State of Connecticut, Department of Developmental Services Application Checklist

Application packets received with <u>all</u> required documents listed below will be processed upon receipt.

Name: _____ Town of Residence: _____ Date of Birth: _____

Step 1- Complete the two page eligibility application.

☐ ***<u>Please sign pages one and two of the application.</u>***

Step 2- Include the following in your application packet:

☐ **Psychological and Educational Testing performed through the age of seventeen (17):** This testing can usually be obtained from schools, agencies, or private psychologists upon your request. For individuals applying for services for the intellectually disabled, psychological evaluations including cognitive and adaptive scores must be done prior to the age of eighteen (18), per Connecticut General State Statute 1-1g. For individuals applying for Autism Spectrum Disorder program, a standardized test of Autism must be done prior to the age of twenty-one (21).

- **Intelligence/Cognitive tests:** Tests such as the Wechsler or Stanford-Binet assess the applicant's intellectual/cognitive ability and generate IQ scores. Please submit IQ tests performed through the age of 17.
- **Adaptive skills tests:** Tests such as the Vineland or Behavior Assessment System for Children (BASC) evaluate the applicant's ability with daily activities such as dressing, grooming, and social skills. Please submit all adaptive tests performed through the age of 17.
- **Autism diagnostic testing (if applicable):** Tests such as the Gilliam Autism Rating Scale (GARS), Childhood Autism Rating Scale (CARS), and Autism Diagnostic Observation Schedule (ADOS) indicate a diagnosis of an Autism Spectrum Disorder.

☐ **Medical History and Most Recent Physical Examination:** This can usually be obtained from your primary care physician upon request. Please include any psychiatric evaluations. If the applicant has been diagnosed with Prader-Willi Syndrome, please include a copy of the physician's report diagnosing this disorder.

☐ **HIPAA Acknowledgement Form:** The form must be complete and signed by the applicant if the applicant is 18 years of age or older, or the applicant's legal guardian if the applicant is 18 years or older and has a court appointed legal guardian.

☐ **Guardianship or Conservatorship Forms:** Provide a Probate Court decree of appointment of guardianship or conservatorship if applicable. If appointed from out of state, a Probate Court decree in the state of CT must be provided; otherwise applicant (age 18+) must sign the application and HIPAA form.

☐ **Proof of CT Residence:** This can include the applicant's CT driver's license or CT non-driver photo ID, DSS Connect card, tax form, IEP, etc.

☐ **Copy of the following:** Birth certificate, Social Security card, health insurance card, and Medicaid card (if applicable).

☐ **Educational Information:** Include the last three (3) years of Individualized Education Programs (IEPs), standardized test scores, and triennial evaluations. For applicants under 3 years of age, please submit a copy of the Individual Family Support Plan (IFSP).

Step 3- If you are MISSING any of the above documentation, you will need to complete a **Release of Information** form and SEND it to your doctor, psychologist, school or clinic and request these records. **Do <u>NOT</u> send the release forms to DDS because DDS CANNOT send these documents for you**.

Send correspondence via:
<u>Postal mail</u>: DDS Eligibility Unit, 460 Capitol Avenue, Hartford, CT 06106; <u>Fax</u>: (860) 622-2797; <u>Email</u>: DDS.Eligibility@ct.gov

Please **<u>do not staple</u>** the documents you submit because staples interfere with our electronic scanning process. Please use paper clips if needed.

Record Retention Policy: Pursuant to Connecticut General Statute §11-8 and §11-8a, DDS retains records used in the eligibility determination process for 10 (ten) years from the date of application. Please **<u>keep a copy</u>** of all documents submitted for your own records.

