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
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
   - 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)
   - SSI annual award letter
   - Letter certifying Medicaid eligibility
   - 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
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

Application for Eligibility 03/14/2013
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:

________________________________________

Application for Eligibility 03/14/2013 2
Does Applicant Reside in a Residential Program? _______Yes* _______No
*If yes, please complete
 Placement
 Provider
 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
 Name of Program/School
 Phone #
 Address

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

Application for Eligibility 03/14/2013
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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
<th>Relationship</th>
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<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Application for Eligibility 03/14/2013
# 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)

<table>
<thead>
<tr>
<th>Individual's Name:</th>
<th>Birthdate:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DDD ID #:**

**Last 4 Digits of Social Security #:**

**Earliest Age of Onset:**

---

## CIRCLE APPLICABLE CODES

<table>
<thead>
<tr>
<th>PRIMARY ICD-10 CODES</th>
<th>ICD-10 DIAGNOSTIC CODE</th>
<th>PRIMARY ICD-10 CODES</th>
<th>ICD-10 DIAGNOSTIC CODE</th>
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</thead>
<tbody>
<tr>
<td>Abetalipoproteinemia</td>
<td>E78.6</td>
<td>Gonadal Dysgenesis (Turner's Syndrome)</td>
<td>Q96.9</td>
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<tr>
<td>Acrocephalosyndactyly (Apert's Syndrome)</td>
<td>Q87.0</td>
<td>Grand Mal Status</td>
<td>G40.409</td>
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<tr>
<td>Adrenoleukodystrophy</td>
<td>E71.329</td>
<td>Hallervorden-Spatz Syndrome</td>
<td>G23.0</td>
</tr>
<tr>
<td>Arginase Deficiency</td>
<td>E72.21</td>
<td>Head Injury, unspecified – Age of onset:</td>
<td>S09.90XA</td>
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<tr>
<td>Agenesis of the Corpus Callosum</td>
<td>Q04.3</td>
<td>Hemiplaga, unspecified</td>
<td>G81.90</td>
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<tr>
<td>Agenesis of Septum Pellucidum</td>
<td>Q04.3</td>
<td>Holoprosencephaly</td>
<td>Q04.2</td>
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<tr>
<td>Aicardi Syndrome</td>
<td>G23.8</td>
<td>Huntington's Chorea</td>
<td>G10</td>
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<tr>
<td>Alcohol Embryo and Fetopathy</td>
<td>F84.5</td>
<td>Hunter's Syndrome</td>
<td>E76.01</td>
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<tr>
<td>Alentheidypehany</td>
<td>Q00.0</td>
<td>Hyperammonemona Syndrome</td>
<td>E72.4</td>
</tr>
<tr>
<td>Angelman Syndrome</td>
<td>Q93.5</td>
<td>T-Cell Disease</td>
<td>E77.0</td>
</tr>
<tr>
<td>Apertger Syndrome</td>
<td>F84.5</td>
<td>Idiopathic Torsion Dystonia</td>
<td>G24.1</td>
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<tr>
<td>Ataxia-Telangectasia</td>
<td>G11.3</td>
<td>Incontinent Pigment</td>
<td>Q82.3</td>
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<tr>
<td>Autistic Disorder (Childhood Autism, Infantile Psychosis, Kanner's Syndrome)</td>
<td>F84.0</td>
<td>Infantile Cerebral Palsy, unspecified</td>
<td>G80.9</td>
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<tr>
<td>Biotinidase Deficiency</td>
<td>D84.1</td>
<td>Intractable Seizure Disorder</td>
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<tr>
<td>Canavan Disease</td>
<td>E75.29</td>
<td>Klinefelter's Syndrome</td>
<td>Q98.4</td>
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<td>Carpenter Syndrome</td>
<td>Q87.0</td>
<td>Krabbe Disease</td>
<td>E75.23</td>
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<tr>
<td>Cerebral Palsy, unspecified</td>
<td>G80.9</td>
<td>Kugelberg-Welander Disease</td>
<td>Q12.1</td>
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<tr>
<td>Cerebral Palsy, Hemipligic, Congenital</td>
<td>G80.2</td>
<td>Larsen's Syndrome</td>
<td>Q74.8</td>
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<td>Cerebral Palsy, Paraplegic, Congenital</td>
<td>G80.1</td>
<td>Leigh Disease</td>
<td>Q81.82</td>
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<td>Cerebral Palsy, Quadriplegic</td>
<td>G80.0</td>
<td>Lesch-Nyhan Syndrome</td>
<td>E79.1</td>
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<tr>
<td>Charcot Marie Tooth Disease</td>
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<td>Lissencephaly</td>
<td>Q04.3</td>
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<tr>
<td>CHARGE Association</td>
<td>Q89.8</td>
<td>Lowe (Terry MacLachlan) Syndrome (Oculocerebreal Dystrophy)</td>
<td>E72.03</td>
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<tr>
<td>Cockayne Syndrome</td>
<td>Q89.8</td>
<td>Maple Syrup Urine Disease</td>
<td>E71.0</td>
</tr>
<tr>
<td>Coffin-Lowry Syndrome</td>
<td>Q89.8</td>
<td>Marfan Syndrome</td>
<td>Q87.40</td>
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<tr>
<td>Congenital Defects of Glycosylation</td>
<td>D80.3</td>
<td>Megalencephaly</td>
<td>Q04.5</td>
</tr>
<tr>
<td>Cornelia de Lange Syndrome</td>
<td>Q89.8</td>
<td>Menkes Disease (X-Linked)</td>
<td>E83.09</td>
</tr>
<tr>
<td>Cri-du-chat Syndrome</td>
<td>Q93.4</td>
<td>Metachromatic Leukodystrophy</td>
<td>E75.25</td>
</tr>
<tr>
<td>Crouzon Syndrome</td>
<td>Q75.1</td>
<td>Methylmalonic Aciduria (Acidemia)</td>
<td>E71.120</td>
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<tr>
<td>DiGeorge Syndrome</td>
<td>D82.1</td>
<td>Microencephaly</td>
<td>Q02</td>
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<tr>
<td>Down Syndrome</td>
<td>Q90.9</td>
<td>Mild Intellectual Disability</td>
<td>F70</td>
</tr>
<tr>
<td>Dubowitz Syndrome</td>
<td>Q07.8</td>
<td>Mixed Conductive and Sensorineural Hearing Loss</td>
<td>H90.8</td>
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<tr>
<td>Duchenne Muscular Dystrophy</td>
<td>Q71.0</td>
<td>Moderate Intellectual Disability</td>
<td>F71</td>
</tr>
<tr>
<td>Dystonia Musculariam Deformans</td>
<td>G24.1</td>
<td>Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye</td>
<td>H54.10</td>
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<tr>
<td>Encephalopathy, not elsewhere classified</td>
<td>G93.40</td>
<td>Mucopolidposis Type IV</td>
<td>E75.11</td>
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<tr>
<td>Epilepsy, unspecified, not intractable, with status epilepticus</td>
<td>G40.901</td>
<td>Mucopolysaccharidosis (Hunter's Syndrome, Halter's Syndrome, Scheie's Syndrome)</td>
<td>E76.01</td>
</tr>
<tr>
<td>Epilepsy, unspecified, not intractable, without status epilepticus</td>
<td>G40.909</td>
<td>Neuroaxonal Dystrophy</td>
<td>G23.0</td>
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<tr>
<td>Epilepsy, unspecified, intractable with status epilepticus</td>
<td>G40.911</td>
<td>Neurofibromatosis (von Recklinghausen's Disease)</td>
<td>Q85.01</td>
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<tr>
<td>Epilepsy, unspecified, intractable, without status epilepticus</td>
<td>G40.919</td>
<td>Neuronal Heterotopia</td>
<td>Q07.8</td>
</tr>
<tr>
<td>Fetah Alcohol Syndrome</td>
<td>Q86.0</td>
<td>Niemann-Pick Disease</td>
<td>E75.249</td>
</tr>
<tr>
<td>Fragile X Syndrome</td>
<td>Q99.2</td>
<td>Noonan Syndrome</td>
<td>Q87.1</td>
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<tr>
<td>Friedreich's Ataxia</td>
<td>G11.1</td>
<td>Other Cerebral Degeneration</td>
<td>G32.89 (non-specified)</td>
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<tr>
<td>Fuososiosis</td>
<td>E77.1</td>
<td>Other Chromosomal Abnormalities, not elsewhere classified</td>
<td>Q99.8</td>
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<td>Gaucher's Disease</td>
<td>E75.22</td>
<td>Other Disorders of Purine and Pyrimidine Metabolism (Lesch-Nyhan Syndrome)</td>
<td>E79.1</td>
</tr>
<tr>
<td>Generalized Convulsive Epilepsy</td>
<td>G40.309</td>
<td>Other Specified Anomalies (Cornelia de Lange Syndrome, Seckel Syndrome)</td>
<td>Q87.1</td>
</tr>
<tr>
<td>Generalized Non-Convulsive Epilepsy</td>
<td>G40.401</td>
<td>Other Specified Anomalies of Nervous System (Familial Dysautonomia, Riley-Day Syndrome)</td>
<td>G90.1</td>
</tr>
</tbody>
</table>

