APPLICATION FOR MEDICAID SERVICES FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

Thank you for your interest in Medicaid developmental disabilities services for children. In order to determine if your child is eligible for services, you will need to complete or obtain each of the items requested as part of the application process.

1. Fill out, sign and return each of the forms listed below. Applications not containing this information will not be accepted. These forms have been included in the application packet for your convenience:
   - Children's Developmental Disability Application
   - Acknowledgement of Receipt of Notice of Privacy Practices

2. In order to process your initial application, the three items must be submitted.

Additionally we recommend you provide the following documentation to assist in eligibility determination:

3. Provide documentation which verifies your child has a diagnosis that qualifies as a developmental disability. The documentation requirements are as follows:

   - If your child's diagnosis is **Cerebral Palsy, Epilepsy,** or closely related condition: Provide medical documentation from a physician.

   OR

   - If your child's diagnosis is **Intellectual Disability or closely related condition**: Provide results of cognitive testing. If the test was not done within the last three years, new testing must be done. Approved test instruments are listed in the "Instructions for Completing the Children's Developmental Disability Services Application" included with this packet.

   OR

   - If the diagnosis is **Autism Spectrum Disorder such as: Autism, Aspergers or Pervasive Developmental Disorder (PDD)**: Provide an assessment completed by a licensed professional qualified to make an autism spectrum diagnosis.

Once you have completed and/or obtained each of the above items, return the information to the Department of Health and Welfare by email, fax, or mail:

Email:
ChildrensDDIntake@dhw.idaho.gov

Fax: (208) 332-7331
Attn: Children's DD Application

Mail or Hand Deliver:
Children's DD Application/Intake
DHW FACS 5th Floor
450 W State Street
Boise Idaho 83720

Upon receipt, we will forward it to the Liberty Health Care who will complete your child's eligibility process. It is important that you submit all the documentation requested at the same time in order for the IAP to process your application in a timely manner.

Once all of the documentation is received by the IAP, they will review the documents and contact you to schedule a time to complete the eligibility assessments.

If you have any questions about the application process or the documents requested, please contact **Central Intake at (208) 334-6500 or toll free at 1-877-333-9681.**

IDAHO DEPARTMENT OF
HEALTH & WELFARE

CHILDREN'S DEVELOPMENTAL DISABILITIES SERVICES APPLICATION R 8_4_2016

Date: _____

Child's Name: _____ Date of Birth: _____

Is the child currently enrolled in Medicaid? ☐ Yes ☐ No MID# _____ Healthy Connections? ☐ Yes ☐ No

Parent(s)/Legal Guardian Name: _____ Lives with: _____

Address: _____ City: _____ State: _____ zip: _____

Mailing address if different: _____

Telephone (1): _____ Telephone (2): _____ Email: _____

Physician Name: _____ Telephone: _____

Physician Address: _____

Name of School, if applicable: _____ Diagnosis _____

What services/supports do you think would benefit the child: _____

_____

Does your child receive any of the following services?

Service Coordination ☐ Yes ☐ No PCS? ☐ Yes ☐ No CBRS? ☐ Yes ☐ No

List enrollment in any other services, including other Department services: _____

Other history or pertinent information regarding the child: _____

_____

Documents to determine eligibility:

☐ Medical records
(If the child's diagnosis is **Cerebral Palsy, Epilepsy, or closely related condition,** include records that verify the disability)

☐ Cognitive Testing
(If the child's diagnosis is **Intellectual Disability or closely related condition,** include IQ/psychometric testing that verify the disability)

☐ Autism Assessment
(If the child's diagnosis is **Autism Spectrum Disorder such as: Autism, Aspergers or Pervasive Developmental Disorder (PDD), or closely related condition**, provide an assessment completed by a licensed professional qualified to make an autism spectrum diagnosis)

Additional collateral documentation if available:

☐ History and Physical (Well Child Check) ***Required before Plan of Service can be written.***

☐ School records/assessments related to disability

☐ Speech/Language, Physical Therapy, Occupational Therapy, CBRS Plan

☐ Other pertinent evaluations _____

Parent/Legal Guardian Signature: _____ Relationship to Applicant: _____

16.05.01.050. When individuals, legal representatives or informal representatives sign an application, they consent for the Department to gather, use and disclose information as needed for an individual to receive Department benefits or services. If none of these individuals provides a consent on an application, service may be denied. An informal representative may only consent to the disclosure of confidential information when permitted by these rules.

*****The Department must receive a signed application in order to process. Applications submitted without a signature, privacy receipt will be returned.**

INSTRUCTIONS FOR COMPLETING THE CHILDREN'S DEVELOPMENTAL DISABILITIES SERVICES APPLICATION

Child's Name: First and last name of the child applying for services.

Date of Birth: The child's birthdate (month, day and year).

Is the child currently enrolled in Medicaid: Check the "yes" box if the child is enrolled in Medicaid and "no" if not.