State of Connecticut, Department of Developmental Services
Eligibility Application Page 1 of 2

Which services are you applying for? 1) Intellectual Disability 2) Autism Spectrum Disorder Program

Applicant (Person in Need of Services)

First, Middle, & Last Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, & Zip: _____ Fax: _____

Date of Birth: _____ Male or Female _____ E-mail Address: _____

Social Security Number: _____-____-_____ Medicaid Number: _____ Private Insurance: YES or NO
(Attach copy of Medicaid card)

Race and/or Ethnicity (mark all that apply AND write in additional details in the spaces below):

☐ American Indian or Alaskan Native – for example, Mashantucket Pequot, Mohegan, etc. _____

☐ Asian – for example, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, etc. _____

☐ Black or African American – for example, African, African American, Haitian, Jamaican, etc._____

☐ Hispanic, Latino/a/e, or Spanish – for example, Dominican, Mexican, Puerto Rican, etc. _____

☐ Middle Eastern or North African – for example, Arab, Egyptian, Lebanese, etc. _____

☐ Native Hawaiian or Pacific Islander – for example, Guamanian or Chamorro, Samoan, etc._____

☐ White – for example, European, Portuguese, etc._____

☐ Some Other Race and/or Ethnicity _____ ☐ Prefer Not to Answer

Applicant Primary Language: _____ ☐ Needs Interpreter

Parent/Guardian/Conservator Primary Language: _____ ☐ Needs Interpreter

Person Requesting Services (Referral Source and Relationship to Applicant)

First, Middle, & Last Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, & Zip: _____ Fax: _____

Organization/Relationship:_____ E-mail address: _____

Has an Intellectual Disability (formerly referred to as Mental Retardation) been determined by evaluation? YES or **NO**
If 'Yes,' where and when _____

Has an Autism Spectrum Disorder been determined by evaluation? YES or **NO**
If 'Yes,' where and when _____

Has a Court of Probate appointed a guardian or conservator for this person? YES or **NO**
If 'Yes,' please attach a copy of the Decree and contact information for the appointed person below:
(If appointed from out of state, please provide copy of Decree from state of Connecticut; otherwise, applicant (Age 18+) must sign the application and HIPAA form).

First, Middle, & Last Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, & Zip: _____ Fax: _____

E-mail Address: _____

Signature: _____ **Date**: _____
Signature of Applicant (Age 18+) or Parent/Guardian/Conservator

Please complete all information on this form (both pages) and sign it before sending it to the Eligibility Unit.

Please **do not staple** the documents you submit because staples interfere with our electronic scanning process. Please use paper clips if needed.
Record Retention Policy**:** Pursuant to Connecticut General Statute §11-8 and §11-8a, DDS retains records used in the eligibility determination process for 10 (ten) years from the date of application. Please **keep a copy** of all documents submitted to DDS for your own records.
Mail: DDS Eligibility Unit, 460 Capitol Ave., Hartford, CT 06106; Fax: (860) 622-2797; Email: DDS.Eligibility@ct.gov**;** Phone: (866) 433-8192 **Rev. 5/3/2024**

Please complete this section **only if** the applicant receives services from **DMHAS** (Department of Mental Health and Addiction Services).

Name of DMHAS Social/Case Worker: _____ Phone: _____

Please complete this section **only if** the applicant receives services from **DCF** (Department of Children and Families). Please note the legal status with DCF below:

☐ Voluntary
☐ Committed
☐ Juvenile Justice Commitment
☐ Family with Service Needs
☐ Case still with Investigations
☐ Other: _____

Name of DCF Social Worker: _____ Phone: _____

If Someone Assists You With This Application

Please complete the information below if someone other than the applicant, guardian, or conservator is helping with the application. The person you choose to assist you may be a family member, friend, teacher, counselor, social worker, etc.

_____ _____ _____
Signature of Person Completing Form Title Date

Name: _____
Relationship to Applicant: _____
Agency: _____
Address: _____
Phone: _____ E-mail Address: _____

I give permission to DDS to discuss my application and records with the person named above for the purpose of completing the eligibility determination process.

