Information for Applicant

Important Information – Please read first!

√	**Please include the following documents in your completed application packet. All documents are *required* prior to scheduling a face to face intake screening.**
	Completed 2-page Application for Developmental Disabilities/Intellectual Disability
	Psychological Evaluation that includes IQ score **and** adaptive skills testing prior to age 18 Example: School psychological Report
	Proof of Lawful Presence in the U.S. – birth certificate, passport, permanent resident card, visa
	Copy of Social Security card
	Copy of Medicaid and/or Medicare card
	Copy of Social Security Benefit information
	Current doctors' names, addresses, and phone numbers
	Notice of Privacy Practices (requires signature)
	The items below may be helpful in addition to the above-mentioned items:
	Copy of reports describing the disability completed by schools attended or by other service agencies (i.e. copies of IEP)
	Copy of guardianship documents (if applicable)

	Additional information provided to assist you:
	Acceptable IQ Test Instruments
	Return the application with the documents listed below to: DBHDD Region 1 1230 Bald Ridge Marina Road, Ste. 800 Cumming, Georgia 30041
	Call 678-947-2818 if you need assistance with completing the application.
	Please refer to the website for more information – Department of Behavioral Health and Developmental Disabilities at **http://dbhdd.georgia.gov/** for more information.

DBHDD

Georgia Department of Behavioral Health and Developmental Disabilities
DIVISION OF DEVELOPMENTAL DISABILITIES

APPLICATION FOR DEVELOPMENTAL DISABILITIES INTELLECTUAL DISABILITIES SERVICES

IF YOU NEED ASSISTANCE COMPLETING THIS APPLICATION, PLEASE CONTACT:
GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
REGION 1 OFFICE
1230 BALD RIDGE MARINA ROAD, STE. 800
CUMMING, GEORGIA 30041
OFFICE 678-947-2818 – FAXES 678-947-2817 - TOLL FREE 1-877-217-4462

I. GENERAL INFORMATION (APPLICANT)

Name: ____
First Middle Last

Address: ____
Street Address (Apartment Number if Applicable)

____
City County State Zip Code

Mailing Address (if different) ____

Telephone Number: ______________________ Birthdate: ______/______/______
Area Code

Social Security # __________-________-__________ Marital Status: S M D W Sex: ______

Race________ Medicaid #__________________________Medicare #____________________

Email____

PRIMARY CONTACT: ____

Address: ____

____
City County State Zip Code

Relationship to Applicant: ______________________ Telephone Number: ______________________
Area Code

LEGAL STATUS OF APPLICANT: ___Minor ___Competent ___Legally Incompetent (Documentation Required)

Name of Legal guardian, if applicable: ____

Address: ____
Street Address (Apartment Number if Applicable)

____
City County State Zip Code

Relationship to Applicant: ______________________ Telephone Number: ______________________
Area Code

II. ASSESSMENT OF DEVELOPMENTAL DISABILITY AND ELIGIBILITY

To be eligible for Georgia's Developmental Disabilities Waiver services, you must be:

a. Medicaid eligible
b. Have mental retardation since birth or before age 18, or another developmental disability since birth or before age 22, which requires similar services to those needed by people with mental retardation.
c. Be at risk for going into an institution for people with mental retardation if you do not get the services you need in your community.

During your initial screening appointment, specific medical information will be collected to confirm the disability. Please read the *Information for Applicant* checklist at the front of this application, and have items or copies available.

III. SERVICE NEEDS

Describe the type of services you believe you need. For example, do you need help with getting a job, help with getting dressed, help in your home, or someplace to live?

____

____

____

____

____

IV. MEDICAL INFORMATION

Describe any special medical needs you have, (if any), and any medications you are taking:

____

____

What medical, developmental disability or mental retardation diagnoses have you been told that he/she have?

