CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PO BOX 726
TRENTON, NJ 08625-0726
Visit us on the web at :
www.state.nj.us/humanservices/ddd

Jennifer Velez
Commissioner

Dawn Apgar
Deputy Commissioner

Elizabeth M. Shea
Assistant Commissioner

TEL. (609) 631-2200

Please mail the completed Intake Application Package to the Community Services Office serving the county in which the applicant resides. Address the envelope to the "Division of Developmental Disabilities, Intake Unit".

Flanders Office
Counties Served: Morris - Sussex - Warren
1-B Laurel Drive
Flanders, NJ 07836
Phone: (973) 927-2600

Paterson Office
Counties Served: Bergen - Hudson - Passaic
100 Hamilton Plaza, 7th Floor
Paterson, NJ 07505
Phone: (973) 977-4004

Newark Office
County Served: Essex
153 Halsey St., 2nd FL
P.O. Box 47013
Newark, NJ 07101
Phone: (973) 693-5080

Plainfield Office
Counties Served: Union - Somerset
110 East 5th Street
Plainfield, New Jersey 07060
Phone: (908) 226-7800

Freehold Office
Counties Served: Ocean - Monmouth
Juniper Plaza, Suite 1 - 11
3499 Route 9 North
Freehold, NJ 07728
Phone: (732) 863-4500

Trenton Office
Counties Served: Hunterdon - Mercer - Middlesex
120 South Stockton Street, Trenton, NJ 08611
Phone: (609) 292-1922
Mailing Address: P.O. Box 706, Trenton, NJ 08625-0706

Mays Landing Office
Counties Served: Atlantic - Cape May - Cumberland - Salem
5218 Atlantic Avenue
Suite 205
Mays Landing, NJ 08330
Phone: (609) 476-5200

Voorhees Office
Counties Served: Burlington - Camden - Gloucester
2 Echelon Plaza
221 Laurel Rd, Suite 210
Voorhees, NJ 08043
Phone: (856) 770-5900

In order to prevent any delay in processing your application, please insure that the Intake package is **not** addressed to PO BOX 726 Trenton, NJ.

Effective: 01/29/2014

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Eligibility Documentation Checklist
Please complete the following forms as directed

Please Note: Individuals must be 18 years old to go through a functional evaluation for services. Individuals who meet functional criteria must also be 21 years old and Medicaid eligible before they can begin receiving services from the Division of Developmental Disabilities (DDD).

A. **DDD Eligibility Forms**:

- **Application for Eligibility.** The person completing the application must sign this form.
- **ICD Code Form.** This form must be completed by a Medical Professional.
- **Health Information and Portability and Accountability Act (HIPAA) information**
  - i. **Notice of Privacy Practices and Acknowledgement Form.** Please read the Department of Human Services *Notice of Privacy Practices* and sign and return the *Acknowledgement Form*.
  - ii. **Authorization for Disclosure of Health Information to Family and Involved Persons.** Gives DDD permission to talk with people the Applicant chooses about his or her health information. Complete, sign and return.
  - iii. **Authorization for the Release of Health Information.** Gives DDD permission to send copies of Applicant's health records to people or organizations chosen by the Applicant. Complete, sign and return.

Consent Form. For use with the documents in Section B

You must include as many of the available documents below that relate to your developmental disability.
The more documentation you are able to provide, the easier it will be to process your application.*

B. Documentation of Developmental Disability

_____ Medical Documentation of Disability
_____ Physician's Statement
_____ Most Recent Psychological Evaluation, (+ IQ Scores)
_____ All Available Psychological Reports
_____ Most Recent Child Study Team or School Reports
_____ Learning Evaluations/Social Summaries
_____ Psychiatric Evaluation
_____ Neurological Evaluation
_____ Hospital Records/Discharge Summary
_____ Physical Therapy Evaluation/Occupational Therapy Evaluation/Speech Therapy Evaluation

C. Legal Documentation of Age, US Citizenship, NJ Residency

_____ Photocopy of Birth Certificate
_____ Photocopy of Social Security Card *or* Proof of US Citizenship *or* Green Card
_____ Photocopy of one of the following: 1) Voter Registration form 2) Pay Stub 3) W2 form 4) Real Estate Tax Bill or 5) Permanent Change of Station Orders to New Jersey (If individual's legal guardian is in the U.S. Military Service)

D. Other Necessary Documents:

_____ Photocopy of Guardianship Order (if applicable)
_____ Photocopy of Medicaid Card
_____ Division of Vocational Rehabilitation Service (DVRS) Records/Evaluations (F3 form)
_____ SSI annual award letter
_____ Letter certifying Medicaid eligibility

E. NJ CAT Assessment: Will be administered by the Developmental Disabilities Planning Institute (DDPI) at a later date.

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Application for Eligibility

Please Note: Individuals must be 18 years old to go through a functional evaluation for services. Individuals who meet functional criteria must also be 21 years old and Medicaid eligible before they can begin receiving services from the Division of Developmental Disabilities (DDD).