_____ _____
Signature of Applicant/Guardian If Under Age 18 **Date**

Please **do not staple** the documents you submit because staples interfere with our electronic scanning process. Please use paper clips if needed.
Record Retention Policy**:** Pursuant to Connecticut General Statute §11-8 and §11-8a, DDS retains records used in the eligibility determination process for 10 (ten) years from the date of application. Please **keep a copy** of all documents submitted for your own records.
Mail: DDS Eligibility Unit, 460 Capitol Ave., Hartford, CT 06106; Fax: (860) 622-2797; Email: DDS.Eligibility@ct.gov; Phone: (866) 433-8192 Rev 5/5/2017

DDS
STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

460 Capitol Avenue, Hartford, Connecticut 06106 ◆ Phone: 860/418-6000 ◆ Fax: 860/622-6001 ◆ Email: ddsct.co@ct.gov

November 2017

Individual and Family Fact Sheet – HIPAA: Health Insurance Portability Accountability Act of 1996

Did you know that DDS now follows the federally mandated HIPAA regulations?

What Is HIPAA?

The federal government has established privacy laws/standards for healthcare information for all citizens. These standards are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and provide the first comprehensive federal protection of the privacy of "health information.*"

Is Protecting My Health Information New?

DDS has always maintained good privacy and confidentiality practices based on State of Connecticut laws. The new federal privacy laws establish a set of standards for all states.

How Does HIPAA Affect DDS Individuals?

These laws/standards and existing state laws ensure that DDS will:

1. Make sure that any individually identifiable health information** is kept private, and
2. Give you a written notice of our legal duties and privacy policy practices with respect to your protected health information.

What Is The Notice Of Health Care Privacy Practices For Protected Health Information ?

The fact sheet of health care privacy practices for protected health information*** is available to all individuals served by the department. The notice describes the way DDS may use and disclose protected health information and explains how you can exercise your rights. The notice will help you understand how we share information about you and how you can ensure its accuracy. A more detailed explanation entitled "Notice of Privacy Practices for Protected Health Information" can be found at www.ct.gov/dds or a copy can be sent to you upon request by contacting 860-418-6000.

How Does DDS Share My Protected Health Information?

DDS and agencies currently providing services to you share your information for your support. A portion of this information is shared for payment activities or quality assessment and improvement. Unless you provide us with authorization, your protected health information will not be shared outside of DDS and agencies currently providing services to you except for the permitted or required disclosures described in the notice.

When Can My Protected Health Information Be Disclosed?

Disclosures that are not permitted or required by law will require an authorization from you.

How Will I Know When My Protected Health Information Is Being Disclosed?

You may ask for an accounting of disclosures of your protected health information. In the event that a disclosure is not permitted or required, your protected health information cannot be disclosed until you or your guardian have been made aware of the request and have signed an authorization specifically releasing that information. Your case manager will notify you or your guardian of any requests for protected health information from an outside entity (any agency outside of DDS and collaborating agencies currently providing services to you).

How Will I Receive The Necessary Authorization Form To Release Protected Health Information To An Outside Entity?

Your case manager will notify you or your guardian of requests DDS receives for your protected health information initiated by a third-party and will provide a form for you via personal visit or mail. If you or your responsible party agree to release this information, complete the form and return it to your case manager. If you are requesting the release of protected health information, you may contact your case manager to obtain an authorization form.

If I Have Any Further Questions About The HIPAA Regulations And How They Impact Me, Who Can I Call?

You may contact the Director of Quality Improvement in your DDS region. In addition, your DDS case manager may be able to assist you.

HIPAA Definitions

*** Health Information**

Any information, whether oral or recorded in any form or medium, that is created or received by a health care agency, health plan, employer, life insurer, school or university. Health information may relates to past, present and future physical or mental health or condition, or future payment for the provision of health care to an individual.

**** Individually Identifiable Health Information**

Information that is a subset of health information, including demographic information collected from an individual and identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

***** Protected Health Information**

Individually identifiable health information: transmitted by electronic media, maintained in any electronic media or any other form or medium. Protected health information excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act (FERPA) or employment records.

While the Department of Developmental Services has always maintained good standards in the area of confidentiality practices, the federal government has established these privacy standards for all health insurers and health care providers to follow to protect personal health information. The federal guidelines address a growing public concern regarding the use of computers and technology by health care organizations. These new federal guidelines will be applied to all human services organizations, i.e. DDS, DCF, DMHAS, DSS and affiliated private agencies to ensure the integrity of confidential personal health information.

