

**Community Developmental Disabilities Organization
of DOUGLAS and JEFFERSON County
Referral for MR/DD Services**

Date: _____

Name:	Date of Birth: _____ Age: _____
Address:	Medicaid #:
City/State/Zip:	Social Security #:
Telephone #:	Contact Person:
Name of Parent/Guardian: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	Contact Person Telephone #:
Parent/Guardian Address:	Person Making Referral: (May be self)
Parent/Guardian City/State/Zip:	School/Teacher:
Home Phone #: Work Phone #: Cell Phone #: Email Address:	Reason for Referral:

- Applicant Information -

Applied for MR/DD services
before? Yes No
If so, when? _____

Name: _____ Date: _____
Maiden Name: _____ Phone: _____
Date of Birth: _____ Age: _____ Gender: Male Female
Address: _____ City/State/Zip: _____
Email Address: _____
Guardian / Parent: Guardian Parent Guardian Name: _____
Guardian / Parent Address: _____
Medicaid Number: _____ Social Security Number: _____
Financial Resources: Social Security Benefits? Payee: _____

MEDICAL / PSYCHOLOGICAL INFORMATION

Diagnosis: _____
Age of onset of Disability: _____ History of Seizures (in the last 5 years): Yes No
List any Physical Impairments / Medical Concerns:

 History of Mental Health Services / Hospitals: (Include Name of City & State)
1. Place Name _____ Date: (Mo. /Yr.) _____
2. Place Name _____ Date: (Mo. /Yr.) _____
 Evaluations from Diagnostic Centers: (Include Name of City & State)
1. Place Name _____ Date: (Mo. /Yr.) _____
2. Place Name _____ Date: (Mo. /Yr.) _____
 Placement in other MR/DD Facilities: (Include Name of City & State)
1. Place Name _____ Date: (Mo. /Yr.) _____
2. Place Name _____ Date: (Mo. /Yr.) _____

(Revised 12-28-11)

BACKGROUND INFORMATION

Name of current or last school attended: _____		
City / State: _____	Highest Grade Level Achieved: _____	
Attended Special Education Classes: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Graduation: _____
<u>Employment History:</u>		
Employer:	Job Title:	Length of Employment:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS

Current Medication	Reason for Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURES

By signing your name below you agree that the information provided in this application is accurate and that you have also received the Notice of Privacy Practices (included in the Eligibility Packet)

Applicant Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

For further MR/DD resources visit our online Resource Directory at the CDDO website:

www.cddo.cwood.org



Cottonwood CDDO

...a division of Cottonwood, Inc.

2801 W. 31st Street · Lawrence, Kansas 66047
785 · 842 · 0550

Date: _____

Revised: 12/11

Third Party Liability

Attach copies of all insurance cards to this form and return to Cottonwood CDDO

Section 1: Identifying Information

Consumer Name: _____ Medicaid #: _____

Current Service Providers:

TCM: _____ PBS: _____

Day Supports: _____

Residential Supports: _____

Financial Management: _____

Section 2: Insurance Policy Information

Medicaid insurance only

Primary insurance other than Medicaid (complete information box below)

Name of insurance company _____			
Street address _____			
City _____	State _____	ZIP _____	Phone number _____
Policyholder name _____			
Policyholder address _____			
Policyholder Social Security number _____			
Policyholder date of birth _____		Policy number _____	
Policy group number _____		Relationship to beneficiary _____	

Section 3: Advance Beneficiary Notice

This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the provider and payment is not made by Medicaid, you may be held responsible for the charges if your services are not covered by Medicaid.

Signature of Responsible Party

Date

COTTONWOOD CDDO
2801 West 31st Street
Lawrence, KS 66047
(785) 842-0550

AUTHORIZATION FOR RELEASE OF INFORMATION
FOR DIAGNOSTIC INFORMATION

I hereby give consent for release/use of information to/from:

(Name & Address of Agency/Person / Phone # / Fax #)

Regarding: _____ (Name) _____ (Date of Birth)

To/From: Cottonwood, Inc. CDDO, 2801 West 31st St., Lawrence, KS 66047

The Following information:

Diagnostic Medical Evaluations & Assessments Psychological Evaluations Social History
 Other: _____

Is requested for the purpose of: Determining eligibility for services for individuals with developmental disabilities.

