Big Lakes Developmental Center, Inc.
Community Developmental Disability Organization (CDDO)
Riley, Geary, Clay and Pottawatomie counties

APPLICATION FOR ELIGIBILITY DETERMINATION

Contact information of person completing this application:

Name:____
Last First Middle

Address: ____
P.O. Box #/Street Address City State Zip

Phone #s: Home: ( )____________________ Alternate: ( )__________________________

E-mail address: ____

Relationship to applicant: ____

GENERAL INFORMATION

Applicant's name: ____
Last First Middle

Address: ____
P.O. Box #/Street Address City State Zip

Sex: □ Male □ Female Current age: ____________________________
Marital status: ____
County of residence: ____
Date of birth: __________/_________/__________
Birthplace (city/county/state): ____
U.S. Citizen? □ Yes □ No
Social Security #: ____
State issued ID#: ____
Drivers license? □ Yes □ No □ N/A
Race: ____
Language understood/spoken: ____
Phone numbers:
Home: ( )________________________ Cell: ( )________________________________

How long have you been a resident of Kansas? ____
Have you ever been determined eligible by another CDDO in Kansas? □ Yes □ No
If yes, which one:
____
Who referred you to our CDDO?
____

Foster child? □ Yes □ No Voluntary placement? □ Yes □ No Child in SRS Custody? □ Yes □ No
Are parental rights severed? □ Yes □ No
If yes, what county did child originate from? ______________________________
Child placing agency: ______________________________
Social worker: ______________________________
Address: ______________________________
Phone number/E-mail: ______________________________
Military family? □ Yes □ No
ETS date: ______________________________
How long have you been stationed at Fort Riley? ____________________

MEDICAL/PSYCHOLOGICAL INFORMATION

Disabilities (diagnosis)	Diagnosed by	Age of Onset

If Mental Retardation is listed as a disability, does individual have an **AXIS II diagnosis of Mental Retardation** made by a licensed, healthcare professional? □ Yes □ No

If yes, date of psychological evaluation: ______________________________
Contact information of where psychological evaluation was completed:
____
____
____
NOTE: although school psychologists may complete IQ testing, not all of them are licensed to diagnose.

If Cerebral Palsy, specify which type: ______________________________
Epilepsy/seizure disorder: □ Yes □ No Vagus nerve stimulator? □ Yes □ No
Which type of seizure(s) has applicant experienced in the last 12 months (mark all that apply):

- □ Simple partial
- □ Complex partial
- □ Generalized-absence (petit mal)
- □ Generalized-tonic-clonic (grand mal)
- □ Had some type of seizure (not sure of type)
- □ No seizures over the past 12 months

Shunt: □ Yes □ No

Incontinence? □ Bowel □ Bladder □ Both □ Day □ Night
Comments: ____

Visual limitations: □ Yes □ No Describe: ____

Hearing impairment: □ Yes □ No Describe: ____

Communication style(s): □ Verbal □ Non-verbal □ Sign language □ Uses gestures □ Uses sounds □ Communication board □ Other
Comments: ____

Is applicant able to read? □ Yes □ No
Comments: ____

Special diet? □ Yes □ No Prescribed by doctor, nutritionist, dietician? □ Yes □ No
Describe: ____

Allergies:
____
____

MEDICAL INFORMATION

Circle any that apply:
Respiratory: asthma, emphysema, sleep apnea, chronic obstructive pulmonary disease, cystic fibrosis, respiratory failure, etc.
Cardiovascular: angina, arteriosclerosis, artherosclerosis, atrial or ventricular septal defect, diseases of the heart valves, hypertension, hypotension, heart failure, high cholesterol, pericarditis, murmur (must be monitored by a physician at least annually), etc.
Gastro-Intestinal: cirrhosis of the liver, colitis, crohn's disease, diverticulosis, dysphagia, encopresis, g-tube, PEG, hepatitis B and/or C, irritable bowel syndrome, celiac disease, ulcers, pancreatitis, etc.
Genito-Urinary: diabetes, incontinence (enuresis), renal failure, hyperthyroidism, hypothyroidism, chronic bladder infections, chronic kidney infections, chronic urinary tract infections, etc.
Neoplastic Disease: cancers/carcinomas, fibroid tumors, leukemia, polyps (must be diagnosed as a neoplastic disease by a physician), tumors (both benign and malignant), etc.
Neurological Disease: Alzheimer's disease, organic brain syndrome, bell's palsy, dementia/dementia with Alzheimer's-like symptoms, encephalopathy, traumatic brain injury, hydrocephalus, macrocephaly, multiple sclerosis, muscular dystrophy, narcolepsy, Parkinson's disease, stroke, sleep apnea, Tourette's syndrome, transient ischemic attacks (TIAs), etc.

