MEDICAID WAIVER APPLICATION PACKET

The following pages are the required forms to get your child/adult on the Medicaid Waiver Waiting list.

Page 1 — Actual application with your child/adult's personal information. *

Question: Describe how your disability affects your life? - this question is asking how your child/adult's disability affects their life. Answer with 2-3 sentences pertaining to activities of daily living, access to the community, awareness of danger, etc.

Page 2-3 — HIPAA forms allow the state to talk to whomever you have listed. Be as general or as specific as you like. For example, you could answer the first question (What personal information are we to disclose) with "anything needed to obtain the waiver."

The DDRS program (on the top of pg 3) - choose Bureau of Developmental Disability Services (BDDS)

Page 4 — Another HIPAA Form. This form gives doctors/therapists/schools permission to disclose information to the state. (make copies as needed)

Page 5 — Notice of Right to Appeal

Page 6 — Confirmation of Diagnosis must be completed by physician—very important

* *If applicant is 18 years or older, they must sign the application unless there is a Court Appointed Guardian. Guardians should include copy of Court documents appointing you as guardian.*

When completed, fax or send by certified mail to the Bureau of Developmental Disability Services at:

Bureau of Developmental Disabilities District 5
2620 Kessler Blvd. E. Dr., Suite 105
Indianapolis, IN 46220-2890
Phone: 317-205-0101
Fax: 1-855-525-9373

Helpful hints:

- Be sure to keep a copy for your records!
- Always follow-up to make sure that your application was received.
- The waitlist time is currently approximately 1 year.
- Mark your calendar to call BDDS at least yearly to check your status.
- If your contact information changes, you will need to update BDDS immediately.

For help completing the application, contact:

- The Arc at 317-977-2375 or 800-382-9100 and ask to speak to a Family Advocate
- Family Voices Indiana at 317.944.8982

For information about the waiver, visit:

- http://www.arcind.org/supports-services/medicaid-waivers/
- http://www.fvindiana.org/Files/SS/FS_MedicaidWaivers_DD.pdf

APPLICATION FOR DEVELOPMENTAL DISABILITY SERVICES

State Form 55068 (8-12)
Indiana Family and Social Services Administration (IFSSA)
Division of Disability and Rehabilitative Services
Bureau of Developmental Disability Services

Print Form

*Note: An electronic version of this form may be found on the Division of Disability and Rehabilitative Services' website at www.IN.Gov/fssa/2328.htm. This document may be located at "**DDRS**" and then under "**APPLY FOR SERVICES**". Please complete the form, print, sign and return to the local BDDS office.*

***THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.**

APPLICANT INFORMATION

Last Name ______ **First Name** ______ **Middle Name** ______

Street Address ______ **County of Residence** ______

City ______ **State** Indiana **ZIP Code** ______

Telephone with Area Code ______ **E-mail Address** ______

Gender ______ **Social Security Number** ______ **Date of Birth** ______

Medicaid Number ☐☐☐☐☐☐☐☐☐☐☐☐ **Medicare** ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other

Ethnicity ☐ White ☐ Native American ☐ Asian *(specify:* ______) ☐ African American
☐ Hispanic *(specify:* ______) ☐ Multiracial ☐ Other *(specify:* ______)

Highest Level of Education ☐ 8th Grade or less ☐ Grades 9 - 11 ☐ High School
☐ Technical or Trade School ☐ Other

Applicant's Housing Situation ☐ Family Home ☐ Foster Home ☐ Group Home ☐ Correctional Facility ☐ Nursing Home
☐ Own Home, rent, subsized ☐ Own Home with others ☐ Psychiatric Facility ☐ Other *(explain:* ______)

GUARDIAN INFORMATION

Does the applicant have a legal guardian? ☐ Yes ☐ No **Name of Guardian, *if applicable*** ______

Telephone ______ **Address** ______ **E-mail Address** ______

Relationship Type/Role ______ **Lives with applicant** ☐ Yes ☐ No

DESCRIBE HOW YOUR DISABILITY AFFECTS YOUR LIFE:

Age first Disabled ______

Have you ever been assessed by Vocational Rehabilitation Services? ☐ Yes ☐ No

SIGNATURE

Signature of Applicant ______________________ **Date** ______

Signature of Guardian ______________________ **Date** ______

AUTHORIZATION FOR DISCLOSURE OF PERSONAL AND HEALTH INFORMATION - DDRS

State Form 54584 (2-11)

FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF DISABILITY AND REHABILITATIVE SERVICES

Purpose

For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of the Division of Disability & Rehabilitative Services (DDRS). Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

Your Name and Identification Information

Name____

Address____

City______________________________ State__________ ZIP Code____________

Telephone (____)______________ E-mail Address______________________________

Date of Birth______________________ Last 4 Digits of Social Security #________________

What personal information, including health information, are we to disclose?

Please describe the type of information we are allowed to disclose; for example, your contact information, your benefits status, your medical condition, your healthcare payment status and history, or "as requested by the authorized person/organization."[1]

____

____

What is the purpose of the requested disclosure of your personal information?

Please describe the purpose for the disclosure (e.g., assistance with obtaining or using DDRS benefits/services, legal assistance, the person is involved in my use of DDRS benefits/services, or simply "at my request").

____

____

____

To whom are we authorized to disclose your personal information?

Please state the names of the individuals or organizations, including contact information.

____

____

____

[1] *If the personal information to be disclosed is identified "as requested by the authorized person/organization", then we will rely on them to identify what information is to be disclosed when receiving their request for disclosure; we will also rely on them to specify the minimum amount of personal information, including health information, that is reasonably necessary to accomplish the purpose of the request.*

Which DDRS program areas are you authorizing to disclose your personal information?

❑ Bureau of Child Development Services (BCDS) ❑ Bureau of Developmental Disabilities Services (BDDS)

❑ Bureau of Quality Improvement Services (BQIS) ❑ Other________________________________

Expiration Date or Event

This authorization will automatically expire sixty (60) calendar days from the date you sign it. You may specify an earlier or later expiration date, or you may specify an event upon which this authorization will expire (e.g., "when my concern has been addressed"). Please select one of the following three:

❑ Allow to automatically expire in sixty (60) calendar days ❑ Expire on this date (month, day and year): ____________

❑ Expire on this event: ________________________________

Right to Revoke

You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice, including e-mail notice, to the DDRS contact below. Any disclosures of your personal information, including health information, which we may have made under this authorization prior to revocation will not be affected (they were made while this authorization was still in effect).

Further Disclosure

Once we disclose your personal information, including health information, to the above persons/organizations, the information may no longer be protected under state or federal privacy laws. We cannot control what these persons/organizations do with your information.

Signature

Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I am authorizing DDRS to disclose my personal information, including health information, to the persons or organizations I have identified above. I understand DDRS will disclose only that information which is necessary to accomplish the stated purpose of the disclosure. The information disclosed will be limited to the minimum necessary. I also understand that I am under no obligation to sign this authorization. I also understand that the services and benefits provided to me by or through DDRS will not be affected whether or not I sign this form.

Signature________________________________ Date________________

If this authorization is signed by an individual's personal representative on behalf of the individual, please complete the following:

Personal Representative's Name________________________________

Contact Information *(include telephone no.)*________________________________

Relationship to the Individual________________________________

It is the policy of DDRS to verify that an individual's authorized representative is identified as such in our files prior to acting on this authorization.

You will be provided with a copy of this authorization after you sign it.

Contact Information

For questions about this authorization or to revoke this authorization prior to the expiration date or event, contact:

The Division of Disability and Rehabilitative Services
402 W. Washington, Room W451, MS26
Indianapolis, IN 46207-7083
Toll Free: 1-800-545-7763 or E-mail: BDDSHelp@fssa.IN.gov

DETERMINATION OF DISABILITY
Authorization for Release of Medical Information
State Form 44554 (R6 / 5-11) / OMPP 3512

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to, or continued receipt of, Medical Assistance administered by the Indiana Family and Social Services Administration. Disclosure of the information requested is **mandatory** pursuant to the provisions of IC 12-15 *et seq*. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on and as authorized by this form will be treated as confidential pursuant to 470 IAC 1-2-7, 470 IAC 1-3-1, 42 CFR 431 Subpart F, 45 CFR 164 Subpart E and 42 CFR Part 2.

