Fayette County Board of
Developmental Disabilities

Fayette County Board of Developmental Disabilities

1330 Robinson Road
Washington Court House, Ohio 43160
(740) 335-7453
Fax (740) 335-2185

TO:

FROM: Robyn Runnels
Intake Coordinator

Please find enclosed an Application for Eligibility, the Diagnosis Verification Form and an Authorization to Release Records to be completed by you to determine if you are eligible for services from the Fayette County Board of DD.

Application for Eligibility:

1) You will notice several services at the top of the form that are provided by the Fayette County Board of DD, check the areas that may interest you.
2) ***You must provide a phone number where you can be contacted or a message can be left.*** Three attempts will be made to contact you to schedule any further appointments needed to determine your eligibility for services.
3) Please make sure to complete all of the application.

Diagnosis Verification Form

This form must be completed by a psychologist, psychiatrist, or your physician (not a certified nurse practitioner/CNP).
We cannot process your application without this document.

Authorization to Release Records:

1) On the first line of this form please provide the name of the person who is authorizing to release the records for the applicant i.e., parent, court-appointed guardian, or the individual.
2) The second line of the form is for the name of the agency or school district that will release information to the Fayette County Board of DD to assist with determining eligibility. ***Be sure to include an address and phone number for the agency or school district.***
3) The fourth and fifth lines are for the ***applicant's name and date of birth.***
4) Please sign and date the second page of the form. *If you are signing as a representative, parent, or court-appointed guardian for the applicant please sign and date as 'signature of personal representative'.*
5) Please make sure to complete the application as outlined above in order to complete the eligibility process as timely as possible.

FAYETTE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

APPLICATION FOR ELIGIBILITY

Check all services of interest: [ ] *Adult Day Services* [ ] *Behavior Support* [ ] *Community Employment*
[ ] *Family Support Services* [ ] *Payee Services* [ ] *Recreation / Socialization* [ ] *Residential Services*
[ ] *Service Coordination* [ ] *Sheltered Workshop* [ ] *Transportation*
[ ] *Other* _____ [ ] *Assistance in Completing Application*

Applicant Name: _____
First Middle Last

Address: _____
Street City State Zip Code

Date of Birth: Month _____ Day _____ Year _____ Sex: _____Male _____Female

Custodial Parent(s)/Guardian Name: _____
Court-Appointed Guardian: ____Yes ____No

Custodial Parent(s)/Guardian Address (if different from above)

_____
Street City State Zip Code

Home Phone: _____/_____/_____ Cell Phone: _____/_____/_____ Work Phone: _____/_____/_____

Emergency Number: _____/_____/_____ Emergency Contact Person: _____

School District: [ ] Miami Trace [ ] Washington City Schools Enrolled: ____Yes ____No ___Vocational

Does applicant have 1 or more disabilities or delays? ____Yes ____No ____Unknown
Please explain: _____

_____

Has applicant received services from another agency/organization/school? _____No _____Yes

If yes, from whom? _____

_____ _____ _____
Applicant Signature Parent/Guardian Signature Date / Time

For County Use Only *Date Application Received*

Recommendations: [ ] Services / Supports Approved
[ ] Services / Supports Denied (referrals made to other agencies)
[ ] Applicant placed on waiting list
[ ] Notified in writing of due process and administrative resolution of complaint availability

_____ _____
Superintendent or Designee Signature Date

Ohio Department of Developmental Disabilities

Diagnosis Verification (Ages birth through age 9)

Individual: _____ DOB: _____

Please have the appropriate clinician complete the below information.

Does the child have at least one of the following:

1. A substantial developmental delay?
   ☐ Yes ☐ No

   In what area(s) do delay(s) exist? _____

   _____

   Instrument: _____ Date administered: _____

OR

2. A diagnosed congenital or acquired condition, other than an impairment caused solely by a mental illness?
   ☐ Yes ☐ No

List the diagnoses: _____

Is the above-mentioned condition and/or delay likely to result in substantial functional limitation in any of the following major life areas if the individual does not receive the appropriate services/supports?

Self-care (bathing, grooming, eating, toileting, etc.)	☐ Yes	☐ No
Expressive/receptive language	☐ Yes	☐ No
Learning/cognition	☐ Yes	☐ No
Mobility (locomotion, positioning, transfers)	☐ Yes	☐ No
Self-direction (decision-making, judgment)	☐ Yes	☐ No
Independent living (household tasks)	☐ Yes	☐ No
Economic proficiency (money management)	☐ Yes	☐ No

_____ _____

Name of Physician or Licensed Psychologist | License number

_____ _____

Signature of Physician or Licensed Psychologist | Date

Ohio | Department of Developmental Disabilities

Ohio Department of Developmental Disabilities

Diagnosis Verification (Ages 10 and above)

Individual: _____ DOB: _____

Please have the appropriate clinician complete the below information. It is not necessary to have both areas completed.

Please complete this section if you are a physician providing diagnosis verification.

1. Does the individual have a medical condition that would be defined as a severe, chronic disability?
   ☐ Yes ☐ No

   Please list the person's disability: _____

   _____

2. Was the onset of the condition prior to age 22? ☐ Yes ☐ No

3. Is the disability attributable to a physical or mental condition other than a sole diagnosed mental health condition?
   ☐ Yes ☐ No

4. Is this condition likely to continue indefinitely? ☐ Yes ☐ No

Physician's Name: _____ License #: _____

Physician's Signature: _____ Date: _____

Please complete this section if you are a licensed psychologist providing diagnosis verification.

