COTTONWOOD CDDO

2801 W 31st St., Lawrence KS 66047
Community Developmental Disability Organization serving Douglas and Jefferson Counties

-Application Guidelines for Eligibility Determination-

Thank you for your interest in applying for I/DD Services. At this time, there is a waiting list for funding for these services. Please review the list below and complete the forms as indicated. Allow up to 45 days to process the application. Incomplete applications will be put on hold until ALL documents have been received. **You will be contacted by the CDDO after eligibility has been determined.**

IT IS THE APPLICANT'S RESPONSIBILITY TO ENSURE THAT THE FOLLOWING DOCUMENTS ARE DELIVERED TO THE CDDO.

Documents can be mailed, faxed or hand delivered to Cottonwood CDDO. Faxed records will also be accepted from professionals. Fax: (785) 576-1124

- ☐ Copy of **Social Security Card**
- ☐ Copy of **Birth Certificate** (http://www.vitalrec.com) or **Permanent Resident Card** (green card)
- ☐ Copy of **Adoption Papers** (if applicable)
- ☐ Copy of **Guardianship Papers** (if you have a guardian)
- ☐ Copy of Military **DD 214 form**, **TriCare verification**, **& proof of KS residence** (if applicable)
- ☐ Copy of **Medicaid Card**
- ☐ **Third Party Liability Form & Copy of Insurance Card(s)**
- ☐ **Eligibility Application** – completed and signed
- ☐ **Releases of Information** that authorize the CDDO to exchange information with any agencies & professionals you are or have been involved with including schools which you are or have attended.

  Top portion of Releases must be Completed & Lower portion must be Signed & Dated
- ☐ **School Records to Include:** IEP, School psychological evaluation, IQ Scores / testing and assessments, & early childhood records.
- ☐ **Services Records to Include:** Speech, Occupational and Physical Therapy, Tiny K and Success by Six and other therapies.
- ☐ **Diagnostic Records:** Documentation of your diagnosis as determined by a licensed professional, a psychological evaluation, supporting documentation of test/assessments used to determine the diagnosis that meets criteria for I/DD Services. (for Eligibility Requirements - see insert; for Psychological Evaluation Information – see insert)
- ☐ **Receipt Page for Privacy Policies** - Completed and signed

If you have not had a psychological evaluation, have not been assessed, have questions about the process or need more information about what documents are necessary to determine eligibility, please contact Angela Levy at (785) 840-1614 Fax (785) 576-1124

Cottonwood Community Developmental Disability Organization
of Douglas & Jefferson Counties

- Applicant Information -

(Revised 8/17/23)

Name: ______________________ **Date:** ______________

Maiden Name: ______________________ **Phone:** ______________

Date of Birth: ______________ **Age:** ________ **Gender:** ☐Male ☐Female ☐Other

Address: ____

Kancare / Medicaid #: ______________ **Social Security #:** ______________

Applied for I/DD services before? ☐ Yes ☐ No **If so, when?** ______________

Active Military or Military Dependent & TriCare Echo eligible? ☐ Yes ☐ No

PARENT CONTACT INFORMATION *(for applicants under 18 years old)*

Parent's Name: ____

Address: ____

Home Phone: ______________ **Work Phone:** ______________ **Cell:** ______________

Email Address: ____

LEGAL GUARDIAN CONTACT INFORMATION *(for applicants 18 years & older or child in custody)*

Guardian's Name: ______________________ ☐ I am also the Parent

Address: ____

Home Phone: ______________ **Work Phone:** ______________ **Cell:** ______________

Email Address: ____

OTHER CONTACT PERSON *(if applicable)*

Contact Person: ____

Address: ____

Home Phone: ______________ **Work Phone:** ______________ **Cell:** ______________

Email Address: ____

Relationship to Applicant: ____

MEDICAL / PSYCHOLOGICAL INFORMATION

Diagnoses: ____________________

NOTE: *Include the name of the facility where the above diagnoses were made in the section below and please remember to complete a Release of Information (included in Eligibility Packet) for this facility as well.*

