Twin Valley Developmental Services, Inc.

CDDO for
Washington and Marshall Counties

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**