

Community Developmental Disabilities Organization For Northwest Kansas

APPLICATION FOR SERVICES

The following information is required to process the application for services and to comply with state licensing regulations for purposes of reporting statistical data as required by Kansas State Department of Social and Rehabilitation Services (SRS).
Confidentially will be maintained.

General Information

Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Sex: Male Female Marital Status: _____

Insurance

Do you have Medicaid? No 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: Family In Community With Supports
 Independently Group Home

Current Day Activity: None Competitive Employment
 Volunteer Work School/Occupational Training
 Day Program
 Other _____

Regular Education (Highest Completed)

- None
- Attended/Attending
- High School Graduate or GED
- Post High School

Special Education (Highest Completed)

- None
- Attended/Attending
- High School Graduate or GED
- Post High School

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

Current School District #: _____ School Name: _____

Check all that apply to your situation:

- 1 Ward of the State
- 2 Guardian (Appointed By Court)
- 3 Conservator
- 4 Payee
- 5 Personal Representative
- 6 Self
- 7 Natural Guardian
(if applicant 17 or younger)
- 8 Limited Guardianship

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

Legally Responsible Person (Required)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to Applicant: _____

Contact Person (Required)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to Applicant: _____

Emergency Contact (Optional)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to Applicant: _____

Have you ever resided in any of the following?

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

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

Private ICF/MR ___ Yes, Where? _____ ___ No

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

Income Sources (Monthly Amounts)

Support From Family \$ _____ Supplemental Security Income \$ _____

Employment \$ _____ Social Security Disability Income \$ _____

Family Subsidy \$ _____ Social Security Survivors Benefits \$ _____

Other (Specify) \$ _____ _____

Adult Day Services

Do you need services or supports during the day? ___ No ___ Yes If yes, please select services needed:

- Personal and Social Skills** - provides day service activities which include opportunities for participation in the community and learning activities such as adult education classes.
- Work Services** - provides opportunities to learn marketable job skills while receiving commensurate wage for part time or full time employment.
- Supported Employment** - provides long term assistance in finding and maintaining employment
- Job Placement** - provides time limited assistance in becoming knowledgeable in job seeking skills, job duties, employment practices, and full integration into a work force.
- Other Day Services** _____

Residential Services

Do you need services or supports for community living? ___ No ___ Yes If yes, please select services needed:

- ICF/MR** - provides continuous active treatment and 24-hour supervision.
- Supervised Group Living** - provides 24 hour staff availability on site to provide assistance with daily living skills and behavioral support.
- Supported Setting** - provides a variety of service options such as budgetary assistance, laundry, along with community supports to meet each individual's needs and desires.
- Host Family (*Foster Care for Children*)** - provides a home for children ages 5-21 who are at risk of placement in an institutional or other congregate residential setting. The host family becomes the primary care giver and provides all child rearing.
- Other Residential Services** _____

Family Supports

Do you need family supports? _____ Yes _____ No

If yes, please select all services needed:

- Supportive Home Care - Personal Assistant** - provides a variety of supports including assistance with daily living activities, therapies, personal hygiene, meal preparation, and other activities to meet the individual's needs.
- Respite Services** - provides temporary care to the developmentally disabled individual as a relief for the individual's family member who serves as the primary care giver.
- Payroll Agent for Self Directed Care** - acts as a payroll agent for the staff of those individuals who choose to self direct their own care.
- Other Family Supports** _____

Children Services

Do you need Children's Services? _____ Yes _____ No

If yes, please select all services needed:

- Early Intervention Services** - provides home based or center based services such as physical therapy, occupational therapy, speech/language, and family service coordination to children ages birth through two, who have a diagnosed disability or are demonstrating developmental delays.
- Other Children Services** _____

Other Supports or Services

Do you need other supports? _____ Yes _____ No

If yes, please select all services needed:

- Transportation** - transportation for individuals to and from service components.
- Case Management** - provides support to eligible persons by developing, linking, coordinating and monitoring services supports and resources. See Case Management Fact Sheet for more information.

Other services needed: _____

Who do you want to receive services from? _____

Where do you need services provided? _____

When would you like for services to begin? (Date) _____

The following information will be used to determine the individual's needs, preferences and choices and to assist in planning for future services. Please complete in as much detail as possible and check all that apply.

Perpetrator: Anyone who has been clinically diagnosed and/or identified through the criminal justice system or by Protective Services/SRS as a perpetrator.

- Pedophile behavior
- Criminal Battery
- Sexual Assault
- Assault with a deadly weapon
- Stalking behavior
- Other (describe):

DOES NOT APPLY

Medically Fragile: Anyone who has been diagnosed with a life threatening condition involving major body systems.

- Brittle Diabetes
- Congestive Heart Failure
- Dementia/Alzheimer's Uncontrolled Seizures
- Diagnosed with terminal illness (specify):
- Other (describe):

DOES NOT APPLY

Applicant has history of refusing to:

- Take prescribed medication
- Follow physician ordered diet
- Agree to a doctor requested test, lab treatment, procedure
- Allow support staff into home/apartment
- Notify support staff of whereabouts
- Attend physician/dental appointments
- Attend therapist appointments
- Follow services prescribed by the Life Planning Team
- Follow Behavior Support/Management Plan
- Follow doctor's orders
- DOES NOT APPLY

Please Describe Incidences and Severity of:	Frequency of Behaviors	Type of Staffing/Supervision Ratio/Training Needed
Property Destruction		
Self Injurious Behaviors		
Injuries to Others		
Sexual Aggressions <input type="checkbox"/> Against children <input type="checkbox"/> Against Adults		
Other Aggressions		

The CDDO is required to serve or arrange to serve all eligible individuals regardless of their disability or background. This information will be used for planning purposes only and will not be used in any way to discriminate by disability or criminal background.

Documentation To Submit Along With the Completed Application

Please submit a copy of the following applicable documentation along 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.

- Most recent psychological evaluation
- School individual education plan
(If applicant was in school within the past 3 years)
- School individual family support plan (if applicable)
- Social History (if available)
- Person-Centered Plan (if applicable)
- Medical Records (if related to disability or functioning level)
- Mental Health record (if applicable)
- Vocational Evaluation (if applicable)

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 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.

Signature: _____ Date: _____

Relationship to Applicant: _____