

**Delaware Health and Social Services
Division of Developmental Disabilities Services
Dover, Delaware**

Title: Intake Eligibility Process

Approved By: Meriame Smith
Division Director

Written/Revised By: DDDS Policy Committee

Date of Origin: November, 1994

Revision Date: February 2004

I. Purpose

To determine the eligibility of applicants for Division Developmental Disabilities Services (DDDS) services.

II. Policy

Eligibility determination shall be based on standardized DDDS eligibility criteria.

III. Application

DSSS Staff

IV. Definitions

- A. **Intake Data Base** – A compilation of an individual's records which may include (but is not limited to): Medical information, Educational information, Individual Profile form, and a psychological evaluation.
- B. **Psychological Evaluation** - For those individuals whose existing psychological evaluation shows an IQ of 55-70, the evaluation should be current within one year. If the psychological evaluation is over one year the evaluation will be reviewed by a licensed psychologist to determine whether it is a current and valid reflection of the individual's functioning or whether a new evaluation should be conducted.
Psychological evaluations obtained for an individual with an IQ of 55 or below will be considered current. If, in the opinion of the Intake Coordinator there is a question of validity based on the age of the evaluation tests used, etc. the evaluation will be referred to a licensed psychologist for review.
- C. **Intake Screening** – Review of an applicant's eligibility for services.
- D. **Eligibility Requirements** – Standards an applicant must meet to be qualified for services through DDDS: Delaware residency, a disability as defined by the Division's eligibility criteria (exhibit A), and a completed application packet
- E. **Delaware Residency-** An applicant is considered a Delaware resident, for the purpose of DDDS's intake eligibility criteria, when they have an established permanent domicile in the State of Delaware and an expressed intent to remain in that domicile indefinitely.
- F. **Complete Application Packet** - a signed and completed Application for Services, Authorization for Release of Information, Financial Responsibility Notice and an Individual Profile form including copies of the applicant's birth certificate, social security card, medical insurance card and (a) immigration papers and (b) guardianship papers, if applicable.
- G. **Applicant** – Person referred for services for whom an application packet has been received.

- H. **Date of Application** – The date of application shall be the date a Completed Application Packet is received and stamped by the DDDS agency.
- I. **Individual Tracking Log** – An individualized form documenting whether an applicant is a Medicaid or non-Medicaid applicant, the Date of Application, date requesting additional information and date received, if needed and date of eligibility determination.
- J. **Registry** – A comprehensive data base of eligible individuals receiving DDDS services which includes individual demographics, identified service needs, services being received, and a priority ranking for residential placement based on set of crisis risk factors completed by a DDDS case manager.

V. Standards

- A. All requests for DDDS Services shall be referred to the Intake Coordinator.
- B. Intake Screening shall be the responsibility of the Coordinator.
- C. The Intake Coordinator shall ensure that each applicant has a complete Intake Data Base.
- D. Psychological Evaluations shall be current within the guidelines specified in Definition B.
- E. Intake Coordinator shall refer the case to a licensed psychologist for further testing, as warranted.
- F. An intake case shall become inactive/closed when:
 - 1. The Intake Coordinator disapproves eligibility for services;
 - 2. Notification requesting withdrawal of the application is received from the individual and/or referral source.
 - 3. The applicant/applicant’s representative/referral source fails to provide the information necessary to complete the application process within the specified time frames.
- G. When an application has been closed for more than six months the case shall be reactivated upon completion of an Application for Services and an Authorization for Release of Information.
- H. Application For Services shall be processed in a timely manner
- I. An individual shall be eligible for the DDDS Home and Community-Based Services (HCBS) Waiver when they are:
 - 1. Eligible for DDDS services
 - 2. Determined to meet ICF/MR Level of Care criteria and are financially eligible for Medicaid, and
 - 3. In need of residential services (as identified via the “Urgent” category of the DDDS *Registry*), or a resident of Stockley Center.
- J. All applicants determined not to have met the eligibility requirement or whose intake case has been closed shall be advised of their right to appeal the decision (via the process delineated in the Appeal to DDDS Decision Administrative Policy).

