

**Early Childhood Autism Waiver
State of Developmental Services –Autism Division
Check List for Application- 3 to 4.6 year olds**

Name: _____ Town of Residence: _____ Date of Birth: _____

Step 1 – Complete the Eligibility Application form.

Step 2 – Include the following in your application packet:

- Autism Diagnostic Observation Schedule 2nd Edition (ADOS-2) Evaluation
- Copy of Birth Certificate
- Copy of Social Security Card
- Copy of Medicaid (HUSKY A) medical card -no services will be provided without HUSKY A card
- Vineland Adaptive Behaviors Scales – II (if completed)
- Individual Family Service Plan (IFSP)
- Individual Education Program (IEP)
- HIPPA Acknowledgement Form

In addition to the above information submit the following assessments, if available:

- Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
- Assessment of Basic Language and Learning Skills (ABLLS)

Return to:
Department of Developmental Services
Division of Autism Spectrum Services
Attention – Early Childhood Autism Waiver
460 Capitol Avenue
Hartford, CT 06105

If you have any questions please feel free to contact Christine Damato at 860-418-6106 (christine.damato@ct.gov) or Cathleen Calway at 860-418-6108 (cathleen.calway@ct.gov)

EARLY CHILDHOOD AUTISM WAIVER

Eligibility Application

Child's Name _____

Date of Birth:: _____ Female Male (Please circle)

Parent(s)/Caregiver(s): _____

Parents/Caregivers Address: Street:: _____

Apt#: _____ City: _____ Zip Code: _____

Home Phone _____ Cell Phone: _____

E-mail Address: _____

Social Security #: _____ Medicaid #: _____

Primary Language: _____

Birth to Three Provider: _____

Contact: _____ Telephone: _____

Date of Autism Diagnosis: _____

Diagnosed by: _____

Standardized diagnostic instruments used: _____

Report/Evaluations is attached- *Required*

- Autism Diagnostic Observation Schedule 2nd Edition (ADOS-2)
- Vineland Adaptive Behaviors Scales-II

Report/Evaluation is attached- *Optional*

- Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
- Assessment of Basic Language and Learning Skills (ABLLS)
- Individual Family Service Plan (IFSP)/Individual Education Program (IEP)

Other Reports/evaluations

Please list other related medical or psychiatric conditions: _____

Parental Agreement for Early Childhood Autism Waiver

- I agree to work with my child's program providers in developing and implementing interventions that will best meet _____ needs and match our family's lifestyle.
- I agree to participate a minimum of five hours per week in _____'s program and assist others working with my child as needed.
- I agree to participate in team meetings to develop and monitor an individualized plan for my child.
- I understand that the staff working with my child will be collecting written data on _____'s behavior and progress and I will also participate in the data collection process.
- I will participate in the transition planning process. Activities to support transition may include attending a Planning and Placement Team Meeting (PPT).

I understand that if I do not comply with the waiver participation requirements my child's services may be terminated. My signature below verifies that I have been informed of my parental obligations and responsibilities for my child's participation in the Early Childhood Autism Waiver and I agree to participate as required.

Parent/Caregiver Signature: _____ Date: _____

Please Note- Eligibility for services does not assure that requests for services can be met immediately. Services of the Department of Developmental Services are provided on a priority basis and within available appropriations.



**STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES**



460 Capitol Avenue, Hartford, Connecticut 06106 ♦ Phone: 860/418-6000 ♦ Fax: 860/622-6001 ♦ Email: ddset.co@ct.gov

November 2007

*Individual and Family Fact Sheet –
HIPAA: Health Insurance Portability Accountability Act of 1996*

Did you know that DDS now follows the federally mandated HIPAA regulations?

What Is HIPAA?

The federal government has established privacy laws/standards for healthcare information for all citizens. These standards are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and provide the first comprehensive federal protection of the privacy of “health information.”*

Is Protecting My Health Information New?

DDS has always maintained good privacy and confidentiality practices based on State of Connecticut laws. The new federal privacy laws establish a set of standards for all states.

How Does HIPAA Affect DDS Individuals?

These laws/standards and existing state laws ensure that DDS will:

1. Make sure that any individually identifiable health information** is kept private, and
2. Give you a written notice of our legal duties and privacy policy practices with respect to your protected health information.

What Is The Notice Of Health Care Privacy Practices For Protected Health Information ?

