



Reno County CDDO  
PO Box 399 • 1300 East Avenue A  
Hutchinson, Kansas 67504-0399  
663-2219 • 620-663-2439 Fax  
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### 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**