Form of information: (forms of information listed below apply)

_____ Written material _____ Verbal _____

I understand that the information used or disclosed may be subject to redisclosure by the person(s) receiving it and no longer protected by the federal privacy regulation. I understand that I may revoke this authorization by notifying Cottonwood staff of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Cottonwood, Inc. in reliance on this authorization. I understand that I may refuse to sign this authorization and that 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 the date of signature.

Signature: _____ Date: _____

Guardian: _____ Date: _____
(Legal Guardian or Parent of a Minor)

Return this signed and completed form to the CDDO

(Revised 12-29-11)

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2801 West 31st Street
Lawrence, KS 66047
(785) 842-0550

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AUTHORIZATION FOR RELEASE OF INFORMATION
FOR SCHOOL RECORDS

I hereby give consent for release/use of information to/from:

(Name & Address / Zip of School / Agency / Person / Phone # / Fax #)

Regarding: _____ (Name) _____ (Date of Birth)

To/From: Cottonwood, Inc. CDDO, 2801 West 31st St., Lawrence, KS 66047

The Following information:

- Diagnostic Medical Evaluations & Assessments Psychological Evaluations
 School Records / Most Recent IEP Communications re: Service Coordination / Eligibility
 Other: IQ Test Results /

Is requested for the purpose of: Determining eligibility for services for individuals with developmental disabilities.

Form of information: (forms of information listed below apply)

_____ Written material Verbal _____

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Signature: _____ Date: _____

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(Legal Guardian or Parent of a Minor)

Return this signed and completed form to the CDDO

(Revised 12-29-11)

Acknowledgment of Receipt of Notice of Privacy Practices

COTTONWOOD, INC.

This is to acknowledge my receipt of Cottonwood, Inc.'s Notice of Privacy Practices effective April 14, 2003.

Date of Individual's or Personal
Representative's Signature

Signature of Individual or
Personal Representative

Individual's Name

Individual's Address

Name of Personal Representative
(If applicable)

Description of Representative's Authority
to Act for the Individual
(If applicable)

**RETURN THIS COMPLETED AND SIGNED FORM
WITH YOUR APPLICATION**

COTTONWOOD, INC.

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

This notice will tell you how we may use and disclose protected health information about you. Protected health information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In the header above, that information is referred to as "medical information." In this notice, we simply call all of that protected health information, "health information."

This notice also will tell you about your rights and our duties with respect to health information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights.

How We May Use and Disclose Health Information About You.

We use and disclose health information about you for a number of different purposes. Each of those purposes is described below.

For Treatment.

We may use health information about you to provide, coordinate or manage the services, supports, and health care you receive from us and other providers. We may disclose health information about you to doctors, nurses, Targeted Case Managers, employers, psychologists, social workers, direct support staff and other agency staff, volunteers and other persons who are involved in supporting you. or providing care. We may consult with other health care providers concerning you and, as part of the consultation, share your health information with them. For example, staff may discuss your information to develop and carry out your individual service plan. Staff may share information to coordinate needed services, such as medical tests, transportation to a doctor's visit, physical therapy, etc. Staff may need to disclose health information to entities outside of our organization (for example, another provider or a state/local agency) to obtain new services for you.

For Payment.

We may use and disclose health information about you so we can be paid for the services we provide to you. This can include billing a third party payor, such as Medicaid or other state agency (for example, Social Rehabilitation Services). For example, we may need to provide the state Medicaid program information about the services we provide to you so we will be reimbursed for those services. We also may need to provide the state Medicaid program with information to ensure you are eligible for the medical assistance program.

For Health Care Operations.

We may use and disclose health information about you for our own operations. These are necessary for us to operate Cottonwood, Inc. and to maintain quality for our consumers. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization, for accreditation or licensing activities, or for our Outcome Management System.

How We Will Contact You.

Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your workplace. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see "Right to Receive Confidential Communications" in this Notice.

Appointment Reminders.

We may use and disclose health information about you to contact you to remind you of an appointment for treatment or services.

Treatment and Service Alternatives.

We may use and disclose health information about you to contact you about treatment and service alternatives that may be of interest to you.