In accordance with the Revised Statute, State of New Jersey, Section 30:4-25.2, application is being made to the Commissioner of the Department of Human Services for a determination of eligibility for services provided through DDD for:

Name: _____
First Middle Last

Date of Birth _____/_____/_____

By signing this application, I am declaring that:

1. This Application and all forms submitted along with it are completed as accurately as possible, and
2. I understand that I have the opportunity to appeal a determination of ineligibility in accordance with N.J.A.C. 10:48-1.1(j).

This application is being made under *R.S.* 30:4-25.2 by virtue of the relationship to the Applicant indicated above:

____ Self

____ Legal Guardian of the person _____ Court of Competent Jurisdiction

Signature or Mark _____ Date: _____

Signature of Witness (if mark) _____

Printed Name of Witness (if mark) _____

Title if Agency or Court representative _____

Do Not Write Below This Line – for DDD use only

_____ Functional Criteria Met **_____Functional Criteria not met**

Eligible for Medicaid Yes_____ No_____ **Closed due to insufficient information_____**

_____ _____ _____

DDD Representative Signature **Title/Discipline** **Date**

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Applicant Name _____

Date of Birth _____

Social Security # _____

Applicant's Primary Address _____

_____

Form Completed by _____

Relationship to Applicant _____

Phone Number _____ Email _____

Does Applicant have a Legal Guardian? ____No _____ Yes*

**If yes, please complete the below and provide a copy of the Guardianship Order with the application.*
Name _____ Phone #:_____
Address _____
Relationship to individual _____

1. APPLICANT RESIDENCY AND OCCUPATION INFORMATION
Place of Birth (hospital, city, state or country if born outside U.S.)
_____
_____
If born outside U.S., is Applicant a U.S. citizen? ____ Yes ____ No
If No, is Applicant a permanent alien resident? ____ Yes ____ No
If Applicant has a legal guardian, is the legal guardian a permanent legal resident of New Jersey?
_____Yes _____ No _____ Has no legal guardian
Is Applicant currently receiving services from any agency in any state other than New Jersey?
_____Yes _____ No If yes:

_____ _____ _____
Name of Agency Address Phone #

Is applicant currently receiving services from the NJ Department of Children and Families?
___ Yes ___ No If yes, specify which services:

_____

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Does Applicant Reside in a Residential Program? _____Yes* _____ No
**If yes, please complete*
Placement Type _____
Provider Name _____
Funding Source _____

Is Applicant Employed? _____ Yes* _____ No
**If yes, please complete*
Employer Name _____
Position _____

Does Applicant Attend a Day Program or School? _____Yes* _____No
**If yes, please complete*
Type of Program _____ Phone # _____
Name of Program/School _____
Address _____
Are you currently under DVR services? _____Yes _____ No
Has DVR assisted you with employment or day services? _____Yes _____ No
Has DVR assisted you with employment or day services? _____Yes _____ No

2. APPLICANT INSURANCE AND BENEFIT INFORMATION

Applicant's Medicaid Number_____
(Note: This is not the number on your Medicaid card. Please call N.J. Medicaid at 800-356-1561 to obtain your Medicaid number.)

Date of Medicaid Eligibility _____

If you do not have Medicaid, have you already applied for it? _____Yes _____No*

*If you do not have Medicaid, are you planning to apply for it? _____Yes _____No
(*Note: you will not be able to receive services without Medicaid.)*

Medicare? _____Yes _____No *If yes*, Medicare Number _____

Private Insurance? _____Yes _____No
If yes,

Policy Name	Policy Number	Telephone Number
_____	_____	_____

Social Security Administration Death or Disability (SSA/SSDI) benefits? _____Yes ____ No
If yes: Claim # _____ Amount received per month: $ _____
If no: _____ Never applied _____ Application pending _____Ineligible

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Supplemental Security Income (SSI) benefits? _____Yes _____No
If yes, please complete
Claim # _____ Amount received per month: $ _____

If no, please complete
_____Never applied _____ Application pending _____Ineligible

