TRI-KO INC.

COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION
Miami, Linn, & Anderson Counties

ELIGIBILITY DETERMINATION

TRI-KO, Inc. CDDO
TRI-KO's Community Developmental Disability Organization, referred to as the "CDDO", is the starting place for the residents of Anderson, Linn, & Miami counties who are seeking intellectual or developmental disability (I /DD) supports. The CDDO determines I/DD program eligibility, presents unbiased options counseling, and connects eligible people to affiliated provider agencies.

Application Processing
The eligibility criteria for intellectual and developmental disability programs in Kansas is set by the Developmental Disability Reform Act of 1996.

The CDDO reviews diagnostic information from licensed professionals, who have worked with the applicant, in order to make an eligibility determination.

The applicant is encouraged to provide the CDDO with copies of their diagnostic, medical, and psychological records. The CDDO can assist with obtaining records only with the written authorization of the applicant and/or legal guardian.

Documentation for Referral

- ☐ Completed Intake Application *
- ☐ Evaluation/testing that diagnosed the disability *
- ☐ Copy of State Issued Birth Certificate
- ☐ Current Individualized Education Plan
- ☐ Copy of Social Security Card
- ☐ Copy of Driver's License or I.D. Card (if applicable)
- ☐ Copy of Insurance Card (if applicable)
- ☐ Copy of Adoption Decree (if applicable)*
- ☐ Copy of Guardianship Decree (if applicable)*

*Required

Eligibility Decision
The CDDO is generally able to make a decision within 5 business days of receiving all of the necessary *diagnostic* information. Please be aware that additional testing may be needed in order to determine eligibility. We will communicate the determination in writing.

If you are determined *eligible* for I/DD services the CDDO will contact you to schedule a service option meeting. During the meeting, we will talk more about the types of I/DD services and providers available in the area and complete the initial functional assessment.

If you are determined *not eligible* for I/DD services, the CDDO will make recommendations about other community resources that may be able to assist you. We will also provide information about your rights and steps to appeal the eligibility decision.

Waiting List
There is a waiting list in Kansas for I/DD service funding. Crisis procedures exist for persons who need immediate funding for I/DD services due to confirmed abuse, or because they are at significant, imminent risk of serious harm to self or others. Special circumstances can be discussed with the CDDO.

Please return application and required documents to:
TRI-KO, Inc. CDDO
301 First Street, Box 2
Phone: 913-755-3025
Or fax to: 844-272-3771
E-mail: robin_griffin-lohman@tri-kocddo.com

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INTAKE APPLICATION

1. APPLICANT INFORMATION:

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____ SEX: ☐ M ☐ F

CITY/STATE _____ COUNTY _____ ZIP _____

PHONE: _____ E-MAIL: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

ARE YOU CURRENTLY COVERED BY TRICARE ECHO? ☐ YES ☐ NO *(for military and family)*

ARE YOU ENROLLED WITH KANCARE? ☐ YES ☐ NO

IF YES, WHICH MANAGED CARE ORGANIZATION ARE YOU ASSIGNED TO? ☐ United Healthcare ☐ Sunflower ☐ Aetna

MEDICAID ID#: _____

HAVE YOU APPLIED TO A CDDO FOR INTELLECTUAL/DEVELOPMENTAL DISABILITY SERVICES IN THE PAST? ☐ YES ☐ NO

IF "YES", WHEN AND WHERE DID YOU APPLY? _____

WHAT WAS THE OUTCOME OF THIS APPLICATION? _____

2. PERSON ASSISTING WITH REFERRAL (if applicable):

NAME OF CONTACT: _____

CONTACT'S ADDRESS: _____

CONTACT's PHONE: _____ CONTACT'S E-MAIL: _____

RELATIONSHIP: _____

3. GUARDIANSHIP (if applicable):

NAME OF GUARDIAN: _____

GUARDIAN PHONE: _____ GUARDIAN'S E-MAIL: _____

TYPE OF GUARDIANSHIP:

☐ NATURAL GUARDIAN (PARENT OF CHILD UNDER 18)

☐ COURT APPOINTED LEGAL GUARDIAN COUNTY OF GUARDIANSHIP: _____

4. DIAGNOSED DISABILITIES

DISABILITY	DIAGNOSED BY	AGE OF ONSET
Primary:		
Other:		
Other:		
Other:		

5. EDUCATION

NAME OF LAST SCHOOL ATTENDED: _____

CITY/STATE OF SCHOOL: _____

MONTH & YEAR OF GRADUATION _____

HIGHEST GRADE LEVEL ACHEIVED: _____

ATTENDED SPECIAL EDUCATION CLASSES : ☐ YES ☐ NO

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6. CURRENT SERVICE INFORMATION:

IS THE APPLICANT CURRENTLY RECEIVING HCBS FUNDED SERVICES IN KANSAS? ☐ YES ☐ NO

IF "YES", WHICH HCBS WAIVER?