1. Does the individual have an intellectual disability that would be defined as a severe, chronic disability?
   ☐ Yes ☐ No

Please list the person's disability: _____

_____

2. Please list the instrument used to determine the presence of the disability and date administered:

   Instrument: _____ Date: _____

3. Was the onset of the condition prior to age 22? ☐ Yes ☐ No

4. Is the disability attributable to a physical or mental condition other than a sole diagnosed mental health condition?
   ☐ Yes ☐ No

5. Is this condition likely to continue indefinitely? ☐ Yes ☐ No

Licensed Psychologist's Name: _____ License #: _____

Licensed Psychologist's Signature: _____ Date: _____

Fayette County Board of DD
Administrative Procedure
Completion of "Authorization to Release Records" Form

Print or type information on this form. If you print, use a pen. Pencil is not permitted.

Complete all sections that request basic demographic and agency information at the top of Page 1.

Specify what information is being requested. Examples are: Medical/Dental/Vision/Hearing Records [may need to specify which one(s)]; Educational Records; Psychological Records; Social History; Copy of Birth Certificate; Therapy Records; Assessments [may need to specify which one(s)]

If applicable, the individual requesting the release of information must initial any box(es) which specifically address requested materials involving:

- Diagnosis/treatment for alcohol and/or drug abuse
- HIV test results
- AIDS/ARC diagnosis and/or treatment
- Diagnosis and/or treatment relating to other communicable diseases
- "Except as limited as follows": Here the individual requesting the release of records write which information is to be excluded from the records sent to the FCBDD.

Write in the purpose for the disclosure of records. Examples are: Eligibility determination; Completion of agency files to meet compliance regulations; File Update; Information necessary to complete individual's habilitation plan; Information necessary to complete individual's educational plan

Check the box if the information is being used for fundraising or levy information.

Before the signatures, write in the expiration date of the Authorization to Release Records Form. At no time shall this date be longer than 365 days from the date of the signature of the individual requesting the release of records.

If the individual responsible for authorizing the release of records containing PHI (the individual, the parent of a minor child, or the court-appointed legal guardian of a person age 18 or older) refuses to sign the Authorization to Release Records Form, then mark the appropriate box below:

- Box One states the person understands that without the release of this information that he/she cannot be made eligible for FCBDD services; and/or
- Box Two states that the person cannot participate in research-related treatment (we will not use this box); and/or
- Box Three: In the first line write "FCBDD" if the information requested is coming to the FCBDD or write the name of another organization that will be RECEIVING the requested information. On the second line re-write the name of the other organization that to which information is being sent if the purpose of the Authorization to Release Records Form is to SEND information to another organization. (i.e. You may be writing "FCBDD" once in the first line and may leave the second line blank OR you may be writing the name of the other organization on both lines.)

In the bottom section of Page 2, the entity releasing the information completes this section.

The original is sent to the organization from which the individual is requesting information. A copy of the form must be kept in the individual's file.

Fayette County Board of DD
AUTHORIZATION TO RELEASE RECORDS

I,_____, authorize
(Name)

_____
(Name or general designation of program making disclosure)
to disclose to:

_____,
(Insert name or identification of person/class of persons to receive information)
the following information regarding:

_____
(Name of individual)
whose date of birth is_____:
(Date of birth)

LIST INFORMATION BEING REQUESTED IN DETAIL

_____
_____
_____
_____
_____

I understand that the information to be released includes: **(initial appropriate boxes, if applicable)**

- ☐ Diagnoses and/or treatment for alcohol and/or drug abuse **see below for rule on redisclosure of information on drug/alcohol diagnosis or treatment.**
- ☐ HIV test results;
- ☐ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;
- ☐ Diagnoses and/or treatment relating to other communicable diseases
- ☐ Except as limited as follows:

_____
_____

The purpose of this authorized disclosure is (state purpose in detail):

_____
_____
_____
_____

Check if applicable:

- ☐ This authorization is for release of protected health information for fundraising or levy purposes. The FCBDD may receive funds as a result of using my protected health information

I understand that I may cancel this consent at any time except to the extent that action has been taken in reliance on it, by stating so in writing with the date and my signature and delivering it to.

_____.
(Name of recipient of PHI)

I understand that these records are protected by federal and Ohio law governing confidentiality rules, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that if I have authorized the FCBDD to disclose my protected health information to persons who are not required by Federal or State law to keep the information confidential, these persons who are receiving the records may disclose my protected health information to others without my consent or authorization.

IF THE INFORMATION DISCLOSED INCLUDES RECORDS OF DIAGNOSIS AND/OR TREATMENT OF DRUG OR ALCOHOL CONDITION:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A copy of this authorization shall have the same force and effect as the original.

If not previously revoked, this consent will terminate on: _____.
(Insert date or condition of expiration within 365 days)

_____ _____
Date Signature

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____ _____
Date Signature of personal representative

If the individual refuses to sign, check what is applicable:

☐ I understand that if I refuse to sign this authorization, I may not be enrolled for services in the FCBDD because the FCBDD cannot get information necessary to determine eligibility for FCBDD services. This authorization for information to determine eligibility is not for the use or disclosure of psychotherapy notes.

☐ I understand that if I refuse to sign this authorization, I may not receive research related treatment.

☐ I understand that this authorization is solely for the purpose of creating protected health information for disclosure to _____. If I refuse to sign, I will not receive health services necessary to develop protected health information to be disclosed by the FCBDD to _____.

For Entity Releasing Information Use Only:

Staff person releasing information: _____
Signature

_____
Print Name

Date information released: _____