ARROWHEAD
WEST CDDO

COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION

APPLICATION FOR ELIGIBILITY DETERMINATION

The following information is required to process the application for eligibility and to comply with state regulations for purposes of reporting statistical data. Confidentiality will be maintained.

General Information:

Name: Date of Birth:

Address:

City: State: Zip:

Home Phone: Work Phone:

Sex: Male Female Marital Status:

Social Security Number: Place of Birth:

Citizenship Status: Language Spoken:

Insurance:

Do you have Medicaid? No Yes If Yes – Medicaid Number:

If No, have you applied? No Yes - Ineligible Yes – Application in Process

Disabilities: **Age of Onset**

Primary:

Other:

Other:

Other:

Current Living Situation:

With Family In Community with Support In Group Home Independently

Other

Current Day Activity:

None Competitive Employment Volunteer Work School/Occupational Training

Day Program Other

Are you at risk of losing your current day activity or require a more structured living setting? No Yes

Parents Name:

Address:

City: State: Zip:

Home Phone: Work Phone:

Guardian's Name:

Address:

City: State: Zip:

Home Phone: Work Phone:

Location of Hearing: Court Case #:

If limited guardianship, what is the limitation?

If guardian has not been appointed, is one needed? No Yes

Conservator or Payee Name:

Address:

City: State: Zip:

Home Phone: Work Phone:

Contact Person Name:

Address:

City: State: Zip:

Home Phone: Work Phone:

Relationship to Applicant:

Siblings, Names and Ages:

Have you ever resided in any of the following?

Kansas State Mental Retardation Hospital (KNI, Parsons, Winfield, Norton) No Yes

Kansas State Mental Health Hospital (Topeka, Larned, Osawatomie) No Yes

Private ICF/MR No Yes If Yes, Where

Please list all other facilities/programs in which you have received services:

Income Sources (Monthly Amounts):

Support from Family $

Employment $

Family Subsidy $

Other (Specify) $

Supplemental Security Income $

Social Security Disability Income $

Social Security Survivors Benefits$

Special Education

None

Attended/Attending

High School Graduate or GED

Post High School

Regular Education

None

Attended/Attending

High School Graduate or GED

Post High School

If currently attending high school, anticipated month and year of completion:

School History:

School Name Dates Attended

Medical Information:

Physical Condition: Excellent Good Poor

Seizures: No Yes

Allergies (Food or Medical):

Current Physician: Phone:

Address of Physician:

Date of Last Examination:

Current Medications:

Prior Medications (Taken within the last year):

What services or supports do you need at this time?

DOCUMENTATION TO SUBMIT ALONG WITH THE COMPLETED APPLICATION:

Please submit a copy of the following applicable documentation along with the completed application. This information will be used to determine if the applicant meets the developmental disability eligibility criteria. Please check the documentation that you have enclosed with the application. Failure to provide the documentation may delay the processing of the application.

Psychological Evaluations (most recent)

School Records/Individual Education Plan (IEP)

Social History

Mental Health Records (if applicable)

Medical Records (if related to disability or functioning level)

Person Centered Support Plan (PCSP) (if applicable)

Vocational Evaluation (if applicable)

Consent and Agreements

1. I have been provided a brochure explaining the purpose of the Community Developmental Disability Organization (CDDO) and the approved service area of Arrowhead West CDDO.

2. 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.

3. I understand that the information I provide within the Application for Eligibility Determination for Services will be used to determine if I (the applicant) meet the eligibility criteria and to obtain statistical data as required by the State of Kansas.

4. I agree to a full investigation of my eligibility including inquiries of doctors and other professionals and release of records that may help to determine my (the applicant's) eligibility for IDD services to include psychological evaluations, school records, social history, medical records, and other available assessment reports. I agree to obtain the necessary reports needed to determine my eligibility and provide these to the CDDO.

5. I understand that I may appeal the decision made with regard to my eligibility if I am dissatisfied with the result. I understand that this appeal must be made in writing to the Admissions Coordinator for the CDDO.

6. I understand that if I am determined to be eligible, I will be expected to report any changes in my circumstances which affect my eligibility, and to fully cooperate in all re-determinations of my eligibility. I further agree to inform the CDDO if I have been accepted and placed on a waiting list in another CDDO area.

7. I understand that even though I may be determined eligible for IDD services, there is no guarantee that I will be immediately accepted into those services. Acceptance will be contingent upon availability of funding and openings for requested services. I understand that there is no guarantee of a continuation of services once accepted if funding for those services is no longer available.

8. I understand that I will be required to participate in at least an initial and annual review for functional eligibility through the BASIS Assessment.

9. I understand that information within this application will remain confidential and will not be further disclosed without the specific written consent of myself or my guardian as applicable. Exceptions to this would be agencies to which the CDDO must release certain types of information such as Kansas Department for Aging and Disability Services (KDADS), Social Security, Department of Labor, funding sources such as Housing and Urban Development, Kansas Rehabilitation Services, and accrediting agencies such as the Commission on Accreditation of Rehabilitation Facilities (CARF). This application will also be shared with community service provider of choice.

By signing below, I agree that the information contained in this application is correct to the vest 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 there are eligibility criteria that I must meet and there is no guarantee of services even if I do meet the eligibility criteria.

I give my approval to share my name with all affiliated community services providers upon their request.

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.

I have received a copy of "Rights for Individuals with Intellectual/Developmental Disabilities (IDD) as approved by the State on 5-8-2018.

Applicant's signature:____ Date:_________________

Guardian's signature:____ Date:_________________