VI. Procedures

Responsibility

Intake Coordinator

Action

- 1. Receives request for services from referral source.
- 2. Recommends possible service alternatives to individual/referral source, as appropriate.
- 3. Sends Application for Services, Authorization for Release of Information, DHSS Confidentiality Notice to Clients and Individual Profile form to referral source.
- 4. Receives completed application and ensures that the Date of Application is made on each application and records in

the Intake Log Book.

5. Refers all non-Medicaid applicants to the appropriate regional Medicaid office for determination of Medicaid eligibility in accordance with Medicaid eligibility regulations.
6. For those applicants receiving Medicaid benefits, applications will be processed within 45 days after date of application and 90 days for non-Medicaid applicants. The DDDS eligibility process will occur concurrently with the processing of an applicants Medicaid application, if applicable.
7. Establishes an individual Intake Data Base and Individual Tracking Log for each applicant.
8. Reviews Intake Data Base and contacts appropriate person/agencies to request additional information as necessary.
9. When psychological evaluation is not available or current, consults with designated licensed psychologist and arranges for further testing.
10. Makes eligibility determination and notation in individual's file.
11. Sends written notification to the applicant, the referral source and the applicant's caretaker relative to eligibility decision.
12. Sends eligible applicants a DDDS brochure describing services provided by the DDDS including case management, day habilitation, supported employment, respite care and DDDS waived services.
13. Enters individual demographic information in the Registry and sends notice to regional managers of due date for Registry forms.
14. Forwards individual file of eligible applicant to HIM for duplication and distribution to the appropriate region for case management assignment.
15. Sends a DDDS appeals process form and coordinates appeal hearing for applicants denied services and wanting to appeal.

VI. References

Mental Retardation: Definition, Classification, and Systems of Supports, 9th Edition; American Association On Mental Retardation, Washington, D.C., 1992.

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition: American Psychiatric Association, Washington, D.C., 1994.

Delaware Register of Regulations, Vol. IV, issue 1, Saturday July1, 2000.

42 CFR 435.911

VII. Exhibits

- A. DDDS Eligibility Criteria
- B. Application for Services
- C. Release of Information Form
- D. DHSS Confidentiality Notice To Clients
- E. Individual Profile Form
- F. Appeals Request Form
- G. Appeal Process
- H. Financial Responsibility Notice



Division of Developmental Disabilities Services

Eligibility Criteria Regulation

- 1.0 The Division of Developmental Disabilities Services provides services to those individuals with a developmental disability who meet all of the following criteria:
- 1.1 citizen or a lawful alien of the United States;
 - 1.2 a resident of the State of Delaware;
 - 1.3 a disability/disorder attributed to one or more of the following:
 - 1.3.1 Mental Retardation; defined as a significant generalized limitation in intellectual functioning. Significant generalized limitation in intellectual functioning is defined as IQ scores approximately two standard deviations below the mean. (American Association on Intellectual and Developmental Disabilities; Classification Manual, 2002); and/or
 - 1.3.2 Autistic Disorder (299.00; American Psychiatric Association; Diagnostic & Statistical Manual - IV, 1994); and/or
 - 1.3.3 Asperger's Disorder (299.80; American Psychiatric Association; Diagnostic & Statistical Manual - IV, 1994); and/or
 - 1.3.4 Prader-Willi Syndrome (documented medical diagnosis; World Health Organization; International Classification of Diseases - 9); and/or
 - 1.3.5 Brain injury or neurological condition related to mental retardation that meets: a) a significant generalized impairment in intellectual functioning (defined in 1.3.1); b) significant limitations in adaptive behavior functioning (defined in 1.4); and c) originates before age 22 (defined in 1.5);
 - 1.4 Significant limitations in adaptive behavior functioning;
 - 1.4.1 Significant limitations in adaptive behavior functioning is defined as performance that is at least two standard deviations below the mean of either:
 - 1.4.1.1 Score on a standardized measure of conceptual, social, or practical skills; or
 - 1.4.1.2 Overall score on a standardized measure of conceptual, social and practical skills;
 - 1.5 the disability originates before age 22;
 - 1.6 Any individual who is receiving services on the effective date of these regulations who meets the requirements of 1.1 and 1.2 of this section and meets either the requirements of the regulations under which the individual initially established eligibility or the requirements of 1.3 through 1.5 shall be deemed eligible for services.
- 2.0 Intellectual functioning, adaptive behavior functioning, Autistic Disorder, and Asperger's Disorder shall be established and based on the use of standardized assessment instruments accepted by the Division.