____

____

VI. COMPLETED BY:

Signature: ______________________________ Date: ______________

Check one: ____Applicant ____Guardian ____Other: ______________

Printed Name: ______________________________

What is the best way to contact you? ______________________________

Acceptable IQ Test Instruments

a. Battelle Developmental Inventory
b. Bayley Scales of Infant Development
c. Cognitive Assessment System
d. Comprehensive Test of Nonverbal Intelligence
e. Differential Ability Scale
f. Kaufman Assessment Battery for Children
g. Kaufman Adolescent and Adult Intelligence Test
h. Leiter International Performance Scale
i. Mullen Scales of Early Learning
j. Nonverbal Intelligence Test
k. Peabody Picture Vocabulary Test
l. Reynolds Intellectual Assessment Scales (RIAS)
m. Stanford Binet
n. Wechsler Adult Intelligence Scale
o. Wechsler Intelligence Scale for Children
p. Wechsler Nonverbal Scale of Ability (Ages 4-21)
q. Wechsler Preschool and Primary Scale of Intelligence
r. Woodcock-Johnson Psycho-Educational Battery

There are abbreviated tests that are used as screening tools, but cannot be used as sole instruments to diagnose mental retardation or developmental disability. They are:

a. K-BIT (Kaufman Brief Intelligence Test)
b. WASI (Wechsler Adult Scale of Intelligence)

Acceptable Adaptive Assessment Tools

a. Vineland
b. AAMR Adaptive Behavior Scale
c. ABAS (Adaptive Behavioral Assessment System)
d. CTAB (Comprehensive Test of Adaptive Behavior)
e. Scales of Independent Behavior
f. Battelle Developmental Inventory

Acceptable Autism Diagnostic Instruments

The following lists are acceptable diagnostic instruments for Autistic Disorder, provided that the instrument was a current version at the time of its use and was used in accordance with chronological age ranges for the instrument and with proper administration and scoring.

a. Autism Diagnostic Interview, Revised (ADI-R)
b. Autism Diagnostic Observation Schedule (ADOS)
c. Childhood Autism Rating Scale (CARS)
d. Gillian Autism Rating Scale (GARS)

There are abbreviated scales that are used as screening tools, but cannot be used as sole instruments to diagnose Autism or Autism Spectrum Disorders. The results of the screening indicate whether an individual should be referred for a complete diagnostic evaluation. They are:

a. Social Communication Questionnaire (SCQ)
b. Social Responsiveness Scale (SRS)

Developmental Disabilities Services

The service a person receives depends on a professional determination of level of need and the services and other community resources available. Services may include:

1. **Adult Occupational Therapy** – these services address the occupational therapy needs of the adult participant that result from his or her developmental disabilities.
2. **Adult Physical Therapy** – these services address the physical therapy needs of the adult participant that result from his or her developmental disabilities.
3. **Adult Speech and Language Therapy** – these services address the speech and language therapy needs of the adult participant those results from his or her developmental disabilities.
4. **Behavioral Supports Consultation** – these services are the professional level services that assist the participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations.
5. **Community Access** – these services are designed to assist the participant in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active participation and independent functioning outside the participant's home or family home.
6. **Community Guide** – these services are only for participants who opt for participant direction and assist these participants with defining and directing their own services and supports and meeting the responsibilities of participant direction.
7. **Community Living Support** – these services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant's continued residence in his or her family home.
8. **Community Residential Alternative** – these services are targeted for people who require intense levels of residential support in small group settings of four or less or in host home/life sharing arrangements and include a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time.
9. **Environmental Accessibility Adaptation** – these services consist of physical adaptations to the participant's of family's home which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home.
10. **Financial Support Services** – these services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended.
11. **Individual Directed Goods and Services** – these services are not otherwise provided through the NOW or Medicaid State Plan but are services, equipment or supplies identified by the participant who opts for participant direction and his or her Support Coordinator or interdisciplinary team.
12. **Natural Support Training** – these services provide training and education to individuals who provide unpaid support, training, companionship or supervision to participants.