Age of onset of Disability: ________ **History of Seizures** (in the last 5 years)**:** ☐ Yes ☐ No

List any Physical Impairments / Medical Concerns:

☐ **Evaluations from Medical Hospitals / Diagnostic Centers:** (Include Name of City & State)

1. Facility Name ____________________ **Date:** (Mo. /Yr.) ________

2. Facility Name ____________________ **Date:** (Mo. /Yr.) ________

☐ **History of Mental Health Services / Hospitals:** (Include Name of City & State)

1. Facility Name ____________________ **Date:** (Mo. /Yr.) ________

2. Facility Name ____________________ **Date:** (Mo. /Yr.) ________

☐ **Placement in other I/DD Facilities:** (Include Name of City & State)

1. Facility Name ____________________ **Date:** (Mo. /Yr.) ________

2. Facility Name ____________________ **Date:** (Mo. /Yr.) ________

BACKGROUND INFORMATION

Name of current or last school attended: ____________________

City / State: ____________________ **Highest Grade Level Achieved:** ________

Attended Special Education Classes: ☐ Yes ☐ No **Date of Graduation:** ________

Involved with Vocational Rehabilitation through DCF (Dept. for Child & Family) ☐ Yes ☐ No

Currently Employed: ☐ Yes ☐ No **If Yes, Name of Employer:** ____________________

Any Previous Employment: ____________________

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:** ________

Cottonwood CDDO
Serving Douglas & Jefferson counties

2801 W. 31 st Street · Lawrence, Kansas 66047
785 · 840 · 1632

Revised: 2/22/17

Third Party Liability

Consumer Name: ____________________________ **Medicaid #:** __________________________

Insurance Policy Information

☐ Medicaid insurance only
☐ Primary insurance other than Medicaid *(complete information box below)*

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

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______________________

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
Tel: (785) 840-1632
Fax: (785) 576-1124

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.

Consumer Signature: ____ Date: ____________

Guardian Signature: ____ Date: ____________

Guardian Print Name: ____________________________________ ☐ DCF custody
(Legal Guardian or Parent of a Minor)

Return this signed and completed form to the CDDO

(Revised 5-9-19)

COTTONWOOD CDDO
2801 West 31st Street
Lawrence, KS 66047
Tel: (785) 840-1632
Fax: (785) 576-1124

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)

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Consumer Signature: ____________________________ Date: __________

Guardian Signature: ____________________________ Date: __________

Guardian Print Name: ____________________________ ☐ DCF custody
(Legal Guardian or Parent of a Minor)

Return this signed and completed form to the CDDO

(Revised 5-9-19)

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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

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.

Consumer Signature: ____________________________________ Date: __________

Guardian Signature: ____________________________________ Date: __________

Guardian Print Name: ____________________________________ ☐ DCF custody
(Legal Guardian or Parent of a Minor)

Return this signed and completed form to the CDDO

(Revised 5-9-19)

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

C 2002 John C. Gilliland TI

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.

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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.

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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.

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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 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

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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

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

ELIGIBILITY REQUIREMENTS

KANSAS DEPARTMENT OF AGING AND DISABILITY SERVICES

The Intellectual / Developmental Disability (I/DD) waiver serves individuals age five and older who meet the definition of intellectual disability, having a developmental disability or are eligible for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Those with a developmental disability may be eligible if their disability was present before age 22 and they have a substantial limitation three or more areas of life functioning.

ELIGIBILITY

1. Must be 5 years of age or older;
2. Have Intellectual Disability that began before the age of 18;
3. Have a diagnosis of a Developmental Disability that began before the age of 22;
4. Must be determined program eligible by the Community Disability Determination Organization;
5. Meet the Medicaid long-term care institutional threshold score;
6. Be financially eligible for Medicaid.