Health Related Benefits and Services.

We may use and disclose health information about you to contact you about health-related benefits and services that may be of interest to you.

Marketing Communications.

We may use and disclose health information about you to communicate with you about a product or service to encourage you to purchase the product or service. This May be:

To describe a health-related product or service that is provided by us;

For your treatment;

For case management or care coordination for you;

To direct or recommend alternative treatments, therapies, health care providers, or settings of care.

We may communicate to you about services in a face-to-face communication by us to you.

Fundraising.

We may use and disclose health information about you to raise funds for Cottonwood, Inc. We will get a release from you before we use your name or picture or any other identifying information.

Disclosures to Family and Others.

We may disclose to a parent/guardian, personal representative, family member, other relative, a close personal friend, or any other person identified by you, health information about you that is directly relevant to that person's involvement with the services and supports you receive or payment for those services and supports. We also may use or disclose health information about you to notify, or assist in notifying, those persons of your location, general condition, or death. If there is a family member, other relative, or close personal friend that you do not want us to disclose health information about you to, please notify your Case Manager or tell our staff member who is providing care to you.

Disaster Relief.

We may use or disclose health information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be done to coordinate with those entities in notifying a parent/guardian, personal representative,

family member, other relative, close personal friend, or other person identified by you of your location, general condition or death.

Required by Law.

We may use or disclose health information about you when we are required to do so by law.

Public Health Activities.

We may disclose health information about you for public health activities and purposes. This includes reporting health information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease. Or, one that is authorized to receive reports of child abuse and neglect. It also includes reporting for purposes of activities related to the quality, safety or effectiveness of a United States Food and Drug administration regulated product or activity.

Victims of Abuse, Neglect or Domestic Violence.

We may disclose health information about you to a government authority authorized by law to receive reports of abuse, neglect, or exploitation, if we believe you are a victim of abuse, neglect, or exploitation. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by you or your personal representative; or, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims, or, if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities.

We may disclose health information about you to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations.

Judicial and Administrative Proceedings.

We may disclose health information about you in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal. We also may disclose health information about you in response to a subpoena, discovery

request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes.

We may disclose health information about you to a law enforcement official for law enforcement purposes:

- a. As required by law.,
- b. In response to a court, grand jury or administrative order, warrant or subpoena.
- c. To identify or locate a suspect, fugitive, material witness or missing person.
- d. About an actual or suspected victim of a crime and that person agrees to the disclosure. If we are unable to obtain that person's agreement, in limited circumstances, the information may still be disclosed.
- e. To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct.
- f. About crimes that occur at our organization.
- g. To report a crime in emergency circumstances.

Coroners and Medical Examiners.

We may disclose health information about you to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death.

Funeral Directors.

We may disclose health information about you to funeral directors as necessary for them to carry out their duties.

Organ, Eye or Tissue Donation.

To facilitate organ, eye or tissue donation and transplantation, we may disclose health information about you to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue.

Research.

You must individually agree to participate in a research project which would be separate from our operations.

To Avert Serious Threat to Health or Safety.

We may use or disclose protected health information about you if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We also may release information about you if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

Inmates; Persons in Custody.

We may disclose health information about you to a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care to you; (b) for the health and safety of others; or, (c) the safety, security and good order of the correctional institution.

Workers Compensation.

We may disclose health information about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Other Uses and Disclosures.

Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying your Case Manager in writing of your desire to revoke it. However, if you revoke such an authorization, it will not have any affect on actions taken by us in reliance on it.

Your Rights With Respect to Health Information About You.

You have the following rights with respect to health information that we maintain about you.

Right to Request Restrictions.

You have the right to request that we restrict the uses or disclosures of health information about you to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member,

other relative, a close personal friend or any other person identified by you; or, (b) public or private entities for disaster relief efforts. For example, you could ask that we not disclose health information about you to your brother or sister.

To request a restriction, you may do so at any time. If you request a restriction, you should do so to your Case Manager and tell us: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and, (c) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction.

Right to Receive Confidential Communications.

You have the right to request that we communicate health information about you to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication.

If you want to request confidential communication, you must do so in writing to your Case Manager. Your request must state how or where you can be contacted.

