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.

December 2018
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:

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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
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).

_________________________________________ Date

Signature of Individual

_________________________________________ Date

Signature of Parent and/or Legal Guardian

_________________________________________ Date

Witness Signature

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.

December 2018
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 ________________ 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.
Notice of Privacy Practices
Effective: November 1, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY DISABILITY PLANNING ORGANIZATION OF KANSAS, INC. (CDDO), AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

What is Protected Health Information?
The term protected health information is synonymous with the terms “personal health information” and “medical information” for purposes of this Notice. Protected health information means any health information about you that identifies you, or for which there is a reasonable basis to believe the information can be used to identify you. This notice describes how health information about you may be used and shared. It tells you about your rights and our duties with respect to health information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights.

Our Responsibilities
We are required by law to:
• Maintain the privacy and security of your protected health information.
• Provide prompt notice to you if a breach occurs that may have compromised the privacy or security of your unsecured health information.
• Abide by the terms and duties of our current notice of privacy practices
• Provide you with an additional current copy of our Notice upon request.

We reserve the right to change the terms of this notice and/or our privacy practices and to make the changes effective for all protected health information that we maintain, even if it was created or received prior to the effective date of the notice revision. If we make a revision to this notice, we will make the notice available at our office upon request or after the effective date of the revision and we will post the revised notice in a clear and prominent location.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Federal privacy rules (regulations) allows providers who have a direct relation with you to use or disclose your protected health information, without your written authorization, to carry out our treatment or health care operations shown below. We may also share your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

Treatment. We may use your health information to determine your eligibility to receive home and community-based services, supports and related services. We may use and disclose health information to discuss with you options for services and supports to meet your needs, and to place your name on the statewide waiting list for the services and supports you want to receive. We may disclose your eligibility for services to the affiliated community service providers or to a contracted provider so that they can perform the services and supports for you. We may use and disclose your health information to remind you of upcoming meetings or the need for your functional assessment. We may use your health information to provide, coordinate or manage the services, supports, and health care you receive from us and other providers. We may disclose health information about you to doctors, nurses, case managers, employers, psychologists, social workers, direct support staff and other agency staff, and other persons who are involved in supporting you or providing care. We may need to disclose health information to entities outside of our organization (for example, another provider or a state/local agency) to obtain new services or continue services for you. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying the CDDO and asking for you to return our call. We will not disclose any health information to any person other than you or your designated guardian, except to leave a message for you to return the call.
**Payment.** We may use and disclose your health information as necessary for reimbursement for the home and community-based services and supports that you receive through CDDO and/or its affiliated providers. We also may provide information to affiliated providers to assist them in obtaining reimbursement for the services and supports which they provide to you.

**Health Care Operations.** We may use and disclose your health information for our internal CDDO operations as well as quality assurance/quality enhancement oversight of the services and supports that you receive, employee review activities, licensing, and conducting or arranging for other business activities. These uses and disclosures are necessary for our day-to-day operations and to make sure that your receive quality, responsive services and supports that respect your rights and offer you choices.

**Business Associates.** There are some services provided in our organization through contracts with independent providers. We may disclose your health information to a contracted provider so that they can perform the job we’ve asked them to do. To protect your health information, however, we require the contracted provider to certify that they also comply with the legally required privacy practices.

**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.

**Other Uses and Disclosures Required By Law.** Certain laws may require that we disclose your health information without your authorization. We are obligated to follow those laws. We will not use or disclose your health information without your authorization, except as explained in this notice or as required by law.

- **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 controlling 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, including protective services, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.
- **Health Oversight Activities.** We may disclose your health information during the course of audits, compliance reviews, investigations, inspections, and other proceedings related to CDDO oversight.
- **Disclosures for judicial and administrative proceedings.** Your protected health information may be disclosed 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.
- **As required by law.** We will use and/or disclose your health information when required by law to do so.

**PLEASE NOTE:** The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization.

If Kansas law protects your confidentiality or privacy more than the federal "Privacy Rule” does, or if Kansas law gives you greater rights than the federal rule does with respect to access to your records, we will abide by Kansas law.
Other Permitted and Required Uses and Disclosure will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that we have taken action in reliance on your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information "in a specific and meaningful fashion."

YOUR HEALTH INFORMATION RIGHTS

Right to Inspect and Copy. You have the right to inspect and copy your protected health information maintained by the CDDO. To do so, you must submit a written request to DPOK Privacy Officer at the contact below, with information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny your request to inspect and copy health information if the health information involved is: a. Psychotherapy notes; b. Information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding. If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed, and how you may complain. If you request a review of our denial, it will be conducted by a licensed healthcare professional designed by us who was not directly involved in the denial. We will comply with the outcome of that 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 submit a written request to the Privacy Officer at the contact below, with information needed to process your request including your supporting reason(s).

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information we have made by us in the six years prior to the date on which the accounting is requested. This does not apply to disclosures for treatment, payment, or health care operations; disclosures authorized by you; and disclosures made to you. To request this list, you must submit a written request to the Privacy Officer at the contact below

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. To do so, you must submit a written request to the Privacy Officer at the contact below. We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction.

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 submit a written request with information needed to process your request to the Privacy Officer at the contact below. We will accommodate all reasonable requests.

Right to Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To do so, send a written request to the Privacy Officer at the contact below.

Right to 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.

CHANGES TO THIS NOTICE

DISABILITY PLANNING ORGANIZATION OF KANSAS, INC. 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.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may take action by filing a written complaint with the Privacy Officer at the contact below. Alternatively, 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. You will not be penalized for filing a complaint.

PRIVACY OFFICER CONTACT

Privacy Officer
Disability Planning Organization of Kansas, Inc.
Phone: (785) 823-3173
Email: info@dpok.com
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

June 2019