



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

PO BOX 726
TRENTON, NJ 08625-0726

Visit us on the web at :
www.state.nj.us/humanservices/ddd

Elizabeth Connolly
Acting 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



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

Elizabeth Connolly
Acting Commissioner

Elizabeth M. Shea
Assistant Commissioner

TEL. (609) 631-2200

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

- | | |
|--|--|
| <input type="checkbox"/> Medical Documentation of Disability | <input type="checkbox"/> Learning Evaluations/Social Summaries |
| <input type="checkbox"/> Physician's Statement | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Most Recent Psychological Evaluation, (+ IQ Scores) | <input type="checkbox"/> Neurological Evaluation |
| <input type="checkbox"/> All Available Psychological Reports | <input type="checkbox"/> Hospital Records/Discharge Summary |
| <input type="checkbox"/> Most Recent Child Study Team or School Reports | <input type="checkbox"/> 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:

- | | |
|---|---|
| <input type="checkbox"/> Photocopy of Guardianship Order (if applicable) | <input type="checkbox"/> SSI annual award letter |
| <input type="checkbox"/> Photocopy of Medicaid Card | <input type="checkbox"/> Letter certifying Medicaid eligibility |
| <input type="checkbox"/> Division of Vocational Rehabilitation Service (DVRS) Records/Evaluations (F3 form) | |

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

Revised 09/23/13



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

PO BOX 726
TRENTON, NJ 08625-0726

Elizabeth Connolly
Acting COMMISSIONER

Elizabeth M. Shea
Assistant Commissioner

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:



CHRIS CHRISTIE
GOVERNOR

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

Elizabeth Connolly
Acting COMMISSIONER

KIM GUADAGNO
LT. GOVERNOR

PO BOX 726
TRENTON, NJ 08625-0726

Elizabeth M. Shea
Assistant Commissioner

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

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



STATE OF NEW JERSEY
 DEPARTMENT OF HUMAN SERVICES
 DIVISION OF DEVELOPMENTAL DISABILITIES

CHRIS CHRISTIE
 GOVERNOR

KIM GUADAGNO
 LT. GOVERNOR

PO BOX 726
 TRENTON, NJ 08625-0726

Elizabeth Connolly
 Acting COMMISSIONER

Elizabeth M. Shea
 Assistant Commissioner

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*

<u>Benefit</u>	<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
#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 _____ 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 #:	Earliest Age of Onset:
Last 4 Digits of Social Security #:	