Comments:
____
____
____
____
____
____
____

Medication(s)	Prescription (yes/no)	Purpose

Is any medication received by injection? □ Yes □ No
List: ____

Is applicant currently receiving mental health services? □ Yes □ No
If yes, where and who is applicants counselor/psychologist?
____

Receiving medication management services? □ Yes □ No
If yes, where?
____

Current Living Situation:
□ Family □ Independent □ Foster home □ Other (friends, crisis center, etc.)
Describe "other":
____

Current Day Activity:
□ None □ School □ Competitive employment □ Other

EDUCATIONAL HISTORY

Current status: □ Elementary □ Middle □ High □ Graduated (year ______) □ Did not graduate
Special Education? □ Yes □ No
Proposed graduation date/year: _______________ *CDDO requests a copy of most current IEP.*
Current school district: #___________________ School name: __________________________________
Has a school psychologist completed IQ testing? □ Yes □ No *CDDO requests a copy of the evaluation.*
Is a behavior intervention plan in place at school? □ Yes □ No *CDDO requests a copy of the evaluation.*
Does applicant plan to stay in school through age 21? □ Yes □ No

FINANCIAL INFORMATION

Applicant's financial resources:
□ None □ Support from family □ Supplemental Security Income (SSI)
□ Supplemental Security Disability Income (SSDI) □ Social Security Survivors' Benefits
□ Employment □ Other (specify): ____

INSURANCE

Medicaid? □ Yes □ No If yes, list number: __________________________ *CDDO requests a copy of Medicaid card.*
If no, have you applied? □ Yes, ineligible □ Yes, application is in process □ No

Medicare? □ Yes □ No

Private insurance? □ Yes □ No
If yes, list insurance carrier(s):
____
____
____

LEGAL STATUS

Please complete information regarding each, if applicable, and forward documentation to the CDDO.

___ **Applicant is his/her own guardian** (18+ years old; legal guardianship has not been completed)

___ **Ward of the State**

___ **Guardianship**
- □ Natural (child is under age 18)
- □ Court-appointed: □ Full guardianship □ Co-guardianship
- □ Guardianship is in process

___ **Conservator**

___ **Payee** Name of Payee: ____

___ **Power-of-Attorney**

___ **Guardian-ad-litem:** ____

Has there been a recent confirmed case of Abuse, Neglect, and/or Exploitation (ANE) involving the applicant? □ Yes □ No Date: ______________________________
____
____

Criminal history? □ Yes □ No
____
____
____

SERVICES

What support/service(s) are you/applicant interested in receiving?

____
____
____
____

What would you like a case manager to assist you with?

____
____
____

Case management services is available immediately and is paid 100% by Medicaid Title XIX (19). Individuals without Medicaid may private pay. Individuals are placed on the statewide waiting list for any additional waiver-funded service(s).

When would you like services to begin? (date): ____

List applicant's biggest challenges and/or needs:

____
____
____
____
____

BEHAVIORS

Should applicant be determined eligible for the Mental Retardation/Developmental Disability (MR/DD) Waiver, behavior tracking will be required.

<u>Please indicate which behavior(s) the applicant has displayed over the past 12 months</u>:

□ Tantrums or emotional outbursts
□ (Deliberately) damages property (his/her own property and/or the property of others)
□ Physically assaults others
□ Disrupts others' activities
□ Is verbally and/or gesturally abusive
□ Is self-injurious
□ Teases or harasses peers (any behavior performed deliberately to annoy another person)
□ Resists supervision
□ Runs or wanders away
□ Steals (deliberately taking belongings, including food, of another)
□ Eats inedible objects (must be swallowed)
□ Displays sexually inappropriate behavior(s)
□ Sexual aggressions: □ against children □ against adults □ against pets/animals
□ Smears feces (deliberately handling, throwing or spreading feces)

Common causes of anger and/or frustration for the applicant:

____
____
____
____

Has applicant spent time in any of the following?

PRTF (psychiatric residential treatment facility)? □ Yes □ No
Inpatient psychiatric/mental health services? □ Yes □ No
Correctional facility? □ Yes □ No
Juvenile detention center? □ Yes □ No
Currently in JJA custody? □ Yes □ No

If yes, please indicate the name and location of the institution(s), length of stay, discharge date(s), etc.:

____
____
____
____

PERSONAL

Hobbies/Interests/Goals/etc:

____
____
____
____
____
____

Extra-curricular activities, club membership, etc. (Special Olympics, 4H, etc.):

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____
____
____
____

Signature page----→

SIGNATURE (required)

My signature below verifies that I have read the information that the CDDO has provided, not only in this application, but also the various handouts and brochures I received. I have been provided the opportunity to contact the CDDO for more information or clarification regarding Mental Retardation/Developmental Disability (MR/DD) services.

I understand that if I fail to provide the CDDO with diagnosis/medical documentation needed for eligibility determination purposes, case closure will result. Closed files may be reopened at any time upon request. The answers I have provided on this application are true to the best of my knowledge and ability.

____

Signature **Relationship to applicant** **Date**

*Parent/guardian signature is required if applicant is not age 18
*Individual's signature is required if applicant is age 18+ (legal guardian may sign on behalf of applicant)

Return application for eligibility determination and documentation to:
Big Lakes Developmental Center CDDO
Teresa Still, CDDO Quality Assurance/Eligibility Specialist
1416 Hayes Drive, Manhattan, KS 66502
Phone: (785) 776-2642 Voice mail available.
Direct CDDO fax: (785) 776-2610
E-mail: tstill@biglakes.org
Business hours: Monday - Friday, 8:00 a.m. – 4:30 p.m.

Big Lakes Developmental Center, Inc. CDDO will not reimburse individuals, families, and/or agencies for psychological evaluation fees, postage, faxes, long-distance phone calls, photocopying, travel costs, and/or any other expenses involved with providing the CDDO with eligibility determination documentation.

For more information about the MR/DD aka "DD" Waiver, visit SRS' website:
http://www.srs.ks.gov/agency/css/Pages/DDwaiver/DevelopmentalDisabilities.aspx

Revised Sept. 2010