



# Hope Haven

## Area Development Center Corporation

1307 Broadway, West Burlington, Iowa 52655 (319)754-4689 [www.hopehavencorp.com](http://www.hopehavencorp.com)

### APPLICATION FOR SERVICES

Date of application: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Applicant: \_\_\_\_\_  
First Middle Last Social Security Number

Address: \_\_\_\_\_  
Street City State Zip Code County

Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Primary Language Spoken In The Home: \_\_\_\_\_  
\_\_\_\_\_

Referred By: \_\_\_\_\_  
Name Relationship to Applicant or Agency/Organization and Title

**What type of services is applicant interested in?**     REC Club     Group Respite  
 Residential     Supported Community Living     Drop In Center  
 Vocational Services:     Evaluation     Work Adjustment     Community Employment  
 Adult Dev. Program     Sheltered Work     Alternative Services     Flexible Serv.

**Education:** Last school attended: \_\_\_\_\_

Last grade achieved: \_\_\_\_\_ Date last attended: \_\_\_\_\_

Special Education:  yes     no

**Work Experience:** Has applicant ever been employed?  yes     no

If yes, type of employment:  Competitive     Sheltered     Supported Employment  
 Work experience through school system

1. Agency or Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
Job responsibilities: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

2. Agency or Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_  
Job responsibilities: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Does applicant receive disability or any other type of support payments? (SSI, SSDI, Pension, etc.)

\_\_\_ yes \_\_\_ no If yes, type of support:

\_\_\_\_\_

Is there a legally appointed guardian? \_\_\_ If yes,

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

Is there a conservator and/or payee and/or power of attorney? \_\_\_ If yes, circle all that apply.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

**Transportation needed/used:**

\_\_\_ RTA \_\_\_ city bus \_\_\_ charter bus \_\_\_ walks \_\_\_ drives \_\_\_ family \_\_\_ Henry Co. van

Is applicant a former client of Hope Haven Development Center? \_\_\_ yes \_\_\_ no

If yes, when: \_\_\_\_\_ What program(s): \_\_\_\_\_

**Living Arrangement**

\_\_\_ independent/spouse \_\_\_ parent(s) \_\_\_ RCF \_\_\_ RCF/MR

\_\_\_ other relative (specify): \_\_\_\_\_ other: \_\_\_\_\_

Does applicant plan to change current living arrangement? \_\_\_ yes \_\_\_ no

If yes, does applicant want Hope Haven to assist with this? \_\_\_ yes \_\_\_ no

**Is applicant currently involved with any other services?** \_\_\_ yes \_\_\_ no

\_\_\_ Case Management \_\_\_ Department of Corrections \_\_\_ DVRS

\_\_\_ Home Care Services \_\_\_ Department for the Blind \_\_\_ IDHS

\_\_\_ Mental Health Services \_\_\_ Community Living Support \_\_\_ SCC

\_\_\_ Area Agency on Aging \_\_\_ Workforce Center \_\_\_ Other Services

Please state names and addresses of any services checked: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Case Manager's or Social Worker's Name: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

**Medical Information**

Attending Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Other Specialist/Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

List all activities or limitations from which applicant is restricted as ordered by physician or attach copy of current physician's order restricting activities, etc. Include limits on work activity, physical activity, work/living environment: \_\_\_\_\_

\_\_\_\_\_

Does applicant currently take any medications? \_\_\_\_\_ yes \_\_\_\_\_ no

Is applicant self-medicating? \_\_\_\_\_ yes \_\_\_\_\_ no

List current medications:

Names	Dose	Frequency	Reason

Does applicant have any of the following:

- |                             |                    |                     |                    |
|-----------------------------|--------------------|---------------------|--------------------|
| Seizures or Convulsions     | _____ yes _____ no | Diabetes            | _____ yes _____ no |
| High Blood Pressure         | _____ yes _____ no | Anemia              | _____ yes _____ no |
| Eating/chewing difficulties | _____ yes _____ no | Incontinence        | _____ yes _____ no |
| Orthopedic Problems         | _____ yes _____ no | Ambulatory Problems | _____ yes _____ no |
| Speech Problems             | _____ yes _____ no | Heart Disease       | _____ yes _____ no |
| Hearing Problems            | _____ yes _____ no | Difficulty Sleeping | _____ yes _____ no |
| Vision Problems             | _____ yes _____ no | Hyperactivity       | _____ yes _____ no |
| Asthma/Hay Fever            | _____ yes _____ no | Psychosis           | _____ yes _____ no |

Aggressive/Self Injurious Behaviors \_\_\_\_\_ yes \_\_\_\_\_ no Sexually Deviant Behaviors \_\_\_\_\_ yes \_\_\_\_\_ no

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Does applicant have any allergies (i.e. Seasonal, food, medications, bees, etc.). Please list, include type of reaction: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does applicant use any assistive devices such as wheelchair, braces, raised toilet seat, etc., or need any specific accommodations: \_\_\_\_ yes \_\_\_\_ no

Explain \_\_\_\_\_

\_\_\_\_\_

Is applicant on a special diet or have dietary restrictions/needs? \_\_\_\_ yes \_\_\_\_ no

Type: \_\_\_\_\_

List any other pertinent medical information - i.e. Any current or chronic medical conditions that the team should be mindful of: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Reason for referral (include barriers to independent living or employment and expectations of the program(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Describe the applicant's criminal history/substance use or abuse: \_\_\_\_\_

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Describe the applicant's relationship with supports, such as family, friends, etc.: \_\_\_\_\_

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\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian/Power of Attorney

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature/Relationship of Person Completing Form

\_\_\_\_\_  
Date