STATE OF DELAWARE
DEPARTMENT HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

EXHIBIT B

APPLICATION FOR SERVICES



1. Name of Applicant: _____ Birthdate: _____

2. Address: _____

3. Social Security Number: _____
Street City County State/Zip

Medicare Number: _____ Other Medical Insurance (Name and Number): _____

* Note: Medicaid furnishes medical assistance to eligible low-income families and to eligible aged, blind and/or disabled people whose income is insufficient to meet the cost of necessary medical services. If you do not currently receive Medicaid, you may apply at your local State Service Center. Information may be obtained by calling 1-800-372-2022.

4. Is applicant a resident of Delaware? Yes No

5. Is applicant a citizen of the United States? Yes No

If no, please indicate your legal status: Lawful Immigrant (**copies of documentation must be supplied**)

Alien (country in which you were born) _____

6. Copies of the following documents are required (*please check the square of each item you have included*):

Birth Certificate

Social Security Card

Medicaid/Medicare Card

Private Health Insurance Card

Guardianship Papers (*if applicable*)

7. Parent/Court Appointed Guardian: _____

If Guardian, please check: Guardian of Person Guardian of Property Both

8. Address: _____

Street City State/Zip

9. Required Signatures:

Applicant (if applicable) Date

(Parent, Court Appointed Guardian, Relative, Personal Advocate) Date Relationship to Applicant

Witness Date Number where you can be reached if necessary

POLICY OF THE STATE OF DELAWARE AS ESTABLISHED BY STATE LAW AND EXECUTIVE ORDER ASSURES EQUAL OPPORTUNITY AND PROHIBITS DISCRIMINATION ON THE BASIS OF RACE, RELIGION, COLOR, ORIGINAL ORIGIN, SEX OR AGE.



**Delaware Health and Social Services
DIVISION OF DEVELOPMENTAL DISABILITIES
SERVICES**

Release of Information Authorization

Applicant: _____ D.O.B. _____ SS# xxx-xx- _____

I, _____ hereby authorize the individuals/agencies indicated
Applicant/Guardian/Parent/Personal Representative

below to release and send information to The Division of Developmental Disabilities Services (DDDS) at Woodbrook Professional Center, 1052 South Governor's Avenue, Suite 101, Dover, Delaware 19904 or fax number (302) 744-9711. The information requested is for the purpose of determining eligibility for the DDDS.

The documents requested include those that were completed before the DDDS applicant turned age 22 and include standardized testing in the areas of cognition/intellectual functioning, adaptive skills, Autism or Asperger's disorder or Prader-Willi syndrome.

A. I. duPont Hospital for Children	Yes ___	No ___
Child Development Watch	Yes ___	No ___
Division of Services for Children, Youth and Their Families (DSCYF)	Yes ___	No ___
Division of Vocational Rehabilitation	Yes ___	No ___
Delaware Autistic Program	Yes ___	No ___
Division of Family Services	Yes ___	No ___
Neurologist (give name) _____	Yes ___	No ___
Psychologist (give name) _____	Yes ___	No ___
_____	Yes ___	No ___
Schools Attended _____	Yes ___	No ___
_____	Yes ___	No ___
Other: _____	Yes ___	No ___
Other: _____	Yes ___	No ___

I understand that this authorization may be revoked (you can change your mind) at any time but this does not include information that was already requested. A request to revoke this authorization must be sent in writing to Dorphene Abrams- Rojas at the address above.