If Applicant receives SSA/SSDI or SSI, is there a Representative Payee? _____Yes* _____No
**If yes, please complete*

Benefit	**Name**	**Address**	**Phone**	**Relationship**
#1_____	_____	_____	_____	_____
#2_____	_____	_____	_____	_____

3. APPLICANT FAMILY AND HOUSEHOLD INFORMATION

Father: _____Living _____Deceased

If living, please complete the following
Name_____ Date of Birth _____
Address, if different from Applicant_____
Phone (Home) _____ (Work)_____ (Cell) _____
E-mail _____
Social Security #_____ Veteran? _____Yes _____No
Marital Status _____ Is Father an Emergency Contact? ____Yes ___ No

Mother: _____ Living _____Deceased

If living, please complete the following
Name_____ Date of Birth: _____
Address, if different from Applicant_____
Phone (Home) _____ (Work)_____ (Cell) _____
E-mail _____
Social Security #_____ Veteran? ___Yes ____No____
Marital Status _____
Marital Status/Maiden Name: _____ Is Mother an Emergency Contact? ____Yes ___ No

Other Members of Applicants Household (Do not include parents if they are listed above)

Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____

NJ DEPT OF HUMAN SERVICES – DIVISION OF DEVELOPMENTAL DISABILITIES

This form MUST be completed by a Medical Professional (DC medical staff, private doctor, nurse, psychiatrist, psychologist, etc.).

IDENTIFYING INFORMATION (please print legibly)

Individual's Name: Birthdate:

DDD ID #: Last 4 Digits of Social Security #: Earliest Age of Onset:

