Request for Determination of Developmental Disability

This request form should be completed with assistance from your local Community Centered Board (CCB)

View a list of all Community Centered Boards online - www.colorado.gov/hcpf/community-centered-boards

Community Centered Board Information	
Community Centered Board:	
Address:	
Phone:	Fax:
Website:	

Applicant Information		
First Name:	Middle Name:	Last Name:
Date of Birth:	Age:	Gender:
Address:		County:
Home Phone:	Cell Phone:	Work Phone/Other:
Email Address:		
Preferred Method of Communication:		Marital Status:
Primary Language:	Ethnicity:	
Person Making Referral:	Current Living Arrangements:	

Primary Contact(s) Information *(complete all that apply)*		
Primary Contact		
Name:	Address:	
Home Phone:	Cell Phone:	Work Phone:
Email Address:	Relationship to Applicant:	
Additional Contact		
Name:	Address:	
Home Phone:	Cell Phone:	Work Phone:
Email Address:	Relationship to Applicant:	
Guardian Information		
Is there a Court Appointed Guardian? ☐ Yes ☐ No		
Guardian Name:	Relationship to Applicant:	

Financial and Medical Benefits Information *(complete all that apply)*		
SSN:	Medicaid State ID:	Medicare ID:
Supplemental Security Income (SSI) Amount:		

Financial and Medical Benefits Information *(complete all that apply)*
Social Security Income (SSDI) Amount:
Other Benefits *(e.g. HCBS-EBD, Children's HCBS, Trusts, etc.):*
Private Medical Insurance:

School Information	
Please list schools beginning with most recent attended:	
School District:	School Name:
Dates of Attendance:	Special Education Program? ☐ Yes ☐ No
School District:	School Name:
Dates of Attendance:	Special Education Program? ☐ Yes ☐ No
School District:	School Name:
Dates of Attendance:	Special Education Program? ☐ Yes ☐ No

Medical Information	
List medical and health needs:	
Name of Medical Provider/Medical Facility:	
Address:	Phone:
Name of Medical Provider/Medical Facility:	
Address:	Phone:

Services and Supports Information

List services and supports received by the applicant such as mental health services, therapies, early intervention, etc.:

Acknowledgements and Signatures *(to be completed in conjunction with Community Centered Board Staff)*

I understand this application is intended to solely determine whether I meet criteria for a Developmental Disability as defined by Colorado Revised Statutes C.R.S. 25.5-10-202.

I understand pursuant to 10 CCR 2505-10 Section 8.607.2 a determination of developmental disability does not constitute a determination of eligibility for services or supports. Eligibility for Health First Colorado (Colorado's Medicaid Program) funded programs specific to persons with developmental disabilities shall be determined pursuant to 10 CCR 2505-10.

I have received and included with the request form, pursuant to 10 CCR 2505-10 Section 8.600 et seq and Sections 25.5-10-202, C.R.S. the following information:

1. a copy of the Confidentiality/Privacy Notice
2. a copy of the Dispute Resolution procedure
3. a copy of the Grievance procedure,
4. a copy of my rights under Colorado Revised Statutes
5. a copy of the current Colorado Developmental Disability Definition

_______ I understand that I have (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.
Initial

_______ I understand that I have the right to request a ninety (90) calendar day extension if necessary.
Initial

Applicant Signature: *(if 18 or older)* Handwritten/Typed Signature: Or Electronic Signature:	Date:
Parent/Guardian Signature: Handwritten/Typed Signature: Or Electronic Signature:	Date:
Authorized Representative Signature: Handwritten/Typed Signature: Or Electronic Signature:	Date:

For CCB Completion Only	
Developmental Disabilities Professional receiving the request:	
Name:	Title:
Date completed and signed request received by CCB (Request Date):	
Date all documents needed for determination received (Determination Date):	

Authorization for Release of Health Information
(For CMA Programs & LTSS members ONLY)

Member's Full Name	Date of Birth	Member or Subscriber ID#	
Member's Street Address	**City**	**State**	**Zip**

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- I may revoke this authorization at any time by notifying Rocky Mountain Health Plans (RMHP) in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.
- In order to be considered eligible for Medicaid Long Term Care Services and Support, Rocky Mountain Health Plans Case Management Agency must be able to obtain and review information related to my personal health. Therefore, if I fail to sign this authorization, Rocky Mountain Health Plans Case Management Agency may not be able to determine whether I am eligible for benefits or to provide me with benefits.

This authorization expires (chose one):

________ When plan terminates (including any gap in coverage)
________ On this specific date:
________ When this event occurs (specify):

Who May Receive and Disclose my Information:

I authorize RMHP and its affiliates to receive from or disclose my individually identifiable health information to physicians, hospitals, pharmacies, medical equipment suppliers, home health agencies, homemaker and personal care persons and agencies, community service providers, other social services organizations, mental health service providers, insurance providers and other sources or organization involved in maintaining my independent living status or nursing home placement. Additionally, I authorize RMHP and its affiliates to receive from or disclose my individually identifiable health information to the following persons(s):

____
(Full Name of Person(s))

____
(Full Address of Person(s))

____
(Full Name of Person(s))

____
(Full Address of Person(s))

____
(Full Name of Person(s))

____
(Full Address of Person(s))

Type of Information to be disclosed:

________ I authorize disclosure of all my health information including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

________ I authorize only the disclosure of the following information:

Purpose of Disclosure:

________ My health information is being disclosed at my request or at the request of my personal representative; or

________ My health information is being disclosed for the following purpose:

____
(Explain Purpose)
****

____
Signature of Member Date

____
Witness Signature (For Illinois Residents Only) Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Guardian or Representative:

____
Name Phone Number

____
Street Address City State Zip Code

____
Signature of Guardian or Representative Date

Please return this form (and documentation, if applicable) to:
Mail: RMHP Case Management Agency
PO Box 10600
Grand Junction, CO 81502-5600

Fax: 970-255-3632

Email: CMAintake@uhc.com