents etc)

Name: _____ Relationship: _____

Street Address _____ City _____ State _____ Zip _____

() ()

Telephone Number – Home _____ Telephone Number – Work _____

Name: _____ Relationship: _____

Street Address _____ City _____ State _____ Zip _____

() ()

Telephone Number – Home _____ Telephone Number – Work _____

Name: _____ Relationship: _____

Street Address _____ City _____ State _____ Zip _____

() ()

Telephone Number – Home _____ Telephone Number – Work _____

Socialization Skills

Does the applicant prefer individual or group activities? _____

What does the applicant do to occupy leisure time?

Does the applicant have any special interests or hobbies?

Behavior

How does the applicant express anger and/or frustration:

Please indicate common causes of anger and/or frustration:

How often do these situations occur?

<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Other:
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Has the applicant ever displayed any self-injurious behavior? _____

Please describe:

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 MR/DD Waiver funding at this time unless I can provide verification that my circumstances meet the definition of a crisis as outlined in the SRS/CDDO contract.

I give approval to share my name with all affiliated community service providers.

Yes _____ No _____

If you do not mark an answer, it will be assumed that you give your approval to share your name upon their request.

Applicant Signature

Date

Guardian Signature

Date

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:

- | | |
|--|--|
| <input type="checkbox"/> BASIS information (including DDP score/tier) | <input type="checkbox"/> Financial Records |
| <input type="checkbox"/> Vocational History | <input type="checkbox"/> Social History |
| <input type="checkbox"/> School Records (IEP, Transcripts, Test Scores) | <input type="checkbox"/> Psychological Evaluations/Reports |
| <input type="checkbox"/> Medical Records (health status, restrictions, current medications, diagnosis) | <input type="checkbox"/> Current needs |
| <input type="checkbox"/> Other (Specify) _____ | <input type="checkbox"/> Communication between agencies |

THE PURPOSE OR NEED IS TO:

- To assist in determining eligibility for HCBS MR/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:

- Delivery of requested information
Other (Specify): _____

Client Signature: _____ Date: _____
 Guardian Signature: _____ Date: _____
 Witness Signature: _____ Date: _____
 Title: _____ Agency: _____

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

Step 3 – Eligibility Determination

1. Referral application and release of information will be reviewed by Director of CDDO Administration
2. If sufficient documentation has been provided to determine eligibility a letter will be mailed to the applicant and/or legal guardian, and an appointment will be scheduled to complete the BASIS assessment.
3. If additional information is needed to determine eligibility then:
 - a. Director of CDDO Administration will send out requests from agencies listed on the release of information
 - b. Director of CDDO Administration will contact person for additional sources and an additional release of information will be mailed to applicant and/or guardian. (if necessary)
 - c. This process will continue until sufficient documentation has been obtained.
4. If all sources have been exhausted and sufficient documentation still has not been obtained in order to make a determination of eligibility then the applicant will be referred to the local mental health center so that a psychological evaluation can be completed. This evaluation will need to include what testing was completed along with a listing of the persons diagnosis.
5. If applicant is not eligible for services they and/or their guardian will be mailed a denial letter along with information on requesting a third party reconsideration. Applicant will also be referred to other agencies who may be able to assist them.

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 MR/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 an 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 SRS/CDDO contract a statewide waiting list for funding was instituted. All individuals across the state will be placed on this statewide waiting list upon completion of the initial BASIS assessment. During this initial assessment the person will be asked to decide which services they would be willing to accept within the next three year time frame. This date will be noted on the service page of the assessment. This is the date that is used to determine their place on the statewide waiting list.