CIRCLE APPLICABLE CODES

PRIMARY ICD-9 CODES	ICD-9 CODE	ICD-10 DIAGNOSTIC CODE	PRIMARY ICD-9 CODES	ICD-9 CODE	ICD-10 DIAGNOSTIC CODE
Abetalipoproteinemia	272.5	E78.6	Hallervorden-Spatz Syndrome	333.0	G23.0
Acrocephalosyndactyly (Apert's Syndrome)	755.55	Q87.0	Head Injury, unspecified – Age of onset: _____	959.01	S09.90XA
Adrenaleukodystrophy	277.86	E71.529	Hemiplegia, unspecified	342.9	G81.90
Arginase Deficiency	270.6	E72.21	Holoprosencephaly	742.2	Q04.2
Agenesis of the Corpus Callosum	742.2	Q04.3	Homocystinuria	270.4	E72.11
Agenesis of Septum Pellucidum	742.2	Q04.3	Huntington's Chorea	333.4	G10
Argyria/Pachygyria/Microgyria	742.2 or 758.33	Q04.3	Hurler's Syndrome	277.5	E76.01
Aicardi Syndrome	333	G23.8	Hyperammonemia Syndrome	270.6	E72.4
Alcohol Embryo and Fetopathy	760.71	F84.5	I-Cell Disease	272.2	E77.0
Anencephaly	655.0	Q00.0	Idiopathic Torsion Dystonia	333.6	G24.1
Angelman Syndrome	759.89	Q93.5	Incontinentia Pigmenti	757.33	Q82.3
Asperger Syndrome	299.8	F84.5	Infantile Cerebral Palsy, unspecified	343.9	G80.9
Ataxia-Telangiectasia	334.8	G11.3	Intractable Seizure Disorder	345.1	G40.309
Autistic Disorder (Childhood Autism, Infantile Psychosis, Kanner's Syndrome)	299.0	F84.0	Klinefelter's Syndrome	758.7	Q98.4
Biotinidase Deficiency	277.6	D84.1	Krabbe Disease	333.0	E75.23
Canavan Disease	330.0	E75.29	Kugelberg-Welander Disease	335.11	G12.1
Carpenter Syndrome	759.89	Q87.0	Larsen's Syndrome	755.8	Q74.8
Cerebral Palsy, unspecified	343.69	G80.9	Leigh Disease	330.8	G31.82
Cerebral Palsy, Hemiplegic, Congenital	343.1	G80.2	Lesch-Nyhan Syndrome	277.2	E79.1
Cerebral Palsy, Paraplegic, Congenital	343	G80.1	Lissencephaly	742.2	Q04.3
Cerebral Palsy, Quadriplegic	343.2	G80.0	Lowe (Terrey MacLachlan) Syndrome (Oculocerebrorenal Dystrophy)	270.8	E72.03
Charcot Marie Tooth Disease	356.1	G60.0	Marfan Syndrome	759.82	Q87.40
CHARGE Association	759.89	Q89.8	Megalencephaly	742.4	Q04.5
Cockayne Syndrome	759.89	Q89.8	Menkes Disease (X-Linked)	275.1	E83.09
Coffin-Lowry Syndrome	759.89	Q89.8	Metachromatic Leukodystrophy	330.0	E75.25
Congenital Defects of Glycosylation	279.03	D80.3	Methylmalonic Aciduria (Acidemia)	270.3 or 270.7	E71.120
Cornelia de Lange Syndrome	759.89	Q89.8	Microencephaly	742.1	Q02
Cri-du-chat Syndrome	758.31	Q93.4	Mild Intellectual Disability	317.0	F70
Crouzon Syndrome	756.0	Q75.1	Mixed Conductive and Sensorineural Hearing Loss	389.2	H90.8
DiGeorge Syndrome	279.11	D82.1	Moderate Intellectual Disability	318.0	F71
Down Syndrome	758.0	Q90.9	Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	369.1	H54.10
Dubowitz Syndrome	742.8	Q07.8	Mucolipidosis Type IV	330.1	E75.11
Duchenne Muscular Dystrophy	359.1	G71.0	Mucopolysaccharidosis (Hunter's Syndrome, Hurler's Syndrome, Scheie's Syndrome)	277.5	E76.01
Dystonia Musculoram Deformans	333.6	G24.1	Neuroaxonal Dystrophy	333	G23.0
Encephalopathy, not elsewhere classified	348.3	G93.40	Neurofibromatosis (von Recklinghausen's Disease)	237.71	Q85.01
Epilepsy, unspecified	345.9	G40.90	Neuronal Heterotopia	742.8	Q07.8
Fetal Alcohol Syndrome	760.71	Q86.0	Niemann-Pick Disease	272.7	E75.249
Fragile X Syndrome	759.83	Q99.2	Noonan Syndrome	759.81	Q87.1
Friedreich's Ataxia	334.0	G11.1	Other Cerebral Degeneration	331.8 or 349.89	G32.89 (non-specified)
Fucosidosis	271.8	E77.1	Other Chromosomal Abnormalities, not elsewhere classified	758.89	Q99.8
Gaucher's Disease	272.7	E75.22	Other Disorders of Purine and Pyrimidine Metabolism (Lesch-Nyhan Syndrome)	277.2	E79.1
Generalized Convulsive Epilepsy	345.1	G40.309	Other Specified Anomalies (Cornelia de Lange Syndrome, Seckel Syndrome)	759.9	Q87.1
Generalized Non-Convulsive Epilepsy	345.0	G40.401	Other Specified Anomalies of Nervous System (Familial Dysautonomia; Riley-Day Syndrome)	742.8	G90.1
Gonadal Dysgenesis (Turner's Syndrome)	758.6	Q96.9	Other Specified Cerebral Degenerations in Childhood (Alper's Disease or Gray-Matter Degeneration; Infantile Necrotizing Encephalomyelopathy; Leigh's Disease; Subaute Necrotizing Encephalopathy or Encephamyelopathy, Rett's Syndrome)	330.8	G31.81
Grand Mal Status	345.3	G40.409	Other Specified Pervasive Developmental Disorders (Asperger's Disorder, Atypical Childhood Psychosis; Borderline Psychosis of Childhood)	299.8	F84.5

