Area Agency Referral

Date of Referral: Date of Intake:

New Referral Re-referral

Name _______________________DUCK _________ DOB ____________
Gender _______________________________
Medicaid ID _________________ MCO _________________Private Insurance____________
Address____
Parent/Guardian____
Address____
Phone___________________________ Email_______________________________________

Referral Source ____

Basis of Referral ____

Parent Acceptable Contact Methods: All _____ Phone____ Email _____ Text________

Contact Log:

121 Railroad Street Keene, New Hampshire 03431 603-352-1304 Fax: 603-352-1637 www.mds-nh.org

Area Agency Application Request for Eligibility Determination

(For internal use only)
Date of Initial Inquiry: ____________________
Date of Completed Application: ____________________

DUCK

Applicant Information:

Client Name: ______________________________ DOB: ____________________________

Soc. Sec. # _ _ _ - _ _ - _ _ _ Gender: ___________________________

Physical Address: ____

Mailing Address: ____
(if different than physical)

Telephone Number: ____
Email: ____

Current Living Arrangements:____

Has applicant ever applied for or received services from a developmental services agency in New Hampshire? Yes_ No___

If yes, under what name?______________________

If yes, please identify most recent area agency:________When:_____

Guardian Information: (Multiple if more than 1)

Does applicant have a court appointed guardian? Yes____________ No __________________
(If yes, copy of decree required)

Type of Guardianship: Person _____________ Estate ___________ Guardian ad litum ___________

Relationship to applicant: _________________________________

Name: ____

Mailing Address: ____

Home Phone: _______________________________ Work Phone: ___________________________
Cell Phone: _________________________________ Email: ________________________________

Is there a Successor Guardian? Yes _____________ No ________________
(If yes, please include in Notes section)

Parent 1 Name: ______________________________ DOB _______ Education __________

Address ____

Email ______________________________ Cell _______________ Other__________________

FT Parent ☐ Employer: ____________________ Work Hours ______________________

Parent 2 Name: ______________________________ DOB _______ Education __________

Address ____

Email ______________________________ Cell _______________ Other__________________

FT Parent ☐ Employer: ____________________ Work Hours ______________________

Is there joint custody? *(If yes, enter other custodial contact)* Yes ______ No ________-

Name: ____

Mailing Address: ____

Physical Address: ____
(if different than above)

Home Phone: _________________________ Work Phone: _____________________________

Cell Phone: _________________________ Email: _____________________________________

Have parental rights been relinquished or terminated? Yes _____________ No ______________

Home Language:

__ English __ Spanish ___ French ___ ASL ___ Chinese ___ Arabic ___ Armenian ___ Finnish
___German ___ Gujarati (India) __ Greek __ Hebrew __ Italian ___ Japanese ___ Kannada (India)
___Khmer (Cambodia) ___Kmer (India) ___Nepali (Nepal) ___Korean ___Lao (Laos)
___Lativan ___ Polish ___Portuguese ___ Russian ___Swahili ___Turkish ___Vietnamese
___ Other: ____
Does the family need a language interpreter? Yes ______ No __________

Race / Ethnicity (check all that apply):
__ American Indian or Alaskan Native __ Black or African American __ Hispanic / Latino
__ Native Hawaiian or Other Pacific Islander __ Asian __ White __ Multi (check all that apply)

MONADNOCK DEVELOPMENTAL SERVICES

Basis for Application:

If applicant has been diagnosed with any of the following developmental disabilities, please check all that apply:

Intellectual Disability ________

Down Syndrome _________

Acquired Brain Disorder (ABD)* _________

Specific Learning Disability ____________

Pervasive Developmental Disorder (PDD) ________

Cerebral Palsy ___________

Autism ___________

Seizure Disorder __________

Other relevant information (Please Specify) ____
____
(including 171(b), PASARR, speech, hearing, visual impairments)

If applicant has been diagnosed with an Acquired Brain Disorder, please describe injury or neurological disease & date of occurrence (if known):

____
____
____

Primary Care Physician:

Name: ____

Address: ____

Phone: ____________________________________ Fax __________________________________

Other Specialists (Neurologist, Psychiatrist, Therapist, Etc.):

Name: ___________________________________ Specialty: _________________________________

Address: ____

Phone: ____________________________ Fax: ____

Name: ___________________________________ Specialty: _________________________________

Address: ____

Phone: ____________________________ Fax: ____

Name: ___________________________________ Specialty: _________________________________

Address: ____

Phone: ____________________________ Fax: ____

Name: ___________________________________ Specialty: _________________________________

Address: ____

Phone: ____________________________ Fax: ____

Name: ___________________________________ Specialty: _________________________________

Address: ____

Phone: ____________________________ Fax: ____

Name: ___________________________________ Specialty: _________________________________