13. **Prevocational Services** – these services prepare a participant for paid or unpaid employment and include teaching such concepts as compliance, attendance, task completion, problem solving and safety.
14. **Respite** – these services provide brief periods of support or relief for caregivers or individuals with disabilities and include maintenance respite for planned or scheduled relief or emergency/crisis respite for a brief period of support for a participant experiencing a crisis (usually behavioral) or due to a family emergency.
15. **Specialized Medical Equipment** – this equipment consists of devices, controls or appliances specified in the Individual Service plan, which enable participants to increase their abilities to perform activities of daily living and to interact more independently with their environment.
16. **Specialized Medical Supplies** – these supplies consist of food supplements, special clothing, diapers, bed wetting protective chunks, and other authorized supplies that are specified in the Individual Service Plan.
17. **Support Coordination** – these services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services with the objective of protecting the health and safety of participants while ensuring access to needed waiver and other services.
18. **Supported Employment** – these services are only supports that enable participants, for who competitive employment at or above the minimum wage, is unlikely absent the provision of supports, and who, because of their disabilities, need supports to work in a regular work setting.
19. **Transportation** – these services enable participants to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population but do not include transportation available through Medicaid non-emergency transportation or as an element of another waiver service; and
20. **Vehicle Adaptation** – these services include adaptations to the participant's or family's vehicle approved in the Individual Service Plan, such as a hydraulic lift, ramps, special seats and other modifications to allow for access into and out of the vehicle as well as safety while moving.

Georgia Department of Behavioral Health & Developmental Disabilities DBHDD, Region 1 1230 Bald Ridge Mariana Road, Suite 800/Cumming, GA 30041 678-947-2818 DBHDD Policies 23-100 and 23-101 **NOTICE OF PRIVACY PRACTICES FORM**	

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective September 1, 2011. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (HIPAA). If you have questions about this Notice please contact your Treatment Provider or Services Provider, or the Department's Privacy Officer at the address below.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is an agency of the State of Georgia responsible for certain programs which deal with medical and other confidential information. Both federal and state laws establish strict requirements regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how the Department may use and disclose your "protected health information" for treatment, payment, health care operations, and for certain other purposes. This notice also describes your rights regarding your protected health information. **Protected health information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. The Department is required to provide you this Notice of Privacy Practices, and to abide by its terms, and may change the terms of this notice at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. The Department will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services from the Department.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by the Department, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.
a. Treatment: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.
b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.
c. Health Care Operations: The Department may use or disclose your protected health information to support the business activities of the Department, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object: Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time to the extent that the Department has not acted upon your authorization, **except** as permitted or required by law as described below. The Department may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, the Department may use and disclose certain protected health information to your representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative.
a. Confidentiality of Alcohol and Drug Abuse Patient Records: The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or the Department, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program or about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

b. AIDS confidential information: AIDS confidential information, including HIV status or testing information, is confidential under state law. Generally, the Department will not disclose AIDS confidential information without your authorization. The Department may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. The

Department may disclose AIDS confidential information in certain circumstances as part of your mental health commitment or by other legal procedures.

3. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object: The Department may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings, such as hearings regarding your hospitalization or commitment or to comply with workers' compensation laws; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the legal representative of your estate.

4. Required Uses and Disclosures: Under the law, the Department must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine the Department's compliance with the requirements of HIPAA regulations beginning at 45 CFR Section 164.500.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
a. You have the right to inspect and copy your protected health information: You may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the Department uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it would be harmful to your physical or mental health.
b. You have the right to request restriction of your protected health information: You may ask the Department not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction you request, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.
c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location: Upon written request to a person listed in section 6 below, the Department will accommodate reasonable requests for alternative means for the communication of confidential information with you, but may condition this accommodation upon your provision of an alternative address or other method of contact. The Department will not request an explanation from you as to the basis for the request.
d. You may have the right to request amendment of your protected health information: If the Department created your protected health information, you may request an amendment of that information for as long as it is maintained by the Department. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your protected health information.
e. You have the right to receive an accounting of certain disclosures the Department has made of your protected health information: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures the Department made to you, to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care, or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring in the six (6) years before your request, subject to certain exceptions, restrictions and limitations.
f. You have the right to obtain a paper copy of this notice from the Department, upon request.

6. Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with the Department facility providing your treatment or services, or your treatment provider or services provider under contract or agreement with the Department which maintains your protected health information at telephone 770 387-5440 facsimile 770 387-5445 or by mail to 650 Henderson Drive, Suite 430, Cartersville, GA 30120. You must state the basis for your complaint. Neither the facility, the provider, nor the Department will retaliate against you for filing a complaint. You may also contact the **Department's Privacy Officer by telephone at (404) 657-2282, facsimile (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia 30303-3142,** for further information about the complaint process or this notice.