CIRCLE APPLICABLE CODES					
Other Spinocerebellar Diseases (Ataxia-Telangiectasia [Louis-Bar Syndrome])	334.8	G11.3	Spina Bifida without mention of Hydrocephalus	741.9	Q05.8
Paraplegia (Paralysis of Both Lower Limbs)	344.1	G82.20	Spinal Cord Injury (Initial Encounter)	952.9	S14.109A
Partial Epilepsy, with Impairment of Consciousness (Psychomotor Epilepsy)	345.4	G40.201	Spinal Muscular Atrophy, Unspecified	335.1	G12.1
Patau's Syndrome	758.1	Q91.7	Sturge-Weber Syndrome	759.6	Q85.8
Pervasive Developmental Disorder- NOS	299.9	F84.9	Symptomatic Torsion Dystonia (Athetoid Cerebral Palsy)	333.7	G80.3
Pick's Disease	331.11	G31.01	Tay-Sachs Disease	330.1	E75.02
Propionic Acidemia	270.3	E71.121	Torch Syndrome	760.02	P00.2
Prader-Willi syndrome	759.81	Q87.1	Trisomy 13	758.1	Q91.13
Profound Intellectual Disabilty	318.2	F73	Trisomy 18 (Edwards' Syndrome)	758.2	Q91.3
Pyruvate Dehydrogenase Deficiency (lactic, pyruvic)	271.8	E74.4	Tuberous Sclerosis	759.5	Q85.1
Quadriplegia and Quadriparesis	344.00	G82.5	Unspecified (Traumatic Blindness NOS)	950.9	S04.019A
Refsum's Disease	356.3	G60.1	Unspecified Anomaly of Brain, Spinal Cord, and Nervous System	742.9	Q07.9
Rett's Syndrome	330.8	F84.2	Unspecified Cause of Encephalitis	323.9	G04.90
Rubinstien-Taybi Syndrome	759.89	Q87.2	Unspecified Delay in Development (Developmental Disorder NOS)	315.9	F89
Sandhoff Disease	330.1	E75.01	Unspecified Disease of Spinal Cord	336.9	G95.9
Sanfillippo Syndrome	277.5	E76.22	Unspecified Intellectual Disability	319	F79
Schindler Disease Type 1	271.8	E77.1	Unspecified Pervasive Developmental Disorder (Pervasive Developmental Disorder NOS)	299.9	F84.9
Schizencephaly	742.4	Q04.6	Untreated Phenylketonuria	270.1	E70.0
Seckel Syndrome	759.89	Q87.1	Urea Cycle Defects	270.6	E72.20
Septo-optic Dysplasia	742.4	Q04.4	Usher Syndrome Type II	694.4	L10.4
Severe Hypoxic Ischemis CNS Injury	768.73	P91.63	Vater Association	759.89	Q87.2
Severe Intellectual Disability	318.1	F72	Werdnig-Hoffman	335.0	G12.0
Sjogren-Larsson Syndrome	757.1	Q80.9	Williams-Beauren Syndrome	758.9	Q87.8
Spastic Hemiplegia	342.1	G80.2	Wilson Disease	275.1	E83.01
Spielmeyer-Vogt Disease	330.1	E75.4	Zellwager Syndrome	277.86	E71.510
Spina Bifida	741	Q05	Psychiatric Disorder or Problem		F99

Description of diagnosis (not listed on the previous pages) related to developmental disability):

Code(s): _____

My signature of this document certifies that the diagnosis identified is based on medical evaluation and documentation and/or established medical evaluation and documentation.

I understand that the information on this document and supporting documentation will be used by the Division of Developmental Disabilities (DDD) to certify Federal reimbursement for services rendered to the individual identified on this form. This form does not guarantee eligibility or services by DDD. My signature certifies that the information is accurate based on medical opinion supported by medical records.

Printed Name of Medical Professional

Signature of Medical Professional

Date
(ICD-10 Form revised 1/24/14)

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
P O Box 700
Trenton, NJ 08625
609-777-2026

NOTICE OF PRIVACY PRACTICES
Effective date: September 23, 2013

Your Information. Your Rights. Our Responsibilities.

This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services and describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information with other healthcare professionals who are either part of the Department of Human Services or who are outside of the Department of Human Services to determine how to diagnose or treat you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Business Associates

There are some services provided in our organization through contracts with business associates:

- Examples include our accountants, consultants and attorneys
- We may disclose your health information to them so that they can perform the job we've asked them to do
- However, we require that the business associates appropriately safeguard your information

Do research

We can use or share your information for health research when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this Notice: September 23, 2013

New Jersey Department of Human Services
Division of Developmental Disabilities

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This form must be signed upon receipt of the Notice of Privacy Practices and returned to the New Jersey Division of Developmental Disabilities. If the Applicant is under 18, a Parent or the Legal Guardian must sign. If Applicant is 18 or older, Applicant or the Legal Guardian must sign.

I, _____ (print or type name),

hereby acknowledge that I have received the Notice of Privacy Practices

on_____.

I am the (please check one):

_____	_____	_____
Applicant	Parent (if applicant is under 18)	Legal Guardian

_____ _____

Applicant, parent or legal guardian signature or mark* Date

If signed by someone other than Applicant:

_____

Applicant Name (please print)

If mark is provided:

_____

Witness signature

_____

Witness Name (please print)

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name:_____

Date of Birth:_____

1. Person(s) authorized to use, disclose or receive information, include legal guardian, if applicable:

Primary Contact:	**Alternate Contact:**
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship:_____
Other Contact:	Other Contact:
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship:_____

Attach additional sheets if needed.