Intellectual Disability means substantial limitations in present functioning that is manifested during the period from birth to age 18 years and is characterized by significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable adaptive skill areas:

1. Communication
2. Self-care
3. Home living
4. Social skills
5. Community use
6. Self-direction
7. Health & safety
8. Functional academics
9. Leisure
10. Work

Other Developmental Disability means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment (or a condition which has received a dual diagnosis of Intellectual Disability and Mental Illness) and is evidenced by a severe, chronic disability which::

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, **AND**

2. is manifest before the age of 22, **AND**

3. is likely to continue indefinitely, **AND**

4. results in substantial functional limitations in any three or more of the following areas of life

functioning:

a. self-care,
b. understanding and use of language,
c. learning and adapting,
d. mobility,
e. self-direction in setting goals and undertaking activities to accomplish those goals,
f. living independently,
g. economic self-sufficiency, **AND**

5. It reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, **AND**

6. Does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.

For Children under the age of six, developmental disability means a severe, chronic disability that meets all of the following criteria:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, **AND**

2. is likely to continue indefinitely, **AND**

3. results in at least three developmental delays as measured by qualified professionals using appropriate diagnostic instruments or procedures, **AND**

4. reflects a need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are lifelong or extended in duration and are individually planned and coordinated, **AND**

5. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill.

Medicaid / Social Security

If you are applying for HCBS I/DD Services please contact the following offices to make an appointment.

Applying for Kansas Medicaid (Kancare) for the elderly and disabled

To apply for a Medicaid Card contact the KanCare Clearinghouse in Topeka, KS

Phone: (800) 792-4884

Fax: 1-844-264-6285

TTY: 1-800-792-4292

Mailing Address

KanCare Clearinghouse

PO Box 3599

Topeka, KS 66601

Apply Online for Medicaid: www.applyforkancare.ks.gov or https://cssp.kees.ks.gov

Print out application: http://www.kancare.ks.gov/docs/default-source/Consumers/apply/elderly-and-disabled/kc1500---medical-assistance-application-for-the-elderly-and-persons-with-disabilities.pdf?sfvrsn=2

Applying for Social Security Benefits

Contact Social Security Administration for Social Security Eligibility.
(Part of Medicaid Eligibility Process)

SSA Website: www.ssa.gov

Social Security Administration:
1440 Wakarusa, Suite 200
Lawrence, KS 66049

Tel: (866) 698-2561
TTY: (800) 325-0778
Toll Free: (800) 772-1213

(Revised: 8-09-2018)

COTTONWOOD CDDO
2801 West 31st Street
Lawrence, KS 66047

Psychological Evaluation / Assessment Resources

(Always ask if they accept your insurance or offer a sliding scale fee)

Blessing Neuropsychological Services (816) 590-3900	1010 Carondelet Dr. Suite 201 Kansas City, MO 64114
Children's Mercy Hospital (816) 234-3674	2401 Gillham Rd. Kansas City, MO 64108
Clinical Associates PA (913) 677-3553	8629 Bluejacket St. Suite 100 Lenexa, KS 66214
Vickie Condra (314) 435-1352 vcondracounseling@gmail.com	1201 Wakarusa Bldg E. Suite 204 Lawrence, KS 66049
The Guidance Center (785) 863-2929	1102 Walnut St. Oskaloosa, KS 66066
KU Child & Family Services Clinic (785) 864-4416	1000 Sunnyside Ave. 2021 Dole Building Lawrence, KS 66044
KU Medical Center Center for Child Health & Development *(913) 588-5900 (for appointment)* *(913) 588-5000 (for records)* *(913) 588-2495 (fax number)*	Mail Stop 4003 3901 Rainbow Blvd. Kansas City, KS 66160-7340
Jason Neufeld (913) 764-1194	511 N. Mur Len Rd. Olathe, KS 66062
Responsive Centers for Psychology & Learning (913) 451-8550	7501 College Boulevard Suite 250 Overland Park, KS 66210
Richard Shapiro (785) 235-2011	225 SW Greenwood Ave Topeka, KS 66606

(Revised: 08-15-2023)