Intellectual & Developmental Disabilities Intake and Eligibility Program

Multnomah County provides services to individuals of all ages diagnosed with Intellectual & other Developmental Disabilities.

Please see enclosures titled The Path to Intellectual & Developmental Disability Services and Intellectual & Developmental Disability Services for program access and service information.

ELIGIBILITY DETERMINATION PROCESS
To apply for Multnomah County Intellectual and Developmental Disabilities services please submit the following via mail, email or fax to:

Multnomah County I/DD Intake & Eligibility Program
209 SW 4th Ave Portland, OR 97204
Email: idd@multco.us Fax: 503-988-3059

1. Request for Eligibility Determination
    - Please complete as thoroughly as possible
    - Sign and date (by parent or guardian if applicant is under 18)
2. Proof of Guardianship *(if applicable)*
3. Documents that support that an Intellectual or Other Developmental Disability
    - School Records
    - Psychological Records
    - Medical Records

OR

4. Complete Authorizations for Disclosure, Sharing and Use of Individual Information (aka ROI). Please see enclosed instructions for assistance with completing the Authorization for Disclosure, Sharing and Use of Individual Information forms. **Only one entity per form.**
    - One for school
    - One for primary care provider
    - One for anywhere a psychological or neuropsychological evaluation has been conducted
    - One for any residential or psychiatric facility

An Eligibility Specialist will be assigned upon receipt of the completed and signed forms. Per the Oregon Administrative Rules, Multnomah County I/DD has 90 days from the signed application date to complete the eligibility determination. If found eligible, a Case Manager will be assigned to develop a service plan.

Questions? Please call 503-988-6258 or email idd@multco.us

The Path to Intellectual & Developmental Disability Services

"In this moment when you are just... trying to survive it may not seem like the time and paperwork investment up front is worth it. But I would encourage you to press on because on the other side it is…life-giving."

- Jillana, parent of child receiving IDD services

1 Contact us

Phone: 503.988.6258
Web: multco.us/dd
Email: idd@multco.us

2 Intake meeting

☑ **What to bring to your fist meeting (if available):**

- Proof of citizenship
- Medical records
- School records
- Psychological records
- Social Security Number/card

3 Records requested and reviewed

☑ To do: Ask your doctors and providers to turn in paperwork

4 Psychological evaluation*

*Only if more information is needed.

5 Eligibility decision

⏳ Takes up to 90 days total, with possible extension. Note: future eligibility reviews may happen.

6 Discuss options for next step

Choice counseling occurs to choose a case management organization. **Please let us know if you have a cultural or language preference**

7 Schedule an in-person meeting

Contact info provided via phone and mail

8 Talk about needs with service coordinator

9 Assessment completed & coordinator builds, designs, funds services

⏳ Up to 90 days after Step 5.

10 Identifying and onboarding service providers

⏳ Can take up to 2 months between steps 9 AND 10.

11 Get services!

Ongoing services and planning

Ongoing Medicaid is Required for Services:
Having Medicaid before step 6 speeds up the process by 2-3 months. If you don't have Medicaid ask about how you can enroll.

We're here to help every step along the way. Here's who to contact at Multnomah County with questions:

Name _____ Phone number _____

Multnomah County

Last updated: 8/2019

Intellectual & Developmental Disability Services

Available to all individuals found eligible for Multnomah County IDD:

Advocacy

Assistance with Health & Safety

Case Management/ Service Coordination

Resources and referral

Supported decision making

Availability of additional services depends on Medicaid eligibility and individual needs.

Medicaid

- You need Medicaid to access the majority of IDD services
- No Medicaid? If found eligible for IDD, your case manager can help you apply

Children and Young Adults

SERVICES

Attendant Care
Support and skill development with day to day living provided by a personal support worker (PSW) or agency.

Assistive devices/ technology

Behavior consultation

Relief care - overnight support

Specialized medical equipment and supplies

In-home support for intensive medical or behavioral needs

Family Training

Environmental Modifications

Vehicle Modifications

FOSTER AND GROUP HOMES

Foster care - 24/7 support in a family home

Group home - 24/7 higher level of care run by an organization

Ongoing Medicaid is Required for Services:
If you don't have Medicaid ask about how you can enroll.