I further understand that information that is disclosed (sent to DDDS) as a result of this authorization may be subject to re-disclosure and is no longer protected under the federal HIPAA Privacy Rule. In other words, we may send the information we receive to other people who request it. The **exception** to this would include drug and alcohol treatment records which are protected by Federal Regulation (42 CFR Part 2) and prohibits the DDDS from re-disclosing this information.

Applicant's Signature (if over age 18)

Date of Signature

Parent of Minor/Personal Representative

Date of Signature

Relationship to Applicant

DELAWARE HEALTH AND SOCIAL SERVICES
CONFIDENTIALITY NOTICE TO CLIENTS

We want you to know why we need to collect information about you and your family, the steps we take to protect your privacy, and your rights to know what information we will keep in our records.

Please ask us for more details if you have any questions.

Why do we keep records? Delaware laws authorize the Department to collect and keep information we need to carry out our duties. This information is important for planning how to best work with you and your family.

Who else may learn this information? For the most part, only Department staff are permitted to know this information, unless you give us written permission to share it with someone else. If you are working with a team of people from different agencies within the Department, information may be shared among the team. The law requires us to share information in some other situations, such as court orders; emergencies threatening health or safety; and investigation of waste, abuse, or fraud.

Will Department staff keep this information confidential? All of our staff sign a confidentiality agreement, which clearly describes their duty to protect the privacy of all of our clients. In addition, the ethical codes of physicians, psychologists, nurses and social workers require them to keep information shared with them confidential.

Information shared with licensed physicians, psychologists and social workers cannot be subpoenaed, with the following exceptions: hospitalization proceedings; court ordered examinations; proceedings in which a guardian is sought, if the client's condition is part of the client's legal claim or defense; and alleged child/impaired adult abuse or neglect cases.

Where is information stored? When not in use, all written records about you are kept under lock. Some information about you may be stored on a computer system. We protect information stored in computers by "locking-out" all but the staff authorized to learn that information.

What are your rights? You have a right to find out what records we keep about you, how they will be used, and how they will be shared with others. You also have a right to review your records, except for certain confidential information and investigative files. If you object to or do not agree with the information in our records, you may ask us to change our records.

If we decide that we cannot change the records, you may give us your information in writing, and we will put it in the records.

What if you have other questions? Please ask the staff person working with you if you have any other questions. If you ask, we will give you a copy of our policy on confidentiality.

ADDENDUM

It may be necessary to speak with various agency personnel regarding your application and the records that we need in order to determine your eligibility for Division of Developmental Disabilities Services (DDDS). In addition, several other agencies sometimes have a need to know the status of your application and your eligibility for DDDS services. Below are listed those agencies with which we are in frequent contact. By checking the appropriate box you can let us know if you object to our discussing your application and eligibility for services. If approved, we will limit our exchange to information that is necessary in assisting you with services and will be kept in strictest confidence. This Authorization will remain in effect for one year from the date of signature.

Approve Disapprove

- Personnel at the School(s) you attended

- Voc Rehab Counselor

- Division of Family Services/Child Mental Health

- Health Care Provider

I have read the information on this page and/or had it read to me and explained in a language I can understand. I understand my confidentiality rights.

(CLIENT/GUARDIAN SIGNATURE)

(DATE Signed)

(DEPARTMENT EMPLOYEE/AGENT SIGNATURE)

(DATE SIGNED)

PARC Approved: 05/00/02
Revised: 11/06/03
01/Admin



YOUR INDIVIDUAL PROFILE

1. INFORMATION ABOUT YOU (the person applying for DDDS services)

Name: _____ Birthdate: _____

Sex (*Male / Female*): _____ Phone No.: _____

Your primary Caretaker if other than yourself:

Name: _____

Address: _____

Phone Number: _____ Relationship to you: _____

Race/Ethnicity: _____ White/Caucasian _____ Oriental/Vietnamese
 _____ Black/African American _____ American Indian
 _____ Spanish Origin _____ Other (Specify) _____

Religious Preference: _____ Christian _____ Jewish
 _____ Muslim _____ Buddhist
 _____ Hindu _____ Other (Specify) _____

INFORMATION ABOUT YOUR FAMILY

Name of Mother: _____

Birth date & Social Security # of Mother: _____

Name of Father: _____

Birth date & Social Security # of Father: _____

Do you have a genetic disorder? No Yes (*please describe*) _____

Did any of the following problems or conditions exist during your mother's pregnancy?

- Bleeding Infections Diseases X-Ray Exams
 Shock Drug Use Falls Strain (physical, mental, emotional)

Please describe anything you have checked _____

2. ABOUT YOUR BIRTH

Were there any difficulties with your birth? No Yes

If yes, please explain:

Were you: Full term Premature (how many months were you when born?) _____

Was anesthesia used during your birth? Yes No Not Sure

Were instruments used? Yes No Not Sure

Did you cry at once? Yes No Not Sure

Were you jaundiced (yellow) at birth or soon after? Yes No Not Sure

If yes, for how long? _____

Did you require special treatment to help with breathing? (injections, oxygen, etc.)

Yes No Not Sure

What was your weight at birth? _____

3. ABOUT YOUR DEVELOPMENT

Did you ever receive early childhood intervention services? Yes No

Please tell us how old you were when the following Developmental Milestones happened for you:

Teething _____ Sitting Alone _____ Standing Alone _____

Walking Alone _____ Beginning to Talk _____ Toilet Trained _____

4. SCHOOL HISTORY

What school did you last attend?

Name _____ Phone: _____

Address: _____

Last Grade attended: _____

Age and dates attended: _____

Were you a Special Education student? Yes No

Did you receive a Certificate of Attendance? Yes No If yes, what year? _____

Did you receive a diploma? Yes No If yes, what year? _____

Have you ever attended a day program? Yes No

If yes, what is the name of the program and when did you attend? _____

5. TEST HISTORY

Date of your last psychological test? _____

Who tested you, and where? _____

6. WORK HISTORY

Where Have You Worked?	What Type of Work Did You Do?	When Did You Work There? (Dates)

7. SERVICE HISTORY: Do you or have you received services from any of the following (please check all that apply)

	Current	Past
A.I. DuPont Institute	<input type="checkbox"/>	<input type="checkbox"/>
Child Development Watch	<input type="checkbox"/>	<input type="checkbox"/>
Division of Child Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Delaware Autistic Program	<input type="checkbox"/>	<input type="checkbox"/>
Delaware Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Division of Family Services	<input type="checkbox"/>	<input type="checkbox"/>
DDDS (Respite-Residential)	<input type="checkbox"/>	<input type="checkbox"/>
Governor Bacon	<input type="checkbox"/>	<input type="checkbox"/>
Elwyn	<input type="checkbox"/>	<input type="checkbox"/>
Kent-Sussex Industries	<input type="checkbox"/>	<input type="checkbox"/>
Meadowood Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Mental Hygiene Clinic/Mental Health Center Location:	<input type="checkbox"/>	<input type="checkbox"/>
Rockford Center	<input type="checkbox"/>	<input type="checkbox"/>
Stockley Center	<input type="checkbox"/>	<input type="checkbox"/>
Terry Center	<input type="checkbox"/>	<input type="checkbox"/>
Vocational Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

8. CRIMINAL HISTORY

Have you ever been convicted of a criminal offense (*Felony or Class A Misdemeanor*)? Yes No

If yes, tell us the type of offense, date & location: _____

Are you currently on probation or parole? Yes No

Comment, if yes: _____

Name and phone number of probation officer: _____

9. PSYCHIATRIC HISTORY

Have you ever received out-patient psychiatric treatment? Yes No

Name and address of physician _____

Dates of Treatment: _____

Have you ever received in-patient psychiatric treatment? Yes No

Name and address of facility _____

Dates of Treatment: _____

10. CURRENT MEDICATIONS

Please tell us about all the medicines you are taking. Please continue on back of next page if needed.