The fact sheet of health care privacy practices for protected health information*** is available to all individuals served by the department. The notice describes the way DDS may use and disclose protected health information and explains how you can exercise your rights. The notice will help you understand how we share information about you and how you can ensure its accuracy. A more detailed explanation entitled “Notice of Privacy Practices for Protected Health Information” can be found at www.ct.gov/dds or a copy can be sent to you upon request by contacting 860-418-6000.

How Does DDS Share My Protected Health Information?

DDS and agencies currently providing services to you share your information for your support. A portion of this information is shared for payment activities or quality assessment and improvement. Unless you provide us with authorization, your protected health information will not be shared outside of DDS and agencies currently providing services to you except for the permitted or required disclosures described in the notice.

When Can My Protected Health Information Be Disclosed?

Disclosures that are not permitted or required by law will require an authorization from you.

How Will I Know When My Protected Health Information Is Being Disclosed?

You may ask for an accounting of disclosures of your protected health information. In the event that a disclosure is not permitted or required, your protected health information cannot be disclosed until you or your guardian have been made aware of the request and have signed an authorization specifically releasing that information. Your case manager will notify you or your guardian of any requests for protected health information from an outside entity (any agency outside of DDS and collaborating agencies currently providing services to you).

How Will I Receive The Necessary Authorization Form To Release Protected Health Information To An Outside Entity?

Your case manager will notify you or your guardian of requests DDS receives for your protected health information initiated by a third-party and will provide a form for you via personal visit or mail. If you or your responsible party agree to release this information, complete the form and return it to your case manager. If you are requesting the release of protected health information, you may contact your case manager to obtain an authorization form.

If I Have Any Further Questions About The HIPAA Regulations And How They Impact Me, Who Can I Call?

You may contact the Director of Quality Improvement in your DDS region. In addition, your DDS case manager may be able to assist you.

HIPAA Definitions

**** Health Information***

Any information, whether oral or recorded in any form or medium, that is created or received by a health care agency, health plan, employer, life insurer, school or university. Health information may relate to past, present and future physical or mental health or condition, or future payment for the provision of health care to an individual.

***** Individually Identifiable Health Information***

Information that is a subset of health information, including demographic information collected from an individual and identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

****** Protected Health Information***

Individually identifiable health information: transmitted by electronic media, maintained in any electronic media or any other form or medium. Protected health information excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act (FERPA) or employment records.

While the Department of Developmental Services has always maintained good standards in the area of confidentiality practices, the federal government has established these privacy standards for all health insurers and health care providers to follow to protect personal health information. The federal guidelines address a growing public concern regarding the use of computers and technology by health care organizations. These new federal guidelines will be applied to all human services organizations, i.e. DDS, DCF, DMHAS, DSS and affiliated private agencies to ensure the integrity of confidential personal health information.



**Acknowledgement Form For HIPAA
Individual and Family Fact Sheet
HIPAA: Health Insurance Portability Accountability Act of 1996**

I have been provided an *Individual and Family Fact Sheet HIPAA: Health Insurance Portability Accountability Act of 1996* that describes how information is used by the Department to provide services. This notice also includes a description of my rights regarding protected health information.

I understand DDS reserves the right to change their practices and notice. Prior to implementation of these changes a new notice will be available to me.

I understand I may be requested to sign specific *authorization* for uses and disclosures of my health information, which are not addressed in the notice.

Formulario de Reconocimiento

HIPAA individual y la Hoja de familia: Ley de Seguro de Salud de Portabilidad Accountability de 1996

Se me ha brindado una *HIPAA individual y la Hoja de familia: Ley de Seguro de Salud de Portabilidad Accountability de 1996*, que describe cómo usa la información el Departamento para brindar servicios. Esta notificación incluye también una descripción de mis derechos con relación a la información protegida sobre la salud.

Entiendo que el DDS se reserva el derecho a cambiar sus prácticas y notificación, y que antes de la implementación de estos cambios tendré a mi disposición una nueva notificación.

Entiendo que se me podrá pedir que firme una *autorización* específica para los usos y divulgaciones de la información sobre mi salud, que no se tratan en la notificación.

Signature of Individual or Legal Representative
Firma de la persona o representante legal

Date
Fecha

Effective Date of Notice: April 14, 2003 [Día de vigencia de la notificación: 14 de abril de 2003]

* Please explain relationship to individual/* Por favor explique su relación con la persona