Application for Appointment to Board of Directors of _____

_____was established in ____ with the passage of a special property tax levy. The agency, through its Board of Directors, purchases and provides services for eligible persons of all ages with developmental disabilities. As an administrative agent of the Department of Mental Health, the scope of services has expanded since establishment of the agency, and has grown to include _____ services. The agency is nationally accredited and has a _____ dollar budget. Additional information about the agency may be obtained at the agency's website, _____, or by contacting the agency.

Composition of the board of directors must meet the statutory requirements of the enabling legislation. Additionally, persons appointed to the board must comply with the provisions of the bylaws of the board, agency policy and **the resolution adopted by the Board regarding disclosure of potential conflicts of interest on file with the Missouri Ethics Commission (NOTE: may not be applicable to every county board)**. As appointees of a statutorily created entity with broad powers, board members have certain fiduciary duties, which require that they conduct themselves without conflict to the interest of the agency they serve. Conflicts of interest are not prohibited, but disclosure is critical. Disclosure should not be construed as creating a presumption of impropriety or as automatically precluding someone from participation. Rather, it reflects the recognition of the many factors that can influence one's judgment and a desire to make as much information as possible available to other participants. Potentially conflicting interests may relate to programs and services or operations, such as contracts with third parties.

APPLICATION

Name: _____
Last *First* *Middle Initial*

Home Address: _____

City: _____ Zip: _____

Employment Address: _____

City: _____ Zip: _____

At which address would you prefer to be contacted: _____ Home _____ _ Business

Email Address (where you wish to be contacted): _____

Home Phone: _____ Business Phone: _____

Section 205.970 RSMo requires that at least 7 of the board members be residents of the county where the facility is located. Are you a _____ County resident and how long have you lived in _____ County? _____Years _____Months

Are you a registered voter? _____ Yes _____ No

Have you previously served as a member of a board? If yes, identify the board and the dates of service.

_____

_____

What other professional, civic or community endeavors are you currently involved in?

_____

_____

Are you or have you previously held any local, state or federal government positions, appointments or elected office(s)? If so, please list dates and positions held.

_____

_____

Section 205.970, Revised Statutes of Missouri, requires that at two of the nine members of the board of directors be related by blood or marriage within the third degree to a handicapped person as defined in Section 205.968 as a person who is "lower range educable or upper range trainable mentally retarded or a person who has a developmental disability." Are you related by blood or marriage within the third degree to a handicapped person as defined in Missouri statutes? [Relationships in the third degree include mother, father, child, brother, sister, (including half, step and in-law relationships in these same categories), and grandparent, grandchild, aunt, uncle, niece, nephew, great grandparent, great grandchild.] If yes, please identify the person and the relationship.

_____

Person *Relationship*

For purposes of the following questions, "related family member" is defined to include relationships within the third degree by blood or marriage. [Relationships in the third degree include mother, father, child, brother, sister, (including half, step and in-law relationships in these same categories), and grandparent, grandchild, aunt, uncle, niece, nephew, great grandparent, great grandchild.]

Have you or a related family member applied for eligibility and been determined eligible or ineligible for services of _____ at any time? If yes, identify the individual who applied, their relationship to you and the date of application.

_____

_____

Explain briefly why you are seeking this position and identify any special qualifications you have for this position.

_____

_____

Do you or any related family member have any financial interest, directly or indirectly, in any contract or subcontract with _____; or have you or a related family member been employed by any agency or entity that contracts or subcontracts with _____; or in the sale to _____ of land, materials, supplies, or services? If yes, please explain.

_____

_____

Are you or any related family member now or have you or a related family member ever been employed by _____? If so, please give dates of employment and position held.

_____

-_____

Do you or does any related family member have any other interest which might conflict or be perceived to conflict with your duty of loyalty to the interests of _____? If so, identify the interest and the relationship.

_____

_____

Have you ever been arrested, charged, or convicted of any felony? _____ Yes _____ No
If yes, please explain.

_____

_____

Have you ever been disciplined, cited, or sanctioned for a breach of ethics or unprofessional conduct by, or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee, or other professional group? _____ Yes _____ No
If yes, please explain.

_____

_____

References:

Name	*Nature of Relationship*	*Contact Information*	*Years Known*
Name	*Nature of Relationship*	*Contact Information*	*Years Known*
Name	*Nature of Relationship*	*Contact Information*	*Years Known*

By my signature, I agree to comply fully with board policy, bylaws, and conflict of interest requirements of the board of directors and certify that the information above is complete and accurate to the best of my knowledge and that should a potential conflict arise during my term, I will bring it to that attention of the Board of Directors of _____.

_____ _____

Signature Date

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES

CHOICE TO TERMINATE PARTICIPATION FROM A DIVISION OF DEVELOPMENTAL DISABILITIES WAIVER

INDIVIDUAL NAME	DATE OF BIRTH
MEDICAID NUMBER	DMH ID NUMBER

Choice to Terminate Participation from a Division of Developmental Disabilities Waiver:

I no longer choose to participate in the:

[ ] Comprehensive Waiver [ ] Community Support Waiver [ ] Sara Jian Lopez Waiver
[ ] Autism Waiver [ ] Partnership for Hope (Prevention) Waiver

I CERTIFY THAT I HAVE CHOSEN TO TERMINATE THE ABOVE WAIVER.