CIRCLE APPLICABLE CODES

PRIMARY ICD-10 CODES	ICD-10 DIAGNOSTIC CODE	PRIMARY ICD-10 CODES	ICD-10 DIAGNOSTIC CODE
Abetalipoproteinemia	E78.6	Gonadal Dysgenesis (Turner's Syndrome)	Q96.9
Acrocephalosyndactyly (Apert's Syndrome)	Q87.0	Grand Mal Status	G40.409
Adrenoleukodystrophy	E71.529	Hallervorden-Spatz Syndrome	G23.0
Arginase Deficiency	E72.21	Head Injury, unspecified – Age of onset: _____	S09.90XA
Agenesis of the Corpus Callosum	Q04.3	Hemiplegia, unspecified	G81.90
Agenesis of Septum Pellucidum	Q04.3	Holoprosencephaly	Q04.2
Argyria/Pachygyria/Microgyria	Q04.3	Homocystinuria	E72.11
Aicardi Syndrome	G23.8	Huntington's Chorea	G10
Alcohol Embryo and Fetopathy	F84.5	Hurler's Syndrome	E76.01
Anencephaly	Q00.0	Hyperammonemia Syndrome	E72.4
Angelman Syndrome	Q93.5	I-Cell Disease	E77.0
Asperger Syndrome	F84.5	Idiopathic Torsion Dystonia	G24.1
Ataxia-Telangiectasia	G11.3	Incontinentia Pigmenti	Q82.3
Autistic Disorder (Childhood Autism, Infantile Psychosis, Kanner's Syndrome)	F84.0	Infantile Cerebral Palsy, unspecified	G80.9
Biotinidase Deficiency	D84.1	Intractable Seizure Disorder	G40.309
Canavan Disease	E75.29	Klinefelter's Syndrome	Q98.4
Carpenter Syndrome	Q87.0	Krabbe Disease	E75.23
Cerebral Palsy, unspecified	G80.9	Kugelberg-Welander Disease	G12.1
Cerebral Palsy, Hemiplegic, Congenital	G80.2	Larsen's Syndrome	Q74.8
Cerebral Palsy, Paraplegic, Congenital	G80.1	Leigh Disease	G31.82
Cerebral Palsy, Quadriplegic	G80.0	Lesch-Nyhan Syndrome	E79.1
Charcot Marie Tooth Disease	G60.0	Lissencephaly	Q04.3
CHARGE Association	Q89.8	Lowe (Terrey MacLachlan) Syndrome (Oculocerebrorenal Dystrophy)	E72.03
Cockayne Syndrome	Q89.8	Maple Syrup Urine Disease	E71.0
Coffin-Lowry Syndrome	Q89.8	Marfan Syndrome	Q87.40
Congenital Defects of Glycosylation	D80.3	Megalencephaly	Q04.5
Cornelia de Lange Syndrome	Q89.8	Menkes Disease (X-Linked)	E83.09
Cri-du-chat Syndrome	Q93.4	Metachromatic Leukodystrophy	E75.25
Crouzon Syndrome	Q75.1	Methylmalonic Aciduria (Acidemia)	E71.120
DiGeorge Syndrome	D82.1	Microencephaly	Q02
Down Syndrome	Q90.9	Mild Intellectual Disability	F70
Dubowitz Syndrome	Q07.8	Mixed Conductive and Sensorineural Hearing Loss	H90.8
Duchenne Muscular Dystrophy	G71.0	Moderate Intellectual Disability	F71
Dystonia Musculorum Deformans	G24.1	Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.10
Encephalopathy, not elsewhere classified	G93.40	Mucopolysaccharidosis Type IV	E75.11
Epilepsy, unspecified, not intractable, with status epilepticus	G40.901	Mucopolysaccharidosis (Hunter's Syndrome, Hurler's Syndrome, Scheie's Syndrome)	E76.01
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909	Neuroaxonal Dystrophy	G23.0
Epilepsy, unspecified, intractable with status epilepticus	G40.911	Neurofibromatosis (von Recklinghausen's Disease)	Q85.01
Epilepsy, unspecified, intractable, without status epilepticus	G40.919	Neuronal Heterotopia	Q07.8
Fetal Alcohol Syndrome	Q86.0	Niemann-Pick Disease	E75.249
Fragile X Syndrome	Q99.2	Noonan Syndrome	Q87.1
Friedreich's Ataxia	G11.1	Other Cerebral Degeneration	G32.89 (non-specified)
Fucosidosis	E77.1	Other Chromosomal Abnormalities, not elsewhere classified	Q99.8
Gaucher's Disease	E75.22	Other Disorders of Purine and Pyrimidine Metabolism (Lesch-Nyhan Syndrome)	E79.1
Generalized Convulsive Epilepsy	G40.309	Other Specified Anomalies (Cornelia de Lange Syndrome, Seckel Syndrome)	Q87.1
Generalized Non-Convulsive Epilepsy	G40.401	Other Specified Anomalies of Nervous System (Familial Dysautonomia; Riley-Day Syndrome)	G90.1