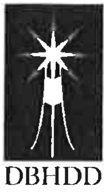
Please sign a copy of this Notice of Privacy Practices for your provider's and the Department's records.

I have received a copy of this Notice on the date indicated below.

Stamp Plate

____________________________________ __________

Signature of Individual or Legally Authorized Person Date



Georgia Department of Behavioral Health & Developmental Disabilities
Frank Berry, Commissioner

DBHDD, Region 1
1230 Bald Ridge Marina Road, Ste.800, Cumming, GA 30064, 678-947-28148, Fax: 678-947-2817
Toll Free: 1-877-217-4462

SPECIAL NEEDS FOR DOCUMENTATION

WHAT WE NEED: Determining someone's eligibility for services based on a developmental disability can be particularly complicated when the applicant:

- is an adult
- has a history of symptoms related to mental illness
- has a history of drug abuse
- has experienced declines in their abilities because of aging, medical illness or traumatic injury

In situations like this, there is an increased need for records from childhood or adolescence. Examples of the kinds of records that are most helpful in determining eligibility are:

- psychological evaluations
- Individualized Education Plans (IEPs) and other school-based assessments
- treatment notes that contain diagnoses of Mental Retardation, Autism or a similar disability
- professional observations and reports concerning level of intellect (IQ) and adaptive behavior/daily living skills

WHY WE NEED IT: We do not want to unfairly deny people of benefits they deserve or make the intake process excessively long and burdensome. But often the <u>only</u> way we can establish an individual's eligibility for services when there are complicating conditions is through records that describe how the person was thinking, behaving, and performing as a child or adolescent. These records may be difficult to find and obtain but they are irreplaceable sources of information.

WHERE TO FIND IT: The following places may have the kind of information that could help us to establish the existence of a developmental disability:

- ☐ Hospitals, Medical Offices or Treatment Centers
    - Did the applicant ever stay in a hospital or treatment center?
    - Did the applicant have a consistent physician or make repeated visits to a particular health care provider?
- ☐ Schools
    - Where did the applicant attend school? Was there a special education program?
    - If records have been lost or destroyed, is there someone still at the school who worked with the applicant and could tell us about the applicant's abilities or diagnoses back then?
- ☐ Job Training or Vocational Rehabilitation Programs
    - Has the applicant ever tried to get help in finding work or applied for a work training program?
- ☐ Social Security Administration Offices
    - Has the applicant ever applied for disability benefits? What county was the applicant living in when those benefits were applied for?
- ☐ Prisons or Detention Centers
    - Has the applicant ever been in prison, a juvenile detention center or any kind of locked facility?

<u>HOW TO GET IT</u>: There are two ways to get the kinds of records that we need.

The applicant or guardian can request the records directly and then send the copies to the Intake and Evaluation Office. Sometimes this method gets the fastest response and it is required for Social Security records. <u>SSA offices will not release records to third parties.</u>

DBHDD

Georgia Department of Behavioral Health & Developmental Disabilities

Name of Individual/Consumer/Patient/Applicant

Social Security Number AND/OR Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the disclosure of records/information

From: ______________________________
(Name of health care provider holding the information - releasing agency)

____
(Address) (Phone/Fax)

To: Region One Intake and Evaluation Office
(Name of Person or Agency to whom information should be given - requesting agency)

1230 Bald Ridge Marina Road, Cumming, GA 30041 678-947-2818/ 678-947-2817
(Address) (Phone/Fax)

____ Initials I authorize the following information from my records (and any specific portion thereof): ______________________________

____ Initials I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below)

____ Initials I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions

The above information is for the purpose of: ______________________________

1. *I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)*

☐ one (1) year OR ☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.

Date | **Signature of Individual/Consumer/Patient/Applicant**

Signature of Witness (Title or Relationship to Individual) | **Signature of (check one): Date**

☐**Parent** ☐**Guardian** ☐**Court-appointed Custodian of Minor**
☐**Agent designated by Individual's Advance Directive**

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142.

Date this authorization is revoked by Individual | **Signature of Individual or legally authorized Representative**