We will accommodate your request. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

Right to Inspect and Copy.

You have the right to inspect and obtain a copy of health information about you.

To inspect or copy health information about you, just ask your Case Manager. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

We will act on your request for copying within fifteen (15) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

We may deny your request to inspect and copy health information if the health information involved is information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding.

If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed, and how you may complain. If you request a review of our denial, it will be conducted by a licensed health care professional designated by us who was not directly involved in the denial. We will comply with the outcome of that review.

Right to Amend.

You have the right to ask us to amend health information about you. You have this right for so long as the health information is maintained by us.

To request an amendment, you must submit your request in writing to your Case Manager. Your request must state the amendment desired and provide a reason in support of that amendment.

We will act on your request within sixty (60) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

If we grant the request, in whole or in part, we will seek your identification of and agreement to share the amendment with relevant other persons. We also will make the appropriate amendment to the health information by appending or otherwise providing a link to the amendment.

We may deny your request to amend health information about you. We may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, we may deny your request to amend health information if we determine that the information:

- a. Was not created by us, unless the person or entity that created the information is no longer available to act on the requested amendment;
- b. Is not part of the health information maintained by us;
- c. Would not be available for you to inspect or copy; or,
- d. Is accurate and complete.

If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreeing with our denial. Your statement may not exceed one page. We may prepare a rebuttal to that statement. Your request for amendment, our denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the health information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of any of that information.

If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the health information involved.

You also will have the right to complain about our denial of your request.

Right to an Accounting of Disclosures.

You have the right to receive an accounting of disclosures of health information about you. The accounting may be for up to six (6) years prior to the date on which you request the accounting but not before April 14, 2003.

Certain types of disclosures are not included in such an accounting:

- a. Disclosures to carry out treatment, payment and health care operations;
- b. Disclosures of your health information made to you;
- c. Disclosures that are incident to another use or disclosure;
- d. Disclosures that you have authorized;
- e. Disclosures to persons involved in your care;
- f. Disclosures for disaster relief purposes;
- g. Disclosures for national security or intelligence purposes;
- h. Disclosures to correctional institutions or law enforcement officials;
- i. Disclosures made prior to April 14, 2003.

Under certain circumstances your right to an accounting of disclosures to a law enforcement official or a health oversight agency may be suspended. Should you request an accounting during the period of time your right is suspended, the accounting would not include the disclosure or disclosures to a law enforcement official or to a health oversight agency.

To request an accounting of disclosures, you must submit your request in writing to your Case Manager. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request and may not include dates before April 14, 2003.

Usually, we will act on your request within sixty (60) calendar days after we receive your

request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary.

There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

Right to Copy of this Notice.

You have the right to obtain a paper copy of our Notice of Privacy Practices. You may request a copy of our Notice of Privacy Practices at any time.

You may obtain a copy of our Notice of Privacy Practices over the Internet at our web site, www.cwood.org

To obtain a paper copy of this notice, contact the Administrator of Services.

Our Duties

Generally.

We are required by law to maintain the privacy of health information about you and to provide individuals with notice of our legal duties and privacy practices with respect to health information.

We are required to abide by the terms of our Notice of Privacy Practices in effect at the time.

Our Right to Change Notice of Privacy Practices.

We reserve the right to change this Notice of Privacy Practices, We reserve the right to make the new notice's provisions effective for all health information that we maintain, including that created or received by us prior to the effective date of the new notice.

Availability of Notice of Privacy Practices.

A copy of our current Notice of Privacy Practices will be posted in the hallway of Bldg. I
A copy of the current notice also will be posted on our web site, www.cwood.org

At any time, you may obtain a copy of the current Notice of Privacy Practices by contacting Administrator of Services

Cottonwood, Inc.
2801 W. 31st St.
Lawrence, KS 66047
(785) 842-0550

Effective Date of Notice.

The effective date of the notice will be stated on the first page of the notice.

Complaints.

You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

To file a complaint with us, contact the Director of Support Services or the Director of CDDO Administration at above address. All complaints should be submitted in writing.

To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him or her in care of: Office for Civil Rights, U.S, Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201.

You will not be retaliated against for filing a complaint.

Questions and Information.

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact Administrator of Services

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