Hope Haven
Area Development Center Corporation

828 North 7th Street, Burlington, IA 52601 *(319)753-6701* *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: _____________

Primary Language Spoken In The Home: ________________

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

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What type of services is applicant interested in?

Residential: ____Site Home ____RCF/ID ____ICF/ID ____RCF (Dual Diagnosis)
____Supported Community Living ____Home Based Habilitation

Day Hab Services: ____Adult Dev Program ____Burlington ____Keokuk ____Mt. Pleasant
____Wapello

Employment Services: ____________ Enclave Follow Along Job Development

____ Group Respite ____ Drop In Center

Is applicant a former client of Hope Haven Area Development Center? ____ yes ____ no

If yes, when: ________________ What program(s): _____________________________________

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: ____

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? ____ yes ____ no If yes,

Name: ______________________________ Relationship: ______________

Address: ____

Home phone: ____________________ Business phone: ____________________

Is there a conservator and/or payee and/or power of attorney? ____ yes ____ no If yes,

Name: ______________________________ Relationship: ______________

Address: ____

Home phone: ____________________ Business phone: ____________________

Education: Last school attended: ______________________________

Last grade achieved: ______________ Date last attended: ____________________

Current 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

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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: ______________________________

Medical Information

Attending Physician: ______________________________________ Phone: ___________________

Address: ____

Other Specialist/Psychiatrist: ________________________________ Phone: ___________________

Address: ____

Dentist: ____ Phone: ___________________

Address: ____

Primary Diagnosis: ____

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: ____

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____

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

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

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____

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: ____

Date of last physical exam:_____________physician and address:________________________________
Date of last dental exam: _____________ dentist and address: _________________________________
Date of last tb test: ___________________by and address:_____________________________________
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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____

What type of insurance does the applicant hold: Please list insurance company, policy holder, and policy number:

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Please specify member ID if enrolled with an MCO: __________________________

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

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How did you hear of Hope Haven?____

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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

Form #100
JE/PE/ms rev. 12/06
CW/cw rev. 4/10
SD/sd rev 2/20