

# 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 / Diagnosis

	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:

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**Adult Day Services**

Do you need services or supports during the day? \_\_\_ Yes \_\_\_ No

If yes, please select services needed:

- Community Inclusion** - 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** \_\_\_\_\_

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**Residential Services**

Do you need services or supports for community living? \_\_\_ Yes \_\_\_ No

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. Individuals typically live on their own or with a roommate.
- 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 when they cannot, for whatever reason, remain in the home of their natural families. The host family becomes the primary care giver and provides all child rearing.
- Other Residential Services** \_\_\_\_\_

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## 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 while living in the family home.
- Respite Services** - provides temporary care to the developmentally disabled individual as a relief for the individual's family member who serves as the unpaid primary care giver.
- Other Family Supports** \_\_\_\_\_  
\_\_\_\_\_

## Children Services

Do you need Children's Services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please select all services needed:

- Early Intervention Services** - (for ages birth to 3) provides home based or center based services such as physical therapy, occupational therapy, speech/language, and family service coordination to children, 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:

- 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.

Please identify your preference in Case Management providers: \_\_\_\_\_

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) \_\_\_\_\_

**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 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 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: \_\_\_\_\_

**Please return application and supporting documentation to:**

DSNWK-CDDO Funding Manager  
PO Box 1016  
Hays, KS 67601  
or fax to: (785) 625-8204

# Targeted Case Management Choice Form for the DSNWK CDDO Area

Person Served: \_\_\_\_\_

**Check the service provider you have chosen to provide Case Management Services (please only check one):**

- Developmental Services of Northwest Kansas, Inc.
- Golden West Community Services
- Jerry Pfeifer Independent Case Management, LLC.
- OCCK, Inc.
- Other: \_\_\_\_\_

DSNWK CDDO will contact the listed Case Manager to initiate the affiliation process.

Special Notice: Targeted Case Management is an essential service in the community service model within Kansas. I understand, however, that I can choose not to receive Targeted Case Management (TCM) Services. By declining TCM services, I understand that some elements of this service are still required by SRS to be completed. A TCM Waiver, on back of this form, must be signed and returned to CDDO Funding Manager, PO Box 1016, Hays, KS 67601.

By signing below, I acknowledge that I have been informed of available Targeted Case Management providers in my area.

\_\_\_\_\_  
Signature (Legally Responsible Person)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Person Served

# TCM Waiver

I have read the Case Management Fact Sheet and choose to decline Targeted Case Management Services. I understand that DSNWK CDDO will contact me annually to update BASIS.

DSNWK CDDO will bill Medicaid under the HCBS MRDD Screening for the initial and annual update of the BASIS Assessment Instrument.

Any assistance or case management services requested by the individual/guardian, will require the selection of a case management provider through the completion of a TCM Choice form ( CDDO-03). Additional case management activities will be billed to Medicaid or the individual.

Case management services may be requested at any time by contacting DSNWK CDDO Funding Manager. The individual/guardian will be offered the choice of case management providers at that time.

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Person Served

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Signature (Legally Responsible Person)

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Date

Send Copy of TCM Waiver to:  
CDDO Funding Manager  
DSNWK  
PO Box 1016  
Hays, KS 67601.