

TARC

Service. Support. Advocacy.

Self Determination Application Instructions

1. The application for services is two (2) pages long (Application and Release of Information). Please complete both forms prior to submitting information.
2. If you have a Guardian, please attach copies of the Letters of Guardianship.
3. Attach a copy of your most recent PCSP and/or school IEP if available.
4. Attach a copy of your most recent BASIS Assessment.
5. Attach a copy of your present Plan of Care.
6. Please be sure to answer all questions listed on the application.
7. Once your application and attachments are in order, please send or deliver to:

**TARC Self-determination Division
ATTN: Mitzie Tyree or Dolores Cummings
2701 Randolph
Topeka, KS 66611
(785) 232-0597**

8. Once the Self-determination division has received your packet, we will contact you to set up an introductory meeting to determine if managing your supports through Self-determination is right for you. We would like attendance by you, your guardian(s) and/or your family member(s), and your case manager to the introductory meeting.
9. Please notify Self-determination if interpreter or alternative format is required.



PHILOSOPHY OF SELF-DETERMINATION

The TARC Self-determination program seeks to give persons with developmental disabilities, their guardians and/or their families, the opportunity to choose or create the supports that will meet their preferred lifestyle. This program allows for more direct control over the funds that an individual deemed eligible to receive. There is greater flexibility in how the money can be spent and allows for an individual to decide how and where the services will be provided.

Values of Self-determination:

- A. **Freedom**- to choose a personal and meaningful lifestyle through non-traditional and traditional sources.
- B. **Authority**- to have control over your own life, with meaningful choices to direct your services and supports
- C. **Support**- allows flexibility and creativity in finding supports to meet your needs and desires.
- D. **Responsibility**-to share and contribute to the world and your community.

How Self-determination works:

- A. **Circle of Support**- to be a participant in the Self-determination program, you must have a strong committed Circle of Support. The Circle members include individuals who are involved in your life: family, friends, neighbors, church members, etc. Circle members must be willing to commit the time and energy to help you make your life what you want. These members must be willing to be there when changes happen to put another plan into action. One person from your Circle of Support will need to become the Personal Administrator of your plan.
- B. **Person Centered Support Plan (PCSP)**- The PCSP involves finding out your dreams and goals and needs to answer the following questions:
 - 1. Where do I want to live and with whom?
 - 2. What work and/or valued activity do I want to do?
 - 3. What do I want to do in my free time?
 - 4. Who do I want to provide my supports?
 - 5. Where and when do I want supports?
 - 6. Other personal and employee information
- C. **Individual Budget**- based on your funding, an individualized budget is created to achieve your PCSP. Certain guidelines must be followed when utilizing HCBS funding, however through Self-determination, there is more creativity and flexibility.



Authorization for Release of Information

I, _____, hereby authorize TARC Inc. Self-determination
(Person Supported or Guardian)
Division to disclose information to, obtain information from, and exchange information with:

- | | |
|--|--|
| <input type="checkbox"/> CDDO | <input type="checkbox"/> Medical _____ |
| <input type="checkbox"/> Kansas Rehabilitation Services | _____ |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Social Rehabilitation Services | _____ |
| <input type="checkbox"/> Local Education Agency, USD _____ | _____ |
| <input type="checkbox"/> CSP _____ | _____ |
| <input type="checkbox"/> CSP _____ | _____ |
| <input type="checkbox"/> CSP _____ | _____ |

Regarding: _____ DOB: _____ SS#: _____
(Person Supported)

The information to be disclosed, obtained or exchanged is:

- | | |
|---|---|
| <input type="checkbox"/> Referral Information | <input type="checkbox"/> Services Rendered |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Release of Records |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Education Records |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Other _____ |
| | (Specify) |

Such information can be: Written Verbal Electronic
(Check all that apply)

The purpose of this disclosure is for providing Self-determination services.

This consent shall remain effective for 90 days after the termination of services unless otherwise specified below. I understand that I may revoke this request in writing at any time except for action already taken.

Specify date, event, or condition upon which the consent will expire: _____

This consent authorizes a copy be considered as valid as the original.

Person Supported

Date

Parent/Guardian/Representative

Date

Witness

Date