Disability Planning Organization of Kansas, Inc.
119 W. Iron Ave., 4th Floor | P.O. Box 1067 | Salina, KS 67402-1067
785-823-3173 | Toll Free 866-886-3765 | Fax 785-823-3299 | www.dpok.com

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 HCP/CDDO 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. mental retardation, 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:

	Date	Place and Address
[ ] Hospital/Clinic	_____	_____
[ ] Mental Health	_____	_____
[ ] Other	_____	_____

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**