STATE OF CONNECTICUT
Department of Developmental Services

Acknowledgement Form For HIPAA
Individual and Family Fact Sheet
HIPAA: Health Insurance Portability Accountiability Act of 1996

I have been provided an *Individual and Family Fact Sheet HIPAA: Health Insurance Portability Accountiability Act of 1996* that describes how information is used by the Department to provide services. This notice also includes a description of my rights regarding protected health information.

I understand DDS reserves the right to change their practices and notice. Prior to implementation of these changes a new notice will be available to me.

I understand I may be requested to sign specific *authorization* for uses and disclosures of my health information, which are not addressed in the notice.

Formulario de Reconocimiento
HIPAA individual y la Hoja de familia: Ley de Seguro de Salud de Portabilidad Accountiability de 1996

Se me ha brindado una *HIPAA individual y la Hoja de familia: Ley de Seguro de Salud de Portabilidad Accountiability de 1996,* que describe cómo usa la información el Departamento para brindar servicios. Esta notificación incluye también una descripción de mis derechos con relación a la información protegida sobre la salud.

Entiendo que el DDS se reserva el derecho a cambiar sus prácticas y notificación, y que antes de la implementación de estos cambios tendré a mi disposición una nueva notificación.

Entiendo que se me podrá pedir que firme una *autorización* específica para los usos y divulgaciones de la información sobre mi salud, que no se tratan en la notificación.

_____ _____

Signature of Individual or Legal Representative — Date
Firma de la persona o representante legal — Fecha

Effective Date of Notice: April 14, 2003 [Día de vigencia de la notificación: 14 de abril de 2003]

---

* Please explain relationship to individual/* Por favor explique su relación con la persona

_____

_____

State of Connecticut

Department of Developmental Services

Authorization for Release of Information

Fill Out This Form Completely. DO NOT SEND THIS FORM BACK TO DDS.
YOU must send this form to each Doctor, Agency, School, etc. from whom you are requesting records. They will send information to DDS.

Applicant Information

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Date of Birth _____

Organization (Agency, Doctor, or business holding the requested information)

Organization Name _____

Contact Person or Title _____

Street Address _____

City _____ State _____ Zip _____

Telephone _____ E-Mail _____

Information Requested (Check all boxes that apply)

❑ School Records:	**Last 3 years of educational records including Individualized Education Programs (IEPs), standardized IQ, adaptive, and autism test scores, and triennial evaluations.**
❑ Medical Records:	**Most recent physical and any medical or psychiatric reports that provide information about intellectual and adaptive functioning during the developmental period (birth through age 17).**
❑ Psychological Records:	**Psychological reports with IQ, adaptive, and autism testing (if applicable). IQ and adaptive testing should be from the developmental period (birth through age 17).**
❑ Vocational Records	
❑ Developmental Records	
❑ Psychiatric Records	

I understand this permission will expire when the information requested has been released to DDS or one year from the signature date. I understand that I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the rescinded date is legal and binding. Instructions to cancel this authorization are included in the named organization's Notice of Healthcare Privacy Practices. I also understand I can request a copy of the Notice of Healthcare Privacy Practices from the named organization at any time. I understand that if my information is protected by the Federal Substance Abuse Confidentiality Regulations or State of Connecticut law regarding HIV infection, AIDS or AIDS-related conditions, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I further understand that I may request a copy of this signed authorization.

* I understand the confidentiality of psychological or psychiatric records is required under chapter 899 of the Connecticut General Statues. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues.

_____ _____ _____

Signature of Applicant or Parent/Guardian* Print Name of Applicant or Parent/Guardian* Date

*Relationship to applicant_____

In order to determine the applicant's eligibility to receive services from the State of Connecticut Department of Developmental Services (DDS), I authorize the organization/person named above to disclose the information requested to:

Mail: Department of Developmental Services Eligibility Unit, 460 Capitol Avenue, Hartford, CT 06106
Right Fax: (860) 622-2797; Alternate Fax: (860) 418-8784; Email: DDS.Eligibility@ct.gov; Toll Free Phone (866) 433-8192

Please **do not staple** the documents you submit because staples interfere with our electronic scanning process. Please use paper clips if needed.

Rev. 5/5/2017