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You have indicated an interest in applying for adult services through the Colorado Developmental Disabilities System. In order to determine your eligibility for these services Starpoint will work with you to gather necessary documents to complete the intake process. We look forward to working with you and your family to access these services.

The following information is needed for Starpoint to make a developmental disability determination. You will need to complete, sign and return these items in the envelope provided.

- ☐ A completed **Disability Determination Form** (included)
- ☐ **Three or More Releases for Confidential Information.** (Included) These will be used to gather information to determine if there is a developmental disability.
- ☐ A Completed and Signed (by your doctor) **Professional Medical Information Page** (included)
- ☐ Copy of your **Photo Identification** (State ID)
- ☐ Copy of your **Medicaid Card** (if receiving it at this time)

When you have completed these forms and returned them to Starpoint we will continue the intake process by requesting information from the agencies, schools, therapists or doctors that you have indicated. Once the necessary information is received we will contact you with the results of the determination.

Please note, any psychological testing (IQ testing), adaptive skills testing or other assessments that you can include with the above forms will assist in moving this process along in a timely manner.

We greatly appreciate your interest in services and look forward to working with you to discuss your long term goals. If you have any questions on the included forms or need assistance in completing any of the information please don't hesitate to contact me for assistance.

Sincerely,

Bryana Marsicano
Case Management Director
719-269-2213
bmarsicano@starpointco.com

DEVELOPMENTAL DISABILITY DETERMINATION APPLICATION FORM

Date Completed Application Received by CCB _____

Community Centered Board _____

CCB Address _____

_____

Phone _____ **Fax** _____

Website _____

APPLICANT CONTACT INFORMATION

Name of Applicant (Include first, middle and last name) _____

Address _____

_____

County _____ **Home Phone** _____

Cell Phone _____ **Work Phone/Other** _____

Email Address _____ **Preferred Mode of Communication** _____

DOB _____ **Age** _____ **Gender** _____

Marital Status _____ **Primary Language** _____

Current Living Arrangement _____ **Ethnicity** _____

Person Making Referral _____ **Relationship** _____

Name of Primary Contact _____ **Relationship** _____

Address of Primary Contact _____

_____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email Address** _____

Name of Additional Contact _____ **Relationship** _____

Address of Contact _____

_____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email Address** _____

Relationship of Primary Contact _____

Is There a Court Appointed Guardian? Yes ☐ No ☐

If "Yes" please complete information below if not the primary contact

Name _____ **Relationship of Primary Contact** _____

Address _____

_____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email Address** _____

FINANCIAL AND MEDICAL BENEFITS INFORMATION

Social Security number _____

Medicaid State ID number _____

Medicare ID number _____

Supplemental Security Income (SSI) **Amount** _____

Social Security (SSA/SSDI) **Amount** _____

Other Benefits (e.g. EBD, Children's HCBS, Trusts) _____

Private Medical Insurance (e.g. Life, Health) _____

SCHOOL INFORMATION

Please list schools beginning with most recent attended

1. School District and School Attended _____

Dates of Attendance _____ **Special Education Program** Yes ☐ No ☐

2. School District and School Attended _____

Dates of Attendance _____ **Special Education Program** Yes ☐ No ☐

3. School District and School Attended _____

Dates of Attendance _____ **Special Education Program** Yes ☐ No ☐

MEDICAL INFORMATION

Please list medical and health needs _____

Name of Medical Provider/Medical Facility _____

City and State _____

Phone _____

SERVICES AND SUPPORTS INFORMATION

Please list services and supports received by the applicant such as mental health services, therapies, or home healt

ACKNOWLEDGMENTS AND SIGNATURES

I understand this application is to solely determine whether I meet criteria for a Developmental Disability.

I have received the following information

1. **Confidentiality/Privacy Notice**
2. **Dispute Resolution procedure**
3. **My rights**
4. **The Colorado definition of Developmental Disability**
5. **Explanation of the process**
6. **Other** _____

I understand that I have ninety (90) calendar days from the date of submission of my completed application, to submi the necessary documents and information needed to make this determination of a Developmental Disability.

Applicant signature _____ **Date** _____

Parent, Guardian Authorized Representative signature _____ **Date** _____

Name & title of CCB person receiving the application _____ **Date** _____

Needed Documents for Determining a Developmental Disability

Below is information that documents a developmental disability and is needed to make a determination.