☐ INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD) ☐ PHYSICAL DISABILITY (PD) ☐ AUTISM WAIVER ☐ FRAIL ELDERLY (FE)

☐ SEVERELY EMOTIONALLY DISTURBED (SED) ☐ TRAUMATIC BRAIN INJURY (TBI) ☐ TECHNOLOGY ASSISTED (TA)

7. PREVIOUS PLACEMENT: Has the applicant resided in any of the following?

HAS APPLICANT BEEN PLACED IN STATE INTELLECTUAL DISABILITY HOSPITAL (Parsons, KNI, Winfield) : ☐ YES ☐ NO

STATE MENTAL HEALTH HOSPITAL (Topeka, Larned, Osawatomie) : ☐ YES ☐ NO

PRIVATE ICF/DD: ☐ YES ☐ NO If yes, where? _____

8. CURRENT LIVING ARRANGEMENT: Check the one that best describes your current living arrangement:

☐ FAMILY HOME/PARENT(S) ☐ SPOUSE/PARTNER ☐ EXTENDED FAMILY (grandparents, sibling, etc.)

☐ FOSTER HOME ☐ LIVING ALONE ☐ NURSING HOME

☐ INTERMEDIATE CARE FACILITY (ICF) ☐ STATE INSTITUTION ☐ OTHER: _____

9. CURRENT DAYTIME ACTIVITY: Check the one that best describes your current daytime routine:

☐ SCHOOL/EDUCATIONAL SETTING ☐ COMPETITIVE EMPLOYMENT ☐ OCCUPATIONAL TRAINING

☐ VOLUNTEER WORK ☐ DAY PROGRAM ☐ NONE

10. STATEWIDE WAITING LIST FOR HOME COMMUNITY BASED SERVICES (HCBS) FUNDING

New persons determined eligible for HCBS are placed on the statewide waiting list for HCBS service funding after the initial functional assessment is completed by the CDDO. While waiting for funding, applicants should contact the CDDO if their needs or timeline for services changes.

The Kansas Department of Aging and Disability Services (KDADS) allocates new HCBS funding, when available, based on the order in which persons were placed on the list. KDADS may allow priority funding for eligible individuals at imminent risk to health, safety and welfare who need immediate services to continue living safely in the community. Special circumstances, which may warrant priority access to funding, should be discussed with the CDDO representative.

11. MARKETING LIST – check one

☐ YES please share my name and address with any affiliated service providers who request a marketing list for individuals on the statewide waiting list for HCBS I/DD Waiver funding.

☐ NO although I am on the waiting list, I would not like my contact information to be shared with affiliated service providers for the purpose of marketing.

11. SIGNATURES

☐ YES I have been provided with a copy of TRI-KO, CDDO's Privacy Practices

I acknowledge that this application does not guarantee eligibility for services, nor does it guarantee funding for services if I am determined eligible. I agree that the information contained in this application is correct to the best of my knowledge.

_____

Legal Representative Signature **Date**

_____

Applicant Signature **Date**

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____
Medicaid Number: _____ Phone Number: _____
Address: _____ City/State, Zip Code: _____

I hereby authorize **TRI-KO, CDDO [301 First Street; Osawatomie, KS 66064**] to obtain information from, disclose information to, and exchange my individually identifiable health information -as described below- in written, electronic or verbal form. I understand that signing this form voluntary.

Persons/Organization(s) PROVIDING the Information
Check All That Apply

☐ Community Mental Health Center:_____

☐ School: _____

☐ Community Developmental Disability Organization: _____

☐ Managed Care Organization:_____

☐ Medical Care Provider:_____

☐ State Agency or Contracted Entity (ADRC, ICF):_____

☐ Other:_____

Description of Information to be used or disclosed:

☐ Psychological Evaluation
☐ School Testing & Evaluation, IEP
☐ Vocational Evaluation
☐ Individual Counseling Notes
☐ Diagnostic Testing Reports
☐ Discharge Summary
☐ History & Physical Examination
☐ Psychiatric Evaluation
☐ Speech Evaluation
☐ Medical Records as permitted by law
☐ Current Funding and Service Information
☐ Other (specify)_____

Purpose of Disclosure

☐ Assist in disability determination process
☐ Continuity of care
☐ Communication
☐ Referral to another agency
☐ Other specific reason(s): _____

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 TRI-KO, CDDO in writing of my desire to revoke it. I understand revoking this authorization will not have any effect on actions taken by TRI-KO, CDDO in reliance on this authorization. I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

This authorization will expire **one year from date of signature or** on the occurrence of the following: _____

_____
Printed Name of Applicant or Legal Representative

_____ _____
Signature of Applicant or Legal Representative Date