INDIVIDUAL	DATE
PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE	DATE
SERVICE COORDINATOR	DATE

DISTRIBUTION: Copy for the INDIVIDUAL/PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE and copy for TCM FACILITY
3/1/11

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
MEDICAID WAIVER, PROVIDER, AND SERVICES CHOICE STATEMENT

INDIVIDUAL NAME	DATE OF BIRTH
MEDICAID NUMBER	DMH ID NUMBER

Choice to Participate in a Division of Developmental Disabilities Waiver
As an alternative to placement in a long term care facility known as an Intermediate Care Facility for Mental Retardation (ICF/MR), you have been recommended for participation in the following Division of Developmental Disabilities Medicaid Home and Community-Based Waiver program:
☐ Comprehensive Waiver ☐ Community Support Waiver ☐ Sara Jian Lopez Waiver ☐ Autism Waiver
☐ Partnership for Hope (Prevention) Waiver

You may request services through this Medicaid Home and Community-Based Waiver, or you may request referral to an ICF/MR facility. Please indicate your choice of the following services:

☐ I wish to participate in the Medicaid Home and Community Based Waiver program specified above. I understand that participation is conditional based on my eligibility for Medicaid and other criteria.

☐ I wish to be referred to an ICF/MR facility.

ELIGIBLE PROVIDERS: SEE ATTACHED LIST.

I HAVE RECEIVED INFORMATION REGARDING THE OPTION TO SELF-DIRECT MY SERVICES:
[ ] YES or [ ] NO

CHOICE OF SERVICE, PROVIDER or SELF-DIRECTED SUPPORTS

Service Choice (List all Services)	Name of Provider or Self-Directed

Additional Choices can be added to Supplemental Page

I CERTIFY THAT I HAVE CHOSEN THE ABOVE SERVICES.
I CERTIFY THAT I HAVE BEEN AFFORDED THE OPPORTUNITY TO SELF-DIRECT MY WAIVER SERVICES AND/OR SELECT FROM THE LIST OF WILLING AND QUALIFIED WAIVER SERVICES PROVIDERS.
I CERTIFY THAT I HAVE CHOSEN TO SELF-DIRECT MY SERVICES AND/OR HAVE CHOSEN THE ABOVE LISTED QUALIFIED WAIVER SERVICES PROVIDERS

INDIVIDUAL	DATE
PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE	DATE
SERVICE COORDINATOR	DATE

DISTRIBUTION: Copy for the INDIVIDUAL/PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE and copy for TCM Provider
2/28/11

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
MEDICAID WAIVER, PROVIDER, AND SERVICES CHOICE STATEMENT
(Supplemental Page)

CHOICE OF SERVICE, PROVIDER or SELF-DIRECTED SUPPORTS

This page is used only when:

1) *Additional space is needed to list service choices in new waiver or*
2) *When the individual, guardian and/or designated representative choose a new service and/ or new provider (changes providers) and/or choose to start self-directing supports*

[ ] 1) Supplemental Page for Initial enrollment of waiver

[ ] 2) Supplemental Page for change of service or provider, or change to self-directed supports
Effective date:

CHOICE OF SERVICE, PROVIDER or SELF-DIRECTED SUPPORTS

Service Choice (List all Services)	Name of Provider or Self-Directed

I CERTIFY THAT I HAVE CHOSEN THE ABOVE SERVICES.
I CERTIFY THAT I HAVE BEEN AFFORDED THE OPPORTUNITY TO SELF-DIRECT MY WAIVER SERVICES AND/OR SELECT FROM THE LIST OF WILLING AND QUALIFIED WAIVER SERVICES PROVIDERS.
I CERTIFY THAT I HAVE CHOSEN TO SELF-DIRECT MY SERVICES AND/OR HAVE CHOSEN THE ABOVE LISTED QUALIFIED WAIVER SERVICES PROVIDERS

INDIVIDUAL	DATE
PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE	DATE
SERVICE COORDINATOR	DATE

DISTRIBUTION: Copy for the INDIVIDUAL/PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE and copy for TCM Provider

2/28/11

Jennifer G. Wooldridge [JGWooldridge@jcddrb.org]

To: Jake Jacobs [JJacobs@eitas.org]; Ann Graff [agraff@chs-mo.org]; dmiller@endlessoptions.org; doris@cabllc.com; Jan Jones [jan@abilitiesfirst.net]; executive director
Wednesday, April 20, 2011 2:28 PM

I would like to ask for discussion around a concern brought up to me by a provider. It is about the article in a recent ANCOR publication: ***CMS Proposes HCBS Waiver Rules***.

Conversation is developing regarding agencies who are indeed participating in the waiver but may have campus based housing.

The proposed rule changes address not waivering:

- segregated settings with a strong institutional nature;
- such settings clearly do not meet the basic understanding of home and community based settings;
- segregated from larger community;
- do not allow choice with whom to live or share a room;
- limit freedom of choice on daily living experiences – meals, visitors, activities, community activities.

Being as there are a number of "campus-like" residential settings, this warrants discussion at the MACDDS and MARF levels. Other areas of focus should not only be on physical plant but most importantly on culture and practices in specialized settings. Embracing waiver standards and other accreditation guidelines should also be important.

Thanks!

Jennifer

Jennifer Wooldridge, Executive Director
Jefferson County Developmental Disabilities Resource Board/
NextStep for Life™
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