Multnomah County

Last updated: 10/2019

Children and Young Adults (continued)

NOT AVAILABLE

Child care
(aka baby sitting)

Supports that school provides

Payment to parents to take care of their children

Reimbursements:
for supplies, trainings and materials made directly to individuals/families. Payments must be made to a vendor of services, which includes approved PSW's.

Adults

CHOICE OF CASE MANAGEMENT ENTITY

- Multnomah County I/DD Service Coordinator - All living situations and ages
- Brokerage Personal Agent - 18 or older, not living in a 24/7 facility

SERVICES

Attendant Care
Support and skill development with day to day living provided by a personal support worker (PSW) or agency.

Assistive devices/ technology

Behavior supports

Home-delivered meals

Specialized medical equipment and supplies

Nursing Care

Day support

Family Training

Home Modifications and supplies

Vehicle Modifications

Transportation Services

Employment

FOSTER AND GROUP HOMES

- Foster homes are run by an individual licensed and monitored by Multnomah County
- Group homes are run by employees of an organization licensed by ODDS
- Live with 3-5 other I/DD Clients
- Caregivers are present 24/7

Office of Developmental Disability Services
Request for Eligibility Determination

Oregon Department of Human Services
INTELLECTUAL/DEVELOPMENTAL DISABILITIES

For CDDP office use only		
Date received	CDDP receiving form Multnomah County	☐ Initial application ☐ Reapplication
Title XIX Medicaid (OSIPM or MAGI) ☐ Yes ☐ No	OHP number or OHP referral date	Prime number

Applicant information (*please print*)			
Last name	First name	Middle initial	Gender

Social Security number	Birthdate	Birthplace	Marital status

Current address	City	State	ZIP
Mailing address (*if different*)	City	State	ZIP
Primary phone number	Email address (*optional*)		

Primary contact, custodial parent or guardian (*if applicable*)			
Name	Relationship (*for example., custodial parent, guardian*)		
Address	City	State	ZIP
Primary phone number	Email address (*optional*)		

Does the applicant have a **court-appointed** guardian?	☐ Yes ☐ No
Appointed guardian's name, address and phone number (*note if same as above*)	
Does the applicant have a health care representative? ORS 127.505	☐ Yes ☐ No
Health care representative's name, address and phone number (*note if same as above*)	

Referral to Community Developmental Disabilities Program (CDDP)	
Name and title of individual who referred applicant	Phone number
Has the applicant ever received, or applied for, services from a disability-related program in Oregon or any State outside of Oregon?	☐ Yes ☐ No
Please list Oregon County or other State(s)	

Applicant's preferred communication format (OAR 943-070-0040)	
In what language do you want us to speak with you?	
In what language do you want us to write to you?	
Do you need an interpreter (*including sign language*)?	☐ Yes ☐ No
Other communication needs:	

Applicant's ethnicity (OAR 943-070-0030)

Ethnicity (*Select as many boxes as apply*)

- ☐ Hispanic/Latino
  - ☐ Cuban
  - ☐ Mexican
  - ☐ Puerto Rican
  - ☐ South or Central American
  - ☐ Other
- ☐ Non-Hispanic
- ☐ Unknown
- ☐ Other:
- ☐ Decline to answer

Applicant's race (OAR 943-070-0030)

Race (*Select as many boxes as apply*)

- ☐ American Indian or Alaska Native
  - ☐ Alaska Native
  - ☐ American Indian
  - ☐ Canadian Inuit, Metis or First Nation
  - ☐ Indigenous Mexican, Central American, or South American
  - ☐ Other American Indian
- ☐ Asian
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino/a
  - ☐ Hmong
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ South Asian
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ White
  - ☐ Eastern European
  - ☐ Middle Eastern
  - ☐ Northern African
  - ☐ Slavic
  - ☐ Western European
  - ☐ Other White
- ☐ African American or Black
  - ☐ African
  - ☐ African American
  - ☐ Caribbean
  - ☐ Other Black
- ☐ Native Hawaiian or Pacific Islander
  - ☐ Guamanian or Chamorro
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ Other:
- ☐ Unknown
- ☐ Decline to answer

