**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