COLORADO
Department of Health Care Policy & Financing

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: Developmental Pathways	
Address: 325 Inverness Drive South Englewood, CO 80112	
Phone: 303-360-6600	Fax: 303-341-0382
Website: https://www.dpcolo.org/	

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

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

_____ Initial 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.

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

Needed Documents for Determining a Developmental Disability

Any information that documents a disability is needed to make a determination. Examples of the kinds of documents needed that would provide this information are: intellectual functioning assessments, psychological evaluations, medical examinations, mental health assessments and adaptive behavior assessments.

1a. Types of Possible Documentation of an Intellectual Impairment:

- Intelligence/IQ testing, using instruments that are comparable to a Wechsler or Stanford-Binet,

OR

1b. Types of Possible Documentation of Adaptive Behavior Impairments:

- Adaptive Behavior testing, using instruments that are comparable to a Vineland-II

2. Types of Possible Documentation of Neurological Condition:

- Neurological or neuropsychological evaluation
- Psychiatric or psychological evaluations
- Medical examinations/Records
- Professional Medical Information Page

3. Types of Possible Documentation for ruling out physical or sensory impairments or mental illness as sole contributors to a disability:

- School assessments and records
- Records of specialized service provision
- Medical evaluations
- Therapy assessments and provision
- Mental health services and assessments
- Psychiatric or psychological evaluations
- Hospitalizations
- Medication history
- Therapy evaluations

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Developmental Pathways
Dedicated to Individuals with Disabilities

Disclosures and Acknowledgements

Name of individual in services: _____

Date of birth: _____ SSN: _____ and/or Medicaid ID:_____

Name of person initialing/signing document: _____

Relationship to individual in services: _____

Initials	Agreement Description
	Notice of Privacy Practices for Protected Health Information: Developmental Pathways (DP) safeguards your Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulations. This notice explains how DP uses and discloses your PHI and how you can exercise your rights under HIPAA. By Initialing the box to the left, you are acknowledging that you have received DP's Notice of Privacy Practices for Protected Health Information.
	Encryption Opt-Out: To safeguard your PHI and ensure confidentiality, DP encrypts external electronic communication which contains your confidential information. This practice is designed to provide an extra level or security and requires the recipient to use a password to access the message. In order to opt-out of this requirement, DP must receive written notification. This written notification is completed by marking the appropriate option and initialing the box. ☐ I would like DP to continue to send electronic communication ***encrypted.*** ☐ I hereby grant DP permission to send electronic communication ***unencrypted.*** This permission applies to me, my team, and my providers, as appropriate.
	Exercising Your Rights: You have the same human and civil rights as every other U.S. citizen. These rights should be limited or changed only to the extent necessary to be helpful to you, and then only with "due process". Due process includes your Individualized Plan (Service Plan), the Packet Review Committee, the Human Rights Committee, and/or legal process. If you would like assistance in exercising your rights, you can select a friend, a family member, a staff person, a Case Manager, the ARC or any other person to support you. By initialing the box, you are acknowledging that you understand these rights.
	Medicaid Appeal Rights: An individual may have the right to a Medicaid Appeal Rights (also known as the right to a Medicaid Fair Hearing) before a State Administrative Law Judge. By initialing the box, you are acknowledging you have received a written summary of the process for requesting a Medicaid Appeal.
	Complaint Process: In any system, there will be disagreements and complaints. Each person has a right to have such disagreements taken seriously and dealt with in a consistent, fair and timely manner. By initialing the box, you are acknowledging that you have received a written summary of the Complaint Process.
	Dispute Resolution: In the event that you are dissatisfied with a decision or action taken by DP, there are steps to dispute that decision or action. By initialing the box, you are acknowledging that you have received an oral and written summary of the Dispute Resolution Process and of the mediation option.

SIGNATURE: **DATE:**

Developmental Pathways
Dedicated to Individuals with Disabilities

Authorization for Release and Exchange of Information

Individual name: _____

Date of Birth: _____ **SSN**: _____ **and/or Medicaid ID**: _____

The following organizations/providers are hereby authorized to release, exchange, and share oral and written protected health information (PHI) with each other regarding the Individual named above:

Developmental Pathways, Inc. and:

- Physicians involved in my care.
- HCBS Providers involved in my care.
- Home Health Providers involved in my care.
- Therapists involved in my care.
- Hospitals and related facilities involved in my care.
- Regional Accountable Entity (RAE) (as listed here): _____
- School District (as listed here): _____
- Others (as listed here): _____

Information to be released, exchanged, and shared:

- Health information including but not limited to diagnosis, treatment, history, master file records, billing records; treatment notes; service and related plans, and information pertaining to home and community-based services (HCBS) and supports

- Other (as described here): _____

Purpose(s) or need for which the information is to be used and disclosed:

- Coordination/Continuity of Care
- Case Management
- Assessment
- Benefits Coordination/Acquisition
- Disability Determination
- Program Compliance
- Other (as listed here): _____

Developmental Pathways
Dedicated to Individuals with Disabilities

I understand that HIV/AIDS related information and/or records, psychotherapy notes, genetic testing information or notes, sickle cell anemia related information and/or records and drug/alcohol diagnosis, and treatment and referral information will not be released without a separate release specifically authorizing such release signed by you.

I understand that I make revoke this Authorization at any time by giving written notice to Developmental Pathways, except to the extent that Developmental Pathways has already taken action on this request. This Authorization will expire on _____ (MM/DD/YYYY), or, if left blank, one year from the date of my signature (whichever event comes first). I release Developmental Pathways from all liability for disclosing the requested information.

Authorization: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is released, it carries with it the potential for unauthorized re-disclosure, and it may no longer be protected by federal confidentiality rules such as HIPAA.

Authorization for Release and Exchange of Information

A copy or facsimile of this Authorization may be used with the same effectiveness as the original.

Individual or Person Authorized to Sign for Individual: _____

If not the individual, please indicate how authorized to sign:

☐ Guardian ☐ Parent (individual is a minor) ☐ Other: _____

Signature: _____ Date: _____