Developmental disabilities

Describe your disability and the age at which it was first observed

Intellectual disability

Observed or diagnosed conditions	If diagnosed, list provider and date
☐ Intellectual Disability	
☐ Global Developmental Delay	
☐ Delayed milestones	

Other developmental disability

Observed or diagnosed conditions	If diagnosed, list provider and date
☐ Autism Spectrum Disorder	
☐ Cerebral Palsy	
☐ Down Syndrome	
☐ Epilepsy	
☐ Prenatal exposure to drugs, alcohol, or other toxin(s)	
☐ Tourette's Disorder	
☐ Acquired/Traumatic Brain Injury	
☐	

Other conditions

Observed or diagnosed conditions	If diagnosed, list provider and date
☐ Attention-Deficit/Hyperactivity Disorder	
☐ Depressive Disorder	
☐ Language Disorder	
☐ Bipolar or Personality Disorder	
☐ Post-traumatic Stress Disorder	
☐ Specific Learning Disorder	
☐ Substance-Related Disorder	
☐	
☐	
☐	

Medical providers		
Primary care physician or clinic	Location	Phone number
Dentist or clinic	Location	Phone number
Preferred hospital	Location	Phone number

Disability evaluations

Please list professionals who have evaluated your disabilities. Include psychologists, neuropsychologists, psychiatrists, neurologists, developmental pediatricians, geneticists and mental health providers. For example, list professionals you have seen for an IQ test, psychological evaluation, medical or genetic evaluation of your disability, or mental health assessment.

Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number
Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number
Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number
Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number

Have you ever been admitted to a treatment center or hospital for psychiatric or medical treatment?	☐ Yes ☐ No

Date	Name and location of facility or hospital name

Other service agencies (***examples include: Child Welfare, Self-Sufficiency, Vocational Rehabilitation, Mental Health***)		
Start/end date	Agency or provider location	Contact's name
Start/end date	Agency or provider location	Contact's name
Start/end date	Agency or provider location	Contact's name

Medical insurance

Applicant's health insurance

☐ Private Health Insurance Carrier	☐ Oregon Health Plan OHP/Medicaid #	☐ Medicare Plan #

☐ I do not currently have health insurance.

Eligibility for certain developmental disability services is dependent on your eligibility for Medicaid. If you have not yet applied, talk with the CDDP about how to apply.

Have you applied for medical assistance? ☐ Yes ☐ No

Sources of applicant's personal income

Applicant's personal income (check all that apply; do not include other household income)

☐ Employment	☐ Temporary Assistance for Needy Families (TANF)
☐ Trust fund(s)	☐ Private disability benefits
☐ Child support for applicant	☐ Adoption or guardianship assistance
☐ Veteran's benefits	☐ No income
☐ Other:	☐ Other:

Social Security

Individuals with disabilities may qualify for one of two federal disability programs: Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). The Social Security Administration (SSA) manages these programs.

Have you applied for Social Security benefits?	☐ Yes ☐ No	Date of application
Do you currently receive Social Security benefits?	☐ Yes ☐ No	Start date
☐ Supplemental Security Income (SSI)	Amount	
☐ Social Security Disability Insurance (SSDI)	Amount	

Have you ever lost SSI due to earnings, receiving a Social Security benefit from a parent or a Cost of Living Allowance increase? ☐ Yes ☐ No

If you have not applied for SSI/SSDI benefits, you can learn more about social security benefits on the Social Security Website. Contact your local SSA office to apply.