1. Testing required

Documentation of an Intellectual Impairment

- Intelligence/IQ testing by a psychologist. using instruments that are comparable to a Wechsler Stanford-Binet

OR

Documentation of Adaptive Behavior Impairments

- Adaptive Behavior testing by a qualified professional. using instruments that are comparable to Vineland-II

2. Documentation of a neurological condition, examples below

- Intelligence/IQ testing or Adaptive Behavior testing may include this information
- Neurological or neuropsychological evaluation
- Psychiatric or psychological evaluations
- Medical records

3. Documentation to show the disability occurred prior to age 22 and for ruling out physical or senso impairments or mental illness as sole contributors to a disability, examples below

- School assessments and records
- Records of specialized services
- Medical records and evaluations
- Therapy assessments and reports
- Mental health services and assessments
- Psychological evaluations or testing
- Psychiatric reports
- Therapy evaluations

MEDICAL HISTORY

NAME_____ DATE_____

APPLICANT'S CURRENT PHYSICAL CONDITION:

DIAGNOSIS:_____

CURRENT STATE OF HEALTH: ☐ Excellent ☐ Fair ☐ Good ☐ Poor

HEIGHT:_____ WEIGHT:_____ HAIR COLOR:_____

EYE COLOR:_____ DISTINGUISHING MARKS:_____

VISION: ☐ Excellent ☐ Good ☐ Poor ☐ Unknown

HEARING: ☐ Excellent ☐ Good ☐ Poor ☐ Unknown

CURRENT MEDICATIONS & DOSAGE:_____

_____

_____

LEFT HANDED/ RIGHT HANDED (circle one)

PROSTHETIC DEVICE NEEDED:_____

LAST TETNIS SHOT:_____

HAS HIS/HER OWN?

	YES	NO
WHEELCHAIR	☐	☐
BRACES	☐	☐
CORRECTIVE SHOES	☐	☐
GLASSES	☐	☐
HEARING AID	☐	☐
OTHER_____	☐	☐

APPLICANT'S MEDICAL HISTORY:

DIAGNOSTIC & MEDICAL CARE:

Applicant has been seen by the following physicians, hospitals, and/or diagnostic clinics:

NAME (Physician/Hospital/Clinic) _____

PHONE:_____ ADDRESS:_____

DATE OF SERVICE: From_____To_____

DIAGNOSTIC & MEDICAL CARE CONT.:

Applicant has been seen by the following physicians. hospitals, and/or diagnostic clinics:

NAME (Physician/Hospital/Clinic) _____

PHONE:_____ ADDRESS:_____

DATE OF SERVICE: From_____To_____

DIAGNOSIS:_____

DENTIST:_____ LAST VISIT:_____

ADDRESS:_____ PHONE:_____

MEDICATION & DOSAGE:_____

NOTES REGARDING MEDICATION:_____

_____

HOSPITAL PREFERRED:_____

FAMILY HEALTH HISTORY

Have any of the following conditions existed in any relative of the applicant? If so, state which relative and on which side of the family.

CONDITION	YES	NO	REALATIVE
•MENTAL RETARDATION			
•EPILEPSY OR SEIZURES			
•CEREBRAL PALSY			
•AUTISM			
•MENTAL ILLNESS			
•SYPHILIS			
•TUBERCULOSIS			
•DIABETES			
•CANCER			
•HEART DISEASE			
•ALCOHOL/DRUG ABUSE			
•DEAFNESSDURING CHILDHOOD			
•LEARNING DISABILITIES			

DEVELOPMENTAL HISTORY

PLEASE LIST ANY SIGNIFICANT PROBLEMS WITH DEVELOPMENT (i.e., walking. speech. toileting, ect.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

APPLICANT'S HISTORY OF ILLNESS

	AGE	DATES
•WHOOPING COUGH	_____	_____
•MUMPS	_____	_____
•RED MEASLES	_____	_____
•CHICKEN POX	_____	_____
•MENINGITIS	_____	_____
•PNEUMONIA	_____	_____
•RHEUMATIC FEVER	_____	_____
•ENCEPHALITIS	_____	_____
•DIARRHEA	_____	_____
•TONSILLITIS	_____	_____
•EAR INFECTION	_____	_____
•DEHYDRATION	_____	_____
•INFLUENZA (serious)	_____	_____
•DIPHTERIA	_____	_____
•POLIO	_____	_____
•HEPATITIS	_____	_____
•TUBERCULOSIS	_____	_____
•IMMUNIZATION REACTION	_____	_____
•OTHER_____	_____	_____

IMMUNIZATIONS:

•DPT_____ •ORAL POLIO_____ •MMR_____
•SMALL POX_____ •TB SKIN TEST_____ • TETNUS BOOSTER_____
•FRACTURES_____ •HEAD INJURY_____ •VISION PROBLESMS_____
HEARING PROBLEMS_____ UPPER RESPIRATORY INFECTION_____

APPLICANT'S ALLERGY HISTORY:

DOES APPLICANT HAVE ANY ALLERGIES OR DRUG REACTIONS? ☐ Yes ☐ No

IF YES. INDICATE WHAT HE/SHE IS ALLERGIC TO:

_____ _____ _____

APPLICANT'S SEIZURE HISTORY:

HAS APPLICANT EVER HAD SEIZURES? ☐ Yes ☐ No

IF YES. WHICH TYPE?_____

IF YES. HOW FREQUENT?
_____TIMES PER DAY
_____TIMES PER WEEK
_____TIMES PER MONTH
_____TIMES PER YEAR
_____HAS NOT HAD SEIZURES OVER ONE YEAR

AT WHAT AGE DID SEIZURES BEGIN?_____YEARS OLD
IS CLIENT ON SEIZURE MEDICATION? ☐ Yes ☐ No
HAS CLENT EVER HAD STATIC SEIZURES? ☐ Yes ☐ No
SYMPTOMS (What to watch for):_____
_____

HISTORY OF ACCIDENTS & HOSPITALIZATIONS:

HAS APPLICANT EVER HAD A SERIOUS ILLNESS, ACCIDENT, FRACTURE OR BURN? ☐ Yes ☐ No
IF YES, WHAT AND WHEN?_____
HAVE ANY OPERATIONS BEEN PERFORMED? ☐ Yes ☐ No
IF YES, OPERATION:_____ DATE_____
NAME OF HOSPITAL_____

I have answered all question to the best of my knowledge.

SIGNED_____ DATE_____
(applicant if he/she is 18 or over and has no legal guardian)

SIGNED_____ DATE_____
(applicant's parent (s), legal guardian or custodian)

_____

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P.O. Box 2080, Canon City, CO 81215-2080 - Phone 719-275-1616 - Fax: 719-275-4619

REQUEST TO RELEASE OR SECURE CONFIDENTIAL INFORMATION

I, authorize Developmental Opportunities to:

☐ Obtain information ☐ Release information to

Name of Person: _____

Name of Agency: _____

Mailing Address: _____

City, State, Zip: _____

Regarding this person: _____
Name D.O.B.

INFORMATION REQUESTED:

☐ Audiometric
☐ Educational- IFSP or IEP
☐ Speech/Language
☐ IP/ISSP/Family Support
☐ Vocational/Residential Assessments
☐ Occupational Therapy
☐ Physical Therapy
☐ Other (Specify) _____
☐ Psychiatric
☐ Psychology
☐ Social Work
☐ Medical History

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the individual, parent, or guardian except as provided by law. In order to provide continuity of services, this consent is valid for the one year from date signed. NOTE: a photocopy of this release shall be as valid as the original.

CONSENT

☐ **YES** ☐ **NO** **I hereby authorize the transfer of information as stipulated above.**

_____ _____
Signature of Individual, Parent or Legal Guardian **Date**

☐ **YES** ☐ **NO** **I hereby authorize the transfer of information as stipulated above.**

_____ _____
Signature of Individual, Parent or Legal Guardian **Date**

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DATE	RELEASED TO	PURPOSE	MATERIAL	RELEASED BY

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☐ Educational- IFSP or IEP
☐ Speech/Language
☐ IP ISSP Family Support
☐ Vocational Residential Assessments
☐ Occupational Therapy
☐ Physical Therapy
☐ Other (Specify) _____
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☐ Social Work
☐ Medical History

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Signature of Individual, Parent or Legal Guardian **Date**

DATE	RELEASED TO	PURPOSE	MATERIAL	RELEASED BY

Fax to: 719-275-4619

Long Term Care Professional Medical Information

Dear Medical Provider:
The following client is participating in a functional needs assessment to determine appropriateness for long term care services. The functional needs assessment is used to determine if the client meets the nursing facility, ICF/MR or hospital level of care. As a part of the functional needs assessment, a licensed medical professional shall complete this form to certify the client's medical necessity for long term care services.

Client Information Section

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____ Male ☐ Female ☐

Medical Information Section

ICD 9 Code	ICD 9 Description	Onset	Medication Name	Dosage	Frequency	Route

Other Services Required for Medical Problems: (oxygen therapy, patient education, monitoring, follow-up care):

Is there a Mental Health Diagnosis? Yes ☐ No ☐
Is there a Traumatic Brain Injury Diagnosis? Yes ☐ No ☐
Diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician.

Neurological Exam Date: _____

If Hospitalized, Reason: _____ Admit Date: _____

Diet Order: _____
Allergies: _____
Prognosis: _____

Medical Provider Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Person Completing this Information: _____ Date Completed: _____

Title of Person Completing this Information:

Signature of Licensed Medical Professional Verifying this Information:

Medical Provider Comments:

Facility/Case Manager Information

Facility/Case Management Agency: Starpoint
Administrator/Case Manager Name (print): _____ Phone Number: _____
Administrator/Case Manager Signature: _____