Human Services Department

Wyandotte County Developmental
Disabilities Organization
701 N 7th St. Room 346 Kansas City, KS 66101
PH: 913-573-5502 FAX 913-573-5511
wcddo@wycokck.org

ELIGIBILITY DETERMINATION APPLICATION

The information given on this application assists in determining the applicant's eligibility for services. Such determination will be made in accordance with the HCP/CDDO Eligibility Determination policy.

General Information

Applicant's Full Name: _____

Current Address: _____
Street or Box Number City State Zip

Telephone: _____ Date of Birth: _____

Social Security: _____ Medicaid #:_____

E-mail address: _____

Services Requested

What kind of services are you looking for? _____

Disability 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, schools, etc.

Please list below information about placements, treatment, testing, or evaluation:

	Date Admitted	Place and Address
Hospitals	_____	_____
	_____	_____
Doctor's	_____	_____
	_____	_____

Mental Health _____ _____
_____ _____

Education

Please list the school or Special Education Cooperative that you have attended.

School: _____Years attended: _____

Address: _____

Guardianship Information

Check all that apply:

[ ] You (applicant) are a ward of the State.

SRS Case Worker Name: _____
SRS Office Location: _____ Telephone: _____

Foster Care/Adoption Case Worker Name: _____

Agency: _____Telephone: _____

[ ] You (applicant) have a legal guardian.

Name: _____

Address: _____

Telephone: _____

Resource Information

Please list all other organizations that you are currently receiving services from:

_____

Please list the name and address of any person who is assisting you with the application process:

Name: _____
Telephone: _____Relationship: _____

Consent and Agreement

I understand the information provided by me in this form will be used in conjunction with supporting documentation for 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 disagree with such decision. I further understand that such a 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 submission and completion of all information, the availability of services, and fiscal limitation.

I understand that my eligibility can be re-determined 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.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Legal Representative Date