These resources may be helpful:

- Understanding SSI: http://www.socialsecurity.gov/ssi/text-income-ussi.htm
- SSI Payment Amounts: http://www.ssa.gov/oact/cola/SSI.html

Educational history

Name of current school or last school attended	Start date	End date
City and state		
Name of former school	Start date	End date
City and state		

Have you ever received special education services at any school (*for example, early intervention, IEP, or 504 plan*)?	☐ Yes
Did you graduate from high school?	☐ Yes ☐ No
If yes, what type of diploma did you receive (*or do you expect to receive*)?	☐ Regular ☐ GED ☐ Unknown ☐ Modified ☐ Certificate

Legal history

Do you have a criminal record or juvenile court record?	☐ Yes ☐ No

State and county of offense	Nature of offense
Parole/Probation officer	Phone number

Other information

Why we need your social security number

Federal laws, 42 USC 1320b-7(a)&(b), 42 CFR 435.910, 42 CFR 435.920, and 42 CFR 457.340(b), as well as OAR 461-120-0210, require applicants to provide ODHS/OHA a SSN on applications for medical benefits, except as provided in OAR 461-120-0210.

ODHS and OHA will use your SSN to help decide if you are eligible for benefits. ODHS and OHA may use your SSN to match the information on your application with records provided to, or created by, other state and federal programs and agencies, such as the IRS, Medicaid, Social Security and Employment Department.

ODHS and OHA may also use your SSN, at the request of funding agencies, to prepare aggregate data or reports about the programs you apply for and receive benefits from. Specifically, ODHS and OHA may use or disclose your SSN to: operate the program you apply for or receive benefits from; conduct quality assessment and improvement activities; verify the correct amount of payments and conduct business with providers; and recover overpaid benefits.

Notification of eligibility decision

If you would like a copy of the CDDP's eligibility decision notice sent to anyone besides yourself, you must provide the name and address of the person. The CDDP must have a written authorization in order to release information and to send a notice to anyone other than the applicant or legal guardian.

Name	Relationship to applicant (*for example, guardian, representative*)		
Address	City	State	ZIP

Signature

By signing below, I agree that the information contained in this application is true and correct, whether given by me or a representative. I also confirm that I have received and reviewed the notice of rights on the following page.

Signature	Date

Print name

Relationship

☐ Self (*adult applicant*)	☐ Adult's court-appointed guardian
☐ Minor's custodial parent or legal guardian	☐

Notice of rights

- You are requesting services from the Oregon developmental disability system. Participation is voluntary; you may withdraw this request at any time.
- The Oregon Department of Human Services (ODHS) does not discriminate. ODHS serves every applicant that qualifies for services, and ODHS will not treat any applicant differently because of age, race, gender, color, national origin, religion, political beliefs, disability or sexual orientation. If you believe ODHS treated you unfairly, you may file a complaint with the Governor's Advocacy Office (1-800-442-5238).
- The CDDP and ODHS will protect your information and records in accordance with the privacy and security polices of ODHS, ORS 179.505 and ORS 179.507. The CDDP needs your authorization to request and release records related to your disability.
- Intake is complete when you sign and submit this form to the CDDP ***and*** sign

authorizations for the CDDP to obtain the records that you do not provide. The CDDP will collaborate with you to assemble a complete application for services within 90 days. The CDDP may contact you to request an extension of the decision timeline beyond 90 days, if the CDDP needs more documents to make an eligibility decision. If the CDDP needs more information to determine the existence of a developmental disability, the CDDP may ask you to attend a diagnostic evaluation, in accordance with ORS 410.060 and 427.105.

- The CDDP must receive a completed application before making an eligibility decision. A completed application includes this form, as well as documents and records necessary to make an eligibility decision. When the CDDP receives all the documents related to your disability (as described in OAR 411-320-0080(1)), the CDDP will send you a written decision notice. Intake and complete application are defined in OAR 411-320-0020.
- The CDDP's written decision notice will contain a notice of hearing rights. If you disagree with the CDDP's decision, you may request a contested case hearing, as described in ORS Chapter 183 and OAR 411-318-0025.
- You may request a contested case hearing by filling out an Administrative Hearing Request Form (SDS 0443DD), or by making a verbal request for a hearing to a CDDP or ODHS employee. ODHS must receive a hearing request within 90 days of the notice of eligibility decision.
- You may appoint another person to represent you or request a hearing on your behalf, including legal counsel or a relative, friend, or other spokesman. You may identify your representative when you request a hearing.