---

Page 1 of 2 – ICD 10 Coding Sheet (Form revised 3/28/16)
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.
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
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)
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:

<table>
<thead>
<tr>
<th>Primary Contact</th>
<th>Alternate Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:___________</td>
<td>Name:_____________</td>
</tr>
<tr>
<td>Address:________</td>
<td>Address:__________</td>
</tr>
<tr>
<td>Phone:__________</td>
<td>Phone:___________</td>
</tr>
<tr>
<td>Alt Phone:_______</td>
<td>Alt Phone:_______</td>
</tr>
<tr>
<td>Relationship:____</td>
<td>Relationship:____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Contact</th>
<th>Other Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:_________</td>
<td>Name:_________</td>
</tr>
<tr>
<td>Address:_______</td>
<td>Address:_______</td>
</tr>
<tr>
<td>Phone:________</td>
<td>Phone:________</td>
</tr>
<tr>
<td>Alt Phone:____</td>
<td>Alt Phone:____</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

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: __________________________________________
AUTHORIZATION FOR
THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
TO RELEASE RECORDS CONTAINING INDIVIDUAL HEALTH 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 if other than person making request:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Telephone #: ____________________________
Fax #: ____________________________

Legal Authority for this request:

☐ 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.

Page 2 of 2
Authorization for the Release of Records
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.