MID: If you checked the "yes" box as the answer to *"enrolled in Medicaid"* indicate the child's Medicaid number. The Idaho Medicaid Number is the first (7) seven digits of the Medicaid identification number as listed on the Idaho Medicaid card.

Health Connections: Check the "yes" box if the child is enrolled in Healthy Connections and the "no" box if they are not. If you do not know the answer to this question, do not check either box.

Parent(s)/Legal Guardian Name: First and last name of the child's parent(s) or legal guardian(s).

Address: Mailing address of the parent or legal guardian (include city, state, zip code).

Telephone (1) & (2): Daytime telephone number(s) where the parent or legal guardian can be contacted. Please include the area code.

Email: Email address of the parent or legal guardian.

Name of Physician: Indicate the first and last name of the child's primary care physician.

Physician Address: Mailing address of the child's primary care physician.

Name of School, if applicable: Name of the child's current school. If the child does not attend school, please leave blank.

Name of Primary Teacher: First and last name of the child's teacher. If the child does not attend school, please leave blank.

Diagnosis: List the child's developmental disability diagnosis(es).

What services /supports do you think would benefit the child: List the services and supports that you believe would benefit the child. A list of traditional services is included in this application packet.

Person Requesting Services: Your (person filling out the application) first and last name.

Relationship to Applicant: Your (person filling out the application) relationship to the child.

List enrollment in any other services, including Department services: List any other services or therapies the child might be involved in (ex: speech therapy, occupational therapy, counseling etc...).

Other history or pertinent information regarding your child: List any other medical and/or psychiatric issues and/or diagnoses. Include any other information that you feel would be important for the person reviewing the application to know. A History and Physical will be required before a Plan of service can be written. We encourage you to check with your child's physician to prevent a delay in services.

Documents to Determine Eligibility: check the boxes in front of the documentation that is included in the application. Only the records listed for the child's disability are required. For example, if the child has Epilepsy, only medical records are required; not Psychological or Psychometric testing.

- **Cognitive Testing:** The following tests will be accepted as documentation: Bayley Scales of Infant Development; Stanford Binet Intelligence Scales; Weschler Preschool and Primary Scales of Intelligence; Weschler Intelligence Scales for Children; Weschler Adult Intelligence Scales.
- **Autism Assessment:** Individuals who are qualified to diagnose a child with Autism Spectrum Disorder include: Developmental Pediatricians, Child Neurologists, Psychologists and Psychiatrists.

Additional Collateral Documentation: check the boxes in front of the documentation that is included in the application. This is additional documentation will be helpful for eligibility but is not required.

Acknowledgement of Receipt of the Notice of Privacy Practices

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name_____
(Please Print your First Name, Middle Initial and Last Name)

By the signature below, I acknowledge that I have received the Notice of Privacy Practices provided by the Idaho Department of Health and Welfare.

Your signature _____ **Date** _____

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Notice of Privacy Practices

Effective September 23, 2013

HW-0320
Revised 08/2013

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@dhw.idaho.gov.

- You may request a copy of this Notice at any time. Copies of this Notice are available at the Department of Health and Welfare offices. This Notice is also available on the Department of Health and Welfare's website at http://www.healthandwelfare.idaho.gov.

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.
We are required to:

- Use and disclose confidential information as required by law;
- Maintain the privacy of your information;
- Give you this Notice of our legal duties and privacy practices for your information; and
- Follow the terms of the Notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. Right to Review and Copy

You have the right to ask to review and copy your information as allowed by law.

If you would like to ask to review and copy your information, a "Records Request" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

If you ask to receive a copy of the information, we may charge a fee.

You will be told if there is information we are legally prevented from disclosing to you.

2. **Right to Amend**

You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. **Right to Restrict Health Information Disclosures**

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request in writing.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction. In situations where you or someone on your behalf pays for an item or service, and you request that information concerning said item or service not be disclosed to a health insurer, we will agree to the requested restriction.

4. **Right to an Alternate Means of Delivery**

You have the right to ask that we communicate with you by alternative means or at alternative locations. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request if it is denied for some reason.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. **Right to a Report of Health Information Disclosures**

You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment**. We may use and share your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care or payment of care, such as family members, informal or legal representatives, or others that give you services as part of your care.

- **For Payment**. We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

- **For Business Operations**. We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For Appointment Reminders
- For Treatment Alternatives
- As Required by Law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- To Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threat to Health or Safety
- To Military and Veterans Organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

Affected individuals will be notified following a breach of unsecured health information.

CHANGES TO THIS NOTICE

The Department has the right to change this Notice. A copy of this Notice is posted at our Department offices or at http://www.healthandwelfare.idaho.gov. The effective date of this Notice is shown at the top of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the Notice that is currently in effect.

COMPLAINTS

If you believe your confidential information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices or its website. To file a complaint with the Department, submit your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U. S. Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S. Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov.

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.