RELEASE OF INFORMATION INSTRUCTIONS

STEP ONE: NAME, DOB, CONTACT INFORMATION

Template: Save As | Reset | Print

Show instruction pages / Hide instruction pages

Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

☒ Check here to add a legal representative

Legal last name:	**First name:**	MI:	Date of birth:
Other names:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification type: Pick one			
Legal last name of representative (*if any*):	**First name:**	MI:	
Relationship to the person listed above:			
Address:	City:	State:	ZIP:
Phone:	Email address:		

Complete fields.

STEP TWO : RELEASE FROM

When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.

Release FROM:	
Purpose of the disclosure, sharing and use: To determine eligibility for services and to provide case management services on my behalf.	
Entity name:	
Date of records: Pick one	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Fax number:	Mutual exchange: ○ Yes ○ No
Expiration date or event*:	
Do you request special health information to be released? ● Yes ○ No **Specially protected information:** (*There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that* ***no information will be disclosed unless*** *I or my representative* ***initial next to the information types below.***) **HIV or AIDS:** **Mental health:** **Genetic testing:** **Alcohol or drug diagnoses, treatment, referral:**	
Is there any specific information **not** to release? ○ Yes ○ No	

Choose yes or no. If yes, initial relevant lines.

STEP THREE: SIGN AND DATE

• **I am signing this authorization of my own free will.**	
Signature:	
Printed name:	Date:
Signature of legal representative (*if any*):	
Printed name:	Date:
If the person legally authorized to act for the person on this form signs, they must give evidence of their authority to do so.	

Sign and Date

Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

Legal last name:	**First name:**	MI:	Date of birth:
Other names:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification type:			
Legal last name of representative (*if any*):	**First name:**		MI:
Relationship to the person listed above:			
Address:	City:	State:	ZIP:
Phone:	Email address:		

When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.

Release FROM:

Purpose of the disclosure, sharing and use:
To determine eligibility for services and to provide case management services on my behalf.

Entity name:	
Date of records:	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*:	

Do you request special health information to be released? ◉ Yes ○ No

Specially protected information: (*There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that* ***no information*** *will be disclosed* ***unless*** *I or my representative* ***initial next to the information types below.***)

HIV or AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol or drug diagnoses, treatment, referral: _____

Is there any specific information **not** to release? ○ Yes ◉ No

Release TO:

Purpose of the disclosure, sharing and use:
To determine eligibility for services and to provide case management services on my behalf.

Entity name: Multnomah County Intellectual & Developmental Disabilities

Specific information to be disclosed:

Date of records:

Contact person:	Address: 209 SW 4th Ave Ste 610
City, state and ZIP: Portland, OR 97204	
Phone number: 503-988-3658	Email address:
Fax number: 503-988-3059	Mutual exchange: ◉ Yes ○ No
Expiration date or event*:	
Is there any specific information **not** to release? ○ Yes ● No	

Your acknowledgment

- I was given the chance to ask questions about this form and what it does.
- I understand what this form means and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from any listed:
  » Agency » Business » Organization » Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.*
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  » Drug and alcohol diagnosis » HIV and AIDS information » Mental health
  » Referral information » Treatment records » Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information may no longer be protected under federal or state law.
- I understand someone may need to contact me about this form to confirm my identity. They may also need to get more information.
- I understand that deciding not to sign this form may:
  » Prevent agencies from deciding if I am eligible for certain programs.
  » Prevent me from getting referrals. It may also make coordination of provider services more difficult.
  » Affect my ability to get health services if it is necessary to share information.
  » Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.
- **I am signing this authorization of my own free will.**

Signature:	
Printed name:	Date:
Signature of legal representative (*if any*):	
Printed name:	Date:
If the person legally authorized to act for the person on this form signs, they must give evidence of their authority to do so.	

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could go to someone you don't want to have the information. If you are not sure how to send a secure email, consider using regular mail or fax.

For questions or help to complete this form, please contact the agency you work with.