NOTICE TO EXAMINING PHYSICIAN

By court order and federal regulation, if the client appeals the decision of the State Medicaid Medical Review Team, this medical information becomes available to the client or his/her legal representative. WARNING: This form does not authorize the release of psychotherapy notes. Furthermore, this form does not authorize the release of mental health records if the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict personal harm or to harm another person.

DETERMINATION OF DISABILITY
Medical Information

Indiana Law [IC 12-14-15-1(2)] requires that, in order to be eligible for Medical Assistance to the Disabled, a person must have a physical or mental impairment, disease, or loss which appears reasonably certain to result in death or that has lasted or appears reasonably certain to last for a continuous period of at least twelve (12) months without significant improvement and which substantially impairs his/her ability to perform labor or services or to engage in a useful occupation. This is not the same definition of disability that is used by the Social Security Administration, or other agencies. The State Medicaid Medical Review Team will make the final disability determination. The records released pursuant to this authorization will be used in making this determination.

PATIENT'S / APPLICANT'S CONSENT FOR RELEASE OF MEDICAL RECORD(S)

Date of birth of patient/applicant (*month, day, year*)	Social Security number of patient/applicant	Case number	Date of consent (*month, day, year*)
	XXX-XX-		

I, ____
First name Middle initial Last name

____
Address (*number and street, city, state, and ZIP code*)

do hereby authorize ____
Name of person releasing information

____
Organization releasing information

____
Address of organization (*number and street, city, state, and ZIP code*)

to release the following medical records:

- Entire medical record for the following dates (*month, day, year*) ____________________
- Portions of the medical record relating to psychiatric, psychological, or mental health counseling for the dates specified above
- Portions of the medical record relating to alcohol, drug, or other substance abuse treatment for the dates specified above
- Portions of the medical record relating to any communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV for the dates specified above

Copies of the records should be furnished to the: **Medical Review Team**
Office of Medicaid Policy and Planning
402 W. Washington St., Rm. W374, MS07
Indianaplis, IN 46204-2739

I understand that this information is protected under Federal and State confidentiality and privacy regulations and cannot be disclosed without any written authorization unless otherwise provided for in the regulations.

I understand that, pursuant to IC 16-39-1-4, this consent for release of medical and mental health information is subject to revocation by me at any time, except to the extent that action has been taken in reliance on the consent. By law this consent might normally expire sixty (60) days from the consent date listed above; however, I expressly waive this time limit and consent to release of medical and mental health information for one (1) year from the consent date. This consent may be revoked in writing by contacting the county office listed above.

Signature of applicant or legal representative	Date signed (*month, day, year*)
If patient is a minor, signature of parent or legal representative	Date signed (*month, day, year*)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES
BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

NOTICE OF RIGHT TO APPEAL

This notifies you of your right to appeal decisions or actions that fall within the direct responsibility of the FSSA/DDARS Bureau of Developmental Disabilities Services. If you have questions, please contact your BDDS Service Coordinator. Your Service Coordinator will work with you to solve your problems. If you are unable to resolve your problems, you may appeal as follows:

1. Appeals must be made within fifteen (15) days of the receipt of the decision or action your are appealing. Requests for appeal hearings must be made in writing. A form is available that provides all information necessary to appeal.
2. An appeal must be signed as follows:
   a) For a child under the age of 18: the parent or other court appointed legal guardian
   b) For an individual over the age of 18: the individual, or court appointed legal guardian, or family member
3. Appeals must be sent to:

Hearings and Appeals
MS 04
402 W. Washington Street
Indianapolis, IN 46204

4. An Administrative Law Judge will be assigned to hear your appeal. You will be informed by letter when your hearing is scheduled.
5. In preparation for your hearing you have the opportunity to discuss the issue with your Service Coordinator, examine all documents that will be used at the appeal, and obtain copies (free of charge) of all documents that will be used at the appeal.
6. At your appeal hearing you will have the opportunity to present additional information and witnesses, be represented by counsel (at your expense) or a person of your choice, and examine all information presented by BDDS.
7. ~~After the hearing, the Administrative Law Judge will make a Recommendation and send a copy to all interested parties.~~
8. If you are not satisfied with the Recommendation, you may send written objections to the address above within fifteen (15) days of the Recommendation.
9. The Director of DDARS or appropriate designee will review the objections, Recommendation, and any additional information, and issue a Final Notice to all interested parties.
10. If you are not satisfied with the Final Order, you may file a petition for judicial review in accordance with IC 4-21.5-5
11. A copy of the appeal process may be obtained from your Service Coordinator.

Your signature acknowledges that you have been informed of your right to appeal.

Individual's Signature or Signature of Legal Representative	Individual's Name (Please Print)	Date

CONFIRMATION OF DIAGNOSIS

State Form 54727 (R / 10-15)
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION (IFSSA)
DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (BDDS)

CONFIDENTIAL

Physician Note: An electronic version of this form may be found on the Division of Disability and Rehabilitative Services' website at www.IN.Gov/fssa/q2328.htm.
This document may be located at "About DDRS" and then under "FORMS".
Please complete the form, print, sign and return to the consumer to take to his/her local BDDS office.

I – CONSUMER INFORMATION					
Last name		First name			Middle initial
Street address *(number and street)*		City		State Indiana	ZIP code
County of residence	Date of birth *(month, day, year)*	Sex	Telephone number ( )	Last 4 digits of Social Security number XXX – XX -	

II – DEVELOPMENTAL DISABILITY (DD) DIAGNOSIS			
Federal and state regulations require a physician's confirmation that the individual's developmental disability / intellectual disability (DD/ID) condition manifested before the age of twenty-two (22).			
Primary diagnosis		Date of primary diagnosis *(month, day, year)*	
Other conditions *(Excluding mental illness)*			
Secondary diagnosis		Date of secondary diagnosis *(month, day, year)*	
Tertiary diagnosis		Date of tertiary diagnosis *(month, day, year)*	
Signature of physician		Date signed *(month, day, year)*	
Printed name of physician			Telephone number ( )
Street address *(number and street)*	City	State Indiana	ZIP code

III – FOR OFFICE USE ONLY		
Signature of BDDS staff	Print name of BDDS staff	Date *(month, day, year)*
Comments:		

CONSENT FOR DISCLOSURE OF INFORMATION

State Form 42224 (R8 / 1-97) / VRS 0014

I hereby give my consent to:
to disclose the following information

to the Division of Disability, Aging, and Rehabilitative Services. The information requested will be used only to assist in the administration of the habilitation/rehabilitation program(s) for the individual named below. All such information will be held to be confidential, and shall not be disclosed, other than in the administration of the individual's habilitation/rehabilitation program(s), except by the written consent of the individual named below and, as applicable, his or her parent, guardian, or other person authorized to sign in lieu of the individual, or as otherwise required by law.

If the information requested concerns drug or alcohol services, federal law forbids any use of this information to investigate or prosecute the individual.

This consent may be revoked at any time, except to the extent that the program which is to make the disclosure has already acted in reliance on it. If not revoked, the consent will expire 12 months (*60 days if the consent is for the release of medical records*) from the date signed, below, or upon a determination that the individual is ineligible or no longer eligible for services.

Signature of DDARS applicant/client:	Date (*month, day, year*)
Printed/typed name and address of DDARS applicant/client:	
(*If applicable*) signature of parent, guardian, or other authorized individual:	Date (*month, day, year*)
Printed or typed name of parent, guardian, or other authorized individual:	
Signature of Division of Disability, Aging and Rehabilitative Services representative:	Date (*month, day, year*)
Please forward the information listed above to:	

DISTRIBUTION: White - Vendor; Canary - Vendor; Pink - Client case file