	Circle Applicable Codes		Circle Applicable Codes
Other Specified Cerebral Degenerations in Childhood (Alper's Disease or Gray-Matter Degeneration; Infantile Necrotizing Encephalomyelopathy; Leigh's Disease; Subacute Necrotizing Encephalopathy or Encephalomyelopathy, Rett's Syndrome)	G31.81	Spina Bifida, Cervical without hydrocephalus	Q05.5
Other Specified Pervasive Developmental Disorders (Asperger's Disorder, Atypical Childhood Psychosis; Borderline Psychosis of Childhood)	F84.5	Spina Bifida, Thoracic without hydrocephalus	Q05.6
Other Spinocerebellar Diseases (Ataxia-Telangiectasia [Louis-Bar Syndrome])	G11.3	Spina Bifida, Lumbar, without hydrocephalus	Q05.7
Paraplegia (Paralysis of Both Lower Limbs)	G82.20	Spina Bifida, Sacral without hydrocephalus	Q05.8
Partial Epilepsy, with Impairment of Consciousness (Psychomotor Epilepsy)	G40.201	Spina Bifida, unspecified	Q05.9
Patau's Syndrome	Q91.7	Spinal Cord Injury (Initial Encounter)	S14.109A
Pervasive Developmental Disorder- NOS	F84.9	Spinal Muscular Atrophy, Unspecified	G12.1
Pick's Disease	G31.01	Sturge-Weber Syndrome	Q85.8
Propionic Acidemia	E71.121	Symptomatic Torsion Dystonia (Athetoid Cerebral Palsy)	G80.3
Prader-Willi syndrome	Q87.1	Tay-Sachs Disease	E75.02
Profound Intellectual Disability	F73	Torch Syndrome	P00.2
Pyruvate Dehydrogenase Deficiency (lactic, pyruvic)	E74.4	Trisomy 13, nonmosaicism	Q91.4
Quadriplegia and Quadriparesis, unspecified	G82.50	Trisomy 13, mosaicism	Q91.5
Quadriplegia C1-C4 complete	G82.51	Trisomy 13, translocation	Q91.6
Quadriplegia C1-C4, incomplete	G82.52	Trisomy 13, unspecified	Q91.7
Quadriplegia C5-C7, complete	G82.53	Trisomy 18 nonmosaicism	Q91.0
Quadriplegia C5-C7, incomplete	G82.54	Trisomy 18, mosaicism	Q91.1
Refsum's Disease	G60.1	Trisomy 18, translocation	Q91.2
Rett's Syndrome	F84.2	Trisomy 18, unspecified	Q91.3
Rubinstien-Taybi Syndrome	Q87.2	Tuberous Sclerosis	Q85.1
Sandhoff Disease	E75.01	Unspecified (Traumatic Blindness NOS)	S04.019A
Sanfillippo Syndrome	E76.22	Unspecified Anomaly of Brain, Spinal Cord, and Nervous System	Q07.9
Schindler Disease Type 1	E77.1	Unspecified Cause of Encephalitis	G04.90
Schizencephaly	Q04.6	Unspecified Delay in Development (Developmental Disorder NOS)	F89
Seckel Syndrome	Q87.1	Unspecified Disease of Spinal Cord	G95.9
Septo-optic Dysplasia	Q04.4	Unspecified Intellectual Disability	F79
Severe Hypoxic Ischemic CNS Injury	P91.63	Unspecified Pervasive Developmental Disorder (Pervasive Developmental Disorder NOS)	F84.9
Severe Intellectual Disability	F72	Untreated Phenylketonuria	E70.0
Sjogren-Larsson Syndrome	Q80.9	Urea Cycle Defects	E72.20
Spastic Hemiplegia	G80.2	Usher Syndrome Type II	L10.4
Spielmeier-Vogt Disease	E.75.4	Vater Association	Q87.2
Spina Bifida, Cervical, with hydrocephalus	Q05.0	Werdnig-Hoffman	G12.0
Spina Bifida, Thoracic, with hydrocephalus	Q05.1	Williams-Beuren Syndrome	Q87.8
Spina Bifida, Lumbar, with hydrocephalus	Q05.2	Wilson Disease	E83.01
Spina Bifida, Sacral, with hydrocephalus	Q05.3	Zellwager Syndrome	E71.510
Spina Bifida, Unspecified with hydrocephalus	Q05.4	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

**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:

<p>Primary Contact:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Alt Phone: _____</p> <p>Relationship: _____</p>	<p>Alternate Contact:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Alt Phone: _____</p> <p>Relationship: _____</p>
<p>Other Contact:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Relationship: _____</p>	<p>Other Contact:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Alt Phone: _____</p> <p>Relationship: _____</p>

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)

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.