

## "Helping Kansans with developmental disabilities access quality community services"

## **Application for Eligibility Determination**

The following information is required to process the application for services and to comply with state licensing regulations for purposes of reporting statistical data as required by Kansas Department for Aging and Disability Services. Applicant confidentially will be maintained.

Please note that if an applicant is his or her own guardian he or she must consent to the eligibility determination process.

## **General Information**

Applicant's Name:	Date of Birth:			
Address: Street/P.O. Box	City	County	State	Zip
Гelephone:	Mar	ital Status:	Gender: _	_MaleFemale
Email Address:	Social Security Number: _		nber:	
Do you have a State of Kansas medical	card?	_Yes N Card Numb	er:	
Managed Care Organization (MCO):	Aetna	Sunflower Health Plan	United H	lealth Care
Place of Birth:		_ Is applicant a citizen of the	United States?	Yes No
Primary Language Spoken:		Is an Interpreter needed?	YesNo	
Are you, or an immediate family memb	er, an acti	ve or recently separated (wi	thin 30 days) m	nilitary personnel?
Legal Repres	entativ	e/Guardianship Inf	<u>ormation</u>	
If a legal representative/guardian has bee other legal representation exists, a copy o	of the Jour			
1 <sup>st</sup> Legal Representative/Guardian Name	e:			
Address: Street/P.O. Box	City	County	Ctata	7:
Home Phone:	•	County Work/Other Phone:	State	Zip
(Legal Representative/Guardianshin Information C	ontinued on i	next nage)		

2 <sup>nd</sup> Legal Representative/Guardian I	Name (if applicable): _			<del></del>		
Address:Street/P.O. Box	City	County	State	Zip		
Home Phone:	Wor	k/Other Phone:				
Relationship to Applicant:						
Location of Legal/Guardianship Hea		Court Case #:				
If limited guardianship, what is the lin	mitation:					
If a guardian has not been appointed	d, is one needed? _	Yes _		No		
	Disability I	<u>Information</u>				
A copy of the paperwork docum diagnosi		d diagnosis signed by ubmitted at time of ap		l who provided the		
Confirmed Diagnosis/Disability:	Agency/Location	n where Diagnosis w	vas received:	Date of Diagnosis		
Intellectual Disability			·····			
Autism Spectrum Disorder						
Cerebral Palsy						
Down Syndrome						
Other:						
What kind of services or assistance	are you looking for:					
Have you applied for Intellectual/Developmental Disability Services before:Yes No						
If so, when, and what was the outco	me?					
	<u>Living S</u>	Situation				
I currently live with: Family	Alone	Other:				
	<u>School</u>	<u>History</u>				
For current students a copy of the most recent Individualized Education Plan (IEP) is to be submitted at time of application.						
Current/Last School Attended:			Dates Atte	nded:		

Address:			
Street/P.O.	City	State	Zip
Telephone:	Fax:		
Check which type of education you received:			
Attended Regular Education	Att	ended Special Edu	cation
ı	Medical Information		
_	_		
Is there a history of Seizures:Yes	•		
Name of Doctor:			
Address: Street/P.O.	City	State	Zip
Telephone:	·		•
тејернопе.	Fax Nullibel		
8.6	etal llasitis information		
<u>ivier</u>	ntal Health Information		
Agency Name:			
Address:			
Street/P.O.	City	State	Zip
Telephone:	Fax Number:		
<u>A</u>	dditional Information		
Who referred you to Southwest Developm	nental Services, Inc. for assistance a	and/or services?	
<u>In</u>	formation Requested		
SDSI requests that you provid submit your application. Please application. Failure to do so may	check the documentation y	ou have enclo	sed with th
Copy of Medical Card Copy of Social Security Card Copy of Driver's License/Identificati Legal Representative/Guardianship	on Card o, DCF/DOC Custody or other Legal on and/or written documentation of d	Representation Pa	

Eligibility is determined, in part, by reviewing documents to include (but is not limited to) medical, psychological and school records. If you request for Southwest Developmental Services, Inc., to obtain records please list below the name of the agency and address of where to obtain these records. You will need to sign an Authorization for Use or Disclosure of Protected Health Information for each agency listed.

Address:	Phone:
City/State/Zip:	Fax:
Name/Agency:	
Address:	Phone:
City/State/Zip:	Fax:
Name/Agency:	
Address:	Phone:
City/State/Zip:	Fax:
Signatures:	
By signing below, I agree that the information contai best of my knowledge.	ned in this application is correct to the
Applicant's Signature:	Date:
Legal Representative Signature:	Date:

\*Please return the Application for Eligibility Determination to SDSI's Admissions Manager. If you have any questions or need assistance filling out this form please contact the person listed below.

Southwest KS applicants please contact: Southwest Developmental Services, Inc. Justin Stevens Admissions Manager 1808 Palace Dr., Suite C Garden City, KS 67846 (620) 275-7521

Fax: (620) 275-1792

Name/Agency:

Central KS applicants please contact: Southwest Developmental Services, Inc. Andrea Jacobs Admissions Manager 1103 Main Street Great Bend, KS 67530

(620) 793-7604 Fax: (620) 793-7906