Address: ____

Phone: ____________________________ Fax: ____

Medical Information:

Date of most recent physical examination: ______________________________________

Current medications: ____
____

Allergies: ____
Adaptive equipment:____

Hospitalizations: (*If additional space is needed, please refer to Notes section)*

Facility:____

Admission Date:_________________Discharge Date:_______________

Facility:____

Admission Date:_________________Discharge Date:_______________

Evaluations and Assessments:

Date of most recent Psychological assessment:____________________________________

Date of most recent Functional Skills/Adaptive Behavior Assessment:_____________

Date of most recent school (re)evaluation:_____________________________________

Other (please specify)_____________Date_________________________________

Educational/Employment/Training/Residential Facilities (Begin with most recent)

Setting Name:_________________________ Start Date: ____________End Date: ___________

Address:____

Setting Name:_________________________ Start Date: ____________End Date: ___________

Address:____

Setting Name:_________________________ Start Date: ____________End Date: ___________

Address:____

Financial Benefits Information (applicant only):

SSA/SSDI Yes____No_____$_________________Per:___________________

SSI Yes____No_____$_________________Per:___________________

Food Stamps Yes____No_____$_________________Per:___________________

APTD Yes____No_____$_________________Per:___________________

RR Yes____No____$_________________Per:___________________

Pension/Annuity Yes____No____$_________________Per:___________________

VA Yes_____No_____$_________________Per:___________________

HUD Yes_____No_____$_________________Per:___________________

Fuel Asst. Yes____No_____$_________________Per:___________________

Personal Income Yes____No_____$_________________Per:___________________
(e.g. alimony, child support, wages)

Voc. Rehab Yes ____No ___ $ ________________Per: ___________________

Does applicant have a Special Needs Trust? Yes_________No__________

Does applicant have a pre-paid burial plan or a Mortuary Trust? Yes______No ________

Insurance Information ***(prospective client/consumer only):***

Private Medical Insurance: Yes_______No________ ID# ______________________

Subscriber Name: ____

Medicare: Yes ___________________ No _____________Claim# _____________________

Medicaid: Yes ___________________ No ______________ID# ______________________

Legal Issues:

Date _______ Nature of Incident __________ Date _________Nature of Incident __________

DCYF Involvement: Yes ________ No _____________

Requested Services:

Provision of services is subject to need and the availability of funding.

__ Family Support
__ Respite
__ High School Transition
__ Service Coordination
__ Benefit Consultation
__ Rep Payee

Funding for the following services is determined by the Department of Health and Human Services, Bureau of Developmental Services. If a person is found eligible for services, service needs are determined during service planning with Area Agency staff and submitted to the Bureau for consideration.

For ages 3-21
__ In Home Supports

For all ages groups
__ Assistive Technology
__ Medical/Behavioral Respite
__ Behavioral Supports (Specialty Services)
__ Environmental Modifications

For age 21 and up
__ Community Support
__ Day Activities
__ Support Employment
__ Integrated Services
__ Residential Personal Care

Would you like information or referral for other services not listed above?
____

Other Agencies Involved:

__ Special Medical Services
__ Home Health Care / Interim Nurses
__ Department of Health & Human Services (DCYF or DEAS)
__ NH Vocational Rehabilitation
__ Mental Health Services
__ Housing
__ GSIL
__ Other (please specify): ____

Would you be willing to receive a telephone call from a member of the Family Council?
__ Yes __ No

______________________________ ____________________
Signature of applicant/guardian Date

______________________________ ____________________
Signature of Person Completing Application Date
(If different from above signature)

MONADNOCK
DEVELOPMENTAL
SERVICES

Additional Notes/information:

121 Railroad Street Keene, New Hampshire 03431 603-352-1304 Fax: 603-352-1637 www.mds-nh.org

High Risk Criteria Checklist

****Please note that this is an important part of planning process for services if individual is found eligible. This* checklist has absolutely NO bearing on eligibility.

Individual:_________________________Respondent:_________________________
Date: _____________________________

	YES	NO
1. Has there ever been an arrest, report or reasonable suspicion of any of the following:		
A. Sexual assault or predation		
B. Pedophillia		
C. Arson or attempted arson		
D. Violent Crime		
2. Is there documentation of past behaviors such as arson, sexualassault, criminal behavior, predatory behaviors (stalking, grooming, voyeurism) or sexual abuse?		
3. Are there indications of the person acting aggressively or inappropriately related to sexual issues or committing assault?		
4. Has the person ever made suicidal threats or attempted suicide?		
5. Has the person ever made homicidal threats or attempted homicide?		
6. Has there been a report of a reasonable suspicion of assaultive action with a weapon?		
7. Has the person ever been arrested?		
8. Has the person ever been or is he/she currently incarcerated in jail?		
9. Has the person had any sort of behavior plan or risk management plan to address any of the above behaviors/issues?		