2. I am authorizing DDD staff to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization

3. I am authorizing the DDD staff to provide the minimum necessary health information to the individuals listed above and/or other individuals who are permitted to visit.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect ability to obtain treatment or payment or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.

7. The authorization expires on _____ or one year from the date of the individual's/legal guardian's signature.

8. A complete copy of this form will be maintained in the client record.

9. To Legal Guardians: If the individual receiving services is over the age of 18 and you have indicated that you are the Legal Guardian for this individual, you must attach a copy of Appointment of Guardianship to this form.

Signature (or mark) of
Individual or Legal Guardian:_____

Date of Signature:_____

Name of Legal Guardian* (if applicable):_____
*Copy of Valid Appointment of Guardianship must be attached.

If Mark is provided in place of signature, the mark must be witnessed:

Witness Signature (if applicable): _____

Witness Name/Title:_____

C: Case Manager - Original
Residential Program (if applicable)
Day Program (if applicable)

AUTHORIZATION FOR
THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
TO RELEASE RECORDS CONTAINING INDIVIDUALHEALTH INFORMATION

I hereby authorize _____ (facility/office) of the Division of Developmental Disabilities to disclose the individually identifiable health information as described below.

Name of Individual whose medical records are being requested:

_____

Name (*Please print*) Social Security Number Date of Birth

The medical records being requested were created between _____ and _____. A specific description of these records is provided below:

_____

_____

Purpose for which records will be used: _____

_____

☐ The records will be reviewed at the facility/agency.

☐ The records are to be copied. They will be picked up at the facility/office.

☐ The records being requested should be copied and sent to the person or organization and address below:

Name & address of person requesting records:

_____

_____

_____

Name & address of person(s) or organization(s) to receive the records <u>if other than person making request</u>:

_____

_____

_____

Telephone #:_____

Fax #_____

<u>Legal Authority for this request:</u>

☐ These are my records, and I am a legally competent adult.
☐ I am the legal guardian of the individual whose records are being requested, and I have attached a valid appointment of guardianship to this authorization.
☐ I am a parent of the individual whose records are being requested, and who is under the age of 18.
☐ I have Power of Attorney for the individual, and the Power of Attorney authorizes me to be able to request the individual's medical records, and a copy of the Power of Attorney is attached.

Understandings and Agreements about this Authorization:

1. This authorization is voluntary and I understand that DDD cannot condition treatment based on the signing of this authorization, unless the authorization is: (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.

2. This authorization will expire _____ (date to be determined by person signing this form) from the date of my signature below.

3. I understand that I may revoke this authorization at any time by notifying DDD in writing, but if I do, it will not have any effect on any actions taken prior to the time DDD received the revocation.

4. I agree to waive all claims against the DDD facility/agency for the release of the requested information.

5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by DDD if the recipient of the information is not a health plan, health care provider, healthcare clearinghouse, or a business associate that has a contract with DDD.

6. I understand that if I request that records be copied and sent to me, DDD will make a good faith effort to send those records to me in reasonable amount of time.

7. I understand that if I wish to have copies made of the records, DDD may assess a fee for copying the records.

***Signature (or mark) of Individual, Parent of Minor Child, Legal Guardian or person with Power of Attorney who is making this Request (please circle correct role)**:

_____

Date of Signature: **Telephone Number:**

_____ _____

_____ (Printed name of person making request)

***If a mark is provided in place of a signature, above, the mark must be witnessed:**

Witness Signature (if applicable):_____

Witness Name:_____

Witness Title:_____

***If person making request is a guardian or Power of Attorney, a copy of Valid Appointment of Guardianship or Power of Attorney must be attached.**

Consent to Release Information
To the
Division of Developmental Disabilities

I, _____, do hereby grant permission for
(Individual, Parent of individual if under 18, Legal Guardian or Power of Attorney)

_____
(Name of individual, institution, agency or other holder of information to be released)

to release the report(s), evaluation(s), summaries or other information described below regarding _____'s application for eligibility for services provided through the N.J. Division of Developmental Disabilities.

Information to be released:

_____

_____

_____

_____

This information is to be released to:

_____, Intake Worker
N.J. Division of Developmental Disabilities_____
Address: _____
_____
_____

Signature or Mark: _____Date: _____

Signature of Witness (if mark): _____

Printed Name of Witness (if mark): _____

If other than Individual Named Above, Relationship: _____

Note: The information received through this release is subject to the confidentiality regulations of the Division and cannot be released outside the Division without written permission unless otherwise provided by N.J.A.C. 10:41 et seq.