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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 health

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 submit 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 sensory 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?

	<u>YES</u>	<u>NO</u>
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.

<u>CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>REALATIVE</u>
•MENTAL RETARDATION	---	---	_____
•EPILEPSY OR SEIZURES	---	---	_____
•CEREBRAL PALSY	---	---	_____
•AUTISM	---	---	_____
•MENTAL ILLNESS	---	---	_____
•SYPHILIS	---	---	_____
•TUBERCULOSIS	---	---	_____
•DIABETES	---	---	_____
•CANCER	---	---	_____
•HEART DISEASE	---	---	_____
•ALCOHOL/DRUG ABUSE	---	---	_____
•DEAFNESS DURING CHILDHOOD	---	---	_____
•LEARNING DISABILITIES	---	---	_____

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 CLIENT 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 _____

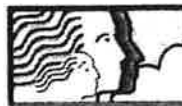
NAME OF HOSPITAL _____

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

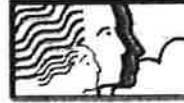
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DATE	RELEASED TO	PURPOSE	MATERIAL	RELEASED BY

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Name of Agency: _____

Mailing Address: _____

City, State, Zip: _____

Regarding this person: _____

Name

D.O.B.

INFORMATION REQUESTED:

- Audiometric
- Educational- IFSP or IEP
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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
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 Physical Therapy
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Signature of Individual, Parent or Legal Guardian _____ Date _____

Table with 5 columns: DATE, RELEASED TO, PURPOSE, MATERIAL, RELEASED BY. The table is currently empty.

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: _____