
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
 - ICDE Consent for Gathering, Use and Disclosure of Information
 - 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 Idaho Center for Disabilities Evaluation (ICDE) office 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 ICDE to process your application in a timely manner.

Once all of the documentation is received by the ICDE, 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.**



CHILDREN'S DEVELOPMENTAL DISABILITIES SERVICES APPLICATION R 3_12_2015

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: _____
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) [] School records/assessments related [] Speech/Language, Physical Therapy, Occupational Therapy, CBRS Plan
Required before Plan of Service can be written.
[] 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 and ICDE release 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, <u>do not</u> 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. <ul style="list-style-type: none">➤ 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.



Consent for Gathering, Use and Disclosure of Information

Child Name: _____ DOB: _____

Mailing Address: _____

Residential Address (if different): _____

Primary Phone: _____

Requestor Name (if different than child's parent/guardian): ICDE _____

I consent to the gathering, use and disclosure of my information by the Idaho Center for Disabilities Evaluation. This information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services and to conduct normal business operations.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Center for Disabilities Evaluation has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Center for Disabilities Evaluation has the right to report the action to the Department of Health and Welfare, which has the right to refuse to provide me with further benefits or services.

If the person consenting to the release is someone other than the parent, they must provide documentation of their authority.

Parent or Legal Guardian: _____ Date: _____

*****This consent expires 1 year from the date signed*****

*****PLEASE RETURN WITH YOUR APPLICATION*****

Location	Idaho State University Address	Phone	Fax
Coeur d'Alene	7950 Meadowlark Way, Ste. C, CDA, ID 83815	208-772-8502	208-772-8504
Lewiston	1118 F Street, 3 rd Floor, Lewiston, ID 83501	208-799-5044	208-799-5082
Meridian	1311 E. Central Drive, Meridian, ID 83642	208-334-1730	208-334-1737
Twin Falls	522 Madrona St., Twin Falls, ID 83301	208-736-5711	208-736-5711
Pocatello	921 So. 8 th Ave., Stop 8082, Pocatello, ID 83209 Physical Address: 1001 N. 7 th Ave., Pocatello, ID 83209	208-282-5465	208-282-1003
Idaho Falls	850 Energy Drive, Suite 141, Idaho Falls, ID 83401	208-525-7050	208-525-7051