Medication: _____
Circle: Prescription or Non-Prescription
Reason Given: _____
How do you take it: _____

Medication: _____
Circle: Prescription or Non-Prescription
Reason Given: _____
How do you take it: _____

Medication: _____
Circle: Prescription or Non-Prescription
Reason Given: _____
How do you take it: _____

Person Helping You Complete This Profile: _____ Phone: _____

Person Providing the Information: _____ Phone: _____

Date Of Completion: _____

Required Signatures:

Signature of Individual Seeking Services _____

Signature of Guardian/Family Member (*if applicable*) _____



Delaware Health And Social Services
Division of Developmental Disabilities Services

APPEALS REQUEST FORM

Section I - To be completed by the applicant\consumer\advocate

Date: _____

Name of Applicant\Consumer: _____

What are you appealing? Why? _____

Please be specific. _____

Please explain what has been done to try
to resolve the issue being appealed, if
applicable.

Requested by: _____ Relationship to _____

Applicant/Consumer: _____

Address: _____ Daytime Phone #: _____

Section II - To be completed by the Appeals Board Chair:

Date reviewed by DDDS Appeal Board: _____

Chairperson: _____

Recommendation: _____

Date

Signature and Title

APPEAL PROCESS

- **Step 1:** If you disagree with a decision of the Division of Developmental Disabilities Services, you may contact the Appeals Board Chair, your case manager or social worker or other appropriate DDDS representative to provide additional information or to discuss the possibility of another review by the team/committee/ individual who made the decision.

- **Step 2** If, after your conversation or meeting with the DDDS representative(s), you still disagree with the decision, you may file a formal written appeal within 30 days of the decision by completing Section I of the appeals Form and returning to:

Mary Anderson, Chairperson
26351 Patriots Way
Georgetown, Delaware 19947

- **Step 3** The DDDS appeal board will review your appeal and conduct a hearing within 30 calendar days of receipt of your appeal. Written notification of the appeal board's decision will be sent to you within 15 working days of the hearing.

**Special
Notice for
Medicaid
Recipients**

Medicaid recipients may request an independent Medicaid Fair Hearing following a DDDS appeal decision by contacting:

Division of Social Services
Medicaid Fair Hearing Officer
PO Box 906
New Castle, DE 19720

(302) 577-4880



**DELAWARE HEALTH
AND SOCIAL SERVICES**
Division of Developmental Disabilities
Services

FINANCIAL RESPONSIBILITY NOTICE

I understand that I may have some financial responsibility for the cost of services provided by the State of Delaware, Department of Health and Social Services, Division of Developmental Disabilities Services, as established by 29 Del. C §7940.

In order to determine any financial responsibility for the services I receive, I will be asked to disclose all information with regard to my financial status and assets including any jointly held financial accounts or accounts bearing my name.

The parents of a minor child receiving services may be asked to disclose their financial status and assets in order to determine any financial obligations and responsibilities they may have for the services provided to their child.

Financial resources received by the Division of Disabilities Services (DDDS) for an individual will be applied to the costs of the service(s) received in accordance with applicable Social Security, Medicaid and State rules and regulations.

Each individual receiving services has the responsibility of informing the DDDS of any changes in their financial status. Periodic updates of an individual's financial status and assets may be necessary during the receipt of services in order to assess the individual's financial responsibility and ensure continued eligibility for federal benefit programs.

Failure to fully disclose one's financial status and assets may result in a denial or loss of services.

I have read and understand the above notice and agree to assist the DDDS in determining any financial obligations I may have for services I receive.

Signature of Applicant

Date

Signature of Parent (if applicant is a minor) or
Substitute Decision-Maker /Legal Guardian (if applicable)

Date

Witness

Date

**PARC Approved: 02/10/04
26/Admin**