Please briefly elaborate on any questions, for which the answer was YES:

Revision: 9/13/2013

APPLICATION EXTENSION REQUEST

Monadnock Developmental Services shall review each application for services, including relevant records and information concerning an applicant provided to, or obtained by, the area agency and shall, within 15 business days after the date of a completed application, make a decision on the eligibility of the applicant for services in accordance with HEM 503.03.

Where the application does not contain sufficient information upon which to make a determination of eligibility, this waiver gives Monadnock Developmental Services authorization to extend the 15 business day period to 30 business days in order to gather all appropriate and necessary information.

I allow Monadnock Developmental Services:

_________ 15 business days to determine eligibility

OR

__________ 30 business days to determine eligibility

_________________________________ _____________________

Applicant/Parent/Guardian Signature Date

_________________________________ _____________________

Witness: Intake Coordinator Date

“Notice of Privacy” Acknowledgement Form
Please read sign and return to the address below

Acknowledgement:

I hereby acknowledge that I received the “**Notice of Privacy**” on
_____________________________ 20___________.

____
Signature of Client or Responsible Party

____
Printed Name of Client

____
Print Name of Responsible Party (if applicable)

DO NOT REMOVE FROM INDIVIDUAL’S FILE

121 Railroad Street ○ Keene, New Hampshire 03431 ○ 603-352-1304 ○ Fax: 603-352-1637 ○ www.mds-nh.org

MONADNOCK DEVELOPMENTAL SERVICES

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Client Name____DOB____________________

Client Address____

Client Phone______________________ClientEmail_________________________________

To disclose/receive information with:

Person/Organization Name____

Address____

Phone_________________________Email_____________________________________

Purpose of Disclosure

___Medical Care ___Insurance ___Transfer to new provider ___Workers Comp ___Legal _X_Coordination of Services ___Benefits

___Personal ___Early Supports & Services ___Eligibility _X_Other___Complete______________________________

Health Information which may be released/exchanged includes

___Psychological ___Financial ___Educational ___Vocational ___Evals _X_Complete Records ___Other___________________

Medical Information which may be released/exchanged includes

___Discharge summaries ___Progress notes ___Operative records ___Consult reports ___Genectic test results ___x-rays & image reports

___lab reports & test results _X_Complete health records ___other______________________________________

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Individual, Parent or (co)Guardian - Signature Date

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Information to be released/exchanged is necessary in determining eligibility and/or the coordination of services. I understand that this release allows MDS and recipients to share information as requested throughout the validity of this release. I understand that a fax or photocopy of this release will have the same validity as the original authorization. Unless earlier revoked I understand this release terminates 1 year from date of signature or upon discharge from services. I understand that this authorization may be revoked at any time and I will do so in writing to MDS.

____ ____________________
Individual, Parent or (co)Guardian - Signature Date

____ ____________________
Individual, Parent or (co)Guardian - Print Name Relationship to Client

(Revised June 2018)

MONADNOCK DEVELOPMENTAL SERVICES

HIPAA Compliant Authorization for Release of Personal Information Pursuant to 45 CFR 164-508

I hereby authorize Monadnock Developmental Services (MDS) to use/disclose/receive/exchange my individually identifiable health information as described below with identified person(s) or organizations. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance co or health care provider, the disclosed information may no longer be protected by federal and state privacy regulations. I understand the disclosure of information may include paper copies, electronic transmissions and/or verbal unless otherwise restricted. I understand that eligibility of benefits, treatment, payment, and enrollment may be conditional upon obtaining individual authorization pursuant to eligibility criteria as defined in the state regulations He-M 503, He-M 510, He-M 519 and He-M 522.

Client Name____DOB____________________

Client Address____

Client Phone______________________ClientEmail__________________________________

To disclose/receive information with:

Person/Organization Name____

Address____

Phone_________________________Email_____________________________________

Purpose of Disclosure

___Medical Care ___Insurance ___Transfer to new provider ___Workers Comp ___Legal _X_Coordination of Services ___Benefits

___Personal ___Early Supports & Services ___Eligibility _X_Other___Complete______________________________

Health Information which may be released/exchanged includes

___Psychological ___Financial ___Educational ___Vocational ___Evals _X_Complete Records ___Other___________________

Medical Information which may be released/exchanged includes

___Discharge summaries ___Progress notes ___Operative records ___Consult reports ___Genectic test results ___x-rays & image reports

___lab reports & test results _X_Complete health records ___other______________________________________

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(Revised June 2018)

121 Railroad Street, Keene, NH 03431 603-352-1304 Fax: 603-352-1637 www.mds-nh.org