DPOK
Disability Planning Organization of Kansas, Inc.

Eligibility Determination Packet Checklist

Name of Adult/Child Applying for Services:_____

Please review all enclosed materials and complete per instructions. Upon completion, please return the items below **in the enclosed envelope.**

Items to be Returned:

- ☐ **Eligibility Determination Application (white)**
- ☐ **Acknowledgement form (blue)**
- ☐ **Authorization form(s) (blue)**
- ☐ **Copies of any documentation and/or records you may have from a licensed and/or medical professional containing information about your developmental disability**
- ☐ **Copy of Legal Guardianship papers (signed by Judge)**

Upon receipt of all completed items, the CDDO will begin the eligibility determination process. You can expect a letter outlining the eligibility decision after receipt of all completed and gathered items. If you have any questions or concerns, please do not hesitate to contact the Disability Planning Organization of Kansas, Inc. at (785) 823-3173.

DPOK
Disability Planning Organization of Kansas, Inc.
119 W. Iron Ave., 4th Floor | P.O. Box 1067 | Salina, KS 67402-1067
785-823-3173 | Toll Free 866-886-3765 | Fax 785-823-3299 | www.dpok.com

ELIGIBILITY DETERMINATION APPLICATION

The information given on this application will assist in determining the applicant's eligibility for services. Such determination will be made in accordance with the State's Eligibility Determination policy, consistent with K.S.A. 39-1803.

General Applicant Information

Applicant's Full Legal Name: _____ Date of Birth: _____

Current Address: _____

Street or Box # City State Zip County

County that you consider to be "home" (if different from above): _____

Phone: _____ Social Security#: _____ Medicaid#: _____ MCO: _____

Services Requested

What support do you need to obtain employment: _____

What kinds of services are you looking for: _____

Disability Evaluation Information

How do you describe your disability (i.e. intellectual disability, seizures, cerebral palsy, etc.)? _____

_____

In order for the CDDO to determine if you meet eligibility requirements, it may be necessary to request information from previous placements, medical personnel, mental health personnel, etc. ***Please sign an Authorization form for the sources you listed below that would have information about your disability.***

Please list below if you have had any of the following evaluations or tests:

	Date	Place and Address
[ ] Hospital/Clinic	_____	_____
[ ] Mental Health	_____	_____
[ ] Other	_____	_____

Please list other people who help you/applicant make decisions: _____

_____

Education

Please list the school or Special Education Cooperative that may have testing and/or diagnosis of your disability: (attach additional sheets if necessary)

School: _____ Years attended _____

Address: _____

(PLEASE COMPLETE BACK OF APPLICATION)

Guardianship Information

Please check all that apply:

[ ] You (applicant) are a ward of the State

DCF Case Worker Name: _____

DCF Office Location: _____ Telephone: _____

Foster Care/Adoption Case Worker Name: _____

Agency _____ Telephone: _____

[ ] You (applicant) have a legal guardian(s)

Name: _____

Address: _____

Telephone: _____ County of court order: _____

Resource Information

Please list the name and address of any person who is assisting you with the application process:

Name: _____

Telephone: _____ Relationship: _____

Consent and Agreements

Persons listed in this application may be contacted regarding completing my eligibility determination.

I understand the information provided by me in this form will be used in conjunction with supporting documentation from a licensed and/or medical professional to determine my eligibility for services.

I understand that I have a right to reconsideration and appeal of the eligibility determination decision made on my application with the CDDO if I am dissatisfied with such decision. I further understand that such request should be made in writing as outlined in the eligibility determination decision letter.

I understand that if I am determined to be eligible, I will be expected to report any changes in my circumstances that affect my eligibility to the CDDO and to cooperate in all re-determinations of my eligibility.

I understand that if I am found to be eligible for services, actual service implementation is still dependent upon the submission/completion of further information, the availability of services, and fiscal limitations.

I understand that my eligibility can be redetermined at any time. The CDDO will not guarantee a continuation of services to individuals when funding is no longer available.

I certify that all of the information included in this form is correct to the best of my knowledge. I understand that the date this form is signed and submitted will be my application date.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Legal Representative **Date**

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119 W. Iron, 4th Fl. / P.O. Box 1067 / Salina, KS 67401
Ph. 785-823-3173 / Fax 785-823-3299

AUTHORIZATION FORM

Individual whose information is being used or disclosed:

Name: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Date of Birth: _____

Agency Authorized to Disclose the information (provide the information):

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

Agency Authorized to Request the information (receive the information):

Name: *Disability Planning Organization of Kansas, Inc.*
Address: *PO Box 1067*
City/State/Zip: *Salina, Kansas 67402-1067* Phone: *785-823-3173*

The information may be used or disclosed for the following purpose:
Determination of eligibility for state of Kansas funds and services for individuals with developmental disabilities.

Description of the Information to be used or disclosed:
Medical records, psychiatric records, psychological testing, and/or any assessments and evaluations associated with diagnosis of intellectual disability and/or developmental disability and associated adaptive functioning.

I understand this authorization will expire *180 days from date signed.*

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. I understand that I may revoke this authorization by notifying the Access Specialist for the CDDO, in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the CDDO in reliance on this authorization (disclosures prior to my written request to revoke).

_____ _____

Signature of Individual **Date**

_____ _____

Signature of Parent and/or Legal Guardian **Date**

_____ _____

Witness Signature **Date**

All information shared as a result of this release of information is strictly confidential and will not be released to any other party without the expressed or written consent of the individual and his or her legal guardian.

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Witness Signature **Date**

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Disability Planning Organization of Kansas, Inc.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice effective October 1, 2013

This Notice of Privacy Practices applies to the following organizations.

Disability Planning Organization of Kansas, Inc.

Please contact our CDDO office with questions or to speak with a Privacy Officer.

Notice of Privacy Practices
August 2018

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Acknowledgment of Receipt of Notice of Privacy Practices

This is to acknowledge my receipt of the Notice of Privacy Practices. Please sign and return to **in the enclosed envelope.**

_____ _____
Printed Name of Individual Date

_____ _____
Signature of Individual Date

_____ _____
Signature of Parent or Guardian (If applicable) Date