Caring Hands & More
1556 1st Ave Suite B
Iowa City, IA 52240
319-337-8922

Applicant Information

Last Name: _____ First Name: _____

Current Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____

Birth Date: ____ _____ _____ Sex: ___ **Height: ____ Weight: _____**

Social Security Number: _____-_____-_____

Medicaid ID Number: _____

Primary Disability (Degree and Type):_____

Other Diagnoses and Conditions:
_____
_____

Primary language and method of communication:
_____

Service(s) Funding Information

County of Financial Responsibility:_____
_____

Funding: HCBS/Waiver eligible: ____ Yes ____ NO _____ Others (Specify) _____
_____

Case Manager/ Social Worker:_____

Phone: _____E-mail:_____

Address: _____

City:_____ State:_____
County: _____ State: _____Zip Code: _____

Family Information

Father's Name: _____

Phone: Home: _____ _____ _____ Cell: _____ _____ _____ Work: _____

Address: _____

Mother's Name: _____

Phone: Home: _____ _____ _____ Cell: _____ _____ _____ Work: _____ _____

Address: _____

Involved Family Members: Address/Phone Number

_____
_____
_____
_____
_____
_____
_____
_____ _____

Supervision Information

What level of supervision is necessary? _____ 24 hours a day _____ can be left alone

If can be left alone, how long and where (at home/in the community)?_____
_____

If can be left alone, do you take the bus or do activities in the community on your own?_____

Other community agencies involved: Contact Person/Address/Phone

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Additional Information About the Applicant

Service(s)

Please Check the Service(s) Applying for:

A. Residential Programs:

_____ Group Living (2-4 person HCBS Waiver Home)
_____ Individually (One person supervised apartment)
_____ Payee Services

B. Hourly Support Services:

_____ SCL (Supported Community Living)
_____ Respite Services
_____CDAC-Consumer Directed Attendant Care

Financial / Legal Information

Do you receive financial assistance? i.e. (SSI, SSDI, and Trust Fund) ____Yes ____No

If yes, list type of assistance: _____ Monthly Amount: $ _____

Income other than financial assistance (monthly Amount) $_____

-Do you have a payee? ____Yes____ No **-Bank Account:** ___Yes ___ No

-Other Assets / Resources: _____

Guardianship

If applicable, who has legal custody or guardianship? ____ Mother ____ Father _____ Both Parents

If other than parents, please specify: Name: _____

Address: _____

Phone: _____ Date of guardianship: _____

PLEASE ATTACH A COPY OF GUARDIANSHIP PAPERS WITH THIS APPLICATION.

Medical Information

List of Current Medications:

Medication	Dose	Frequency	Route	Purpose

Other Medical Information

Current Doctor: _____ Date of last exam: _____
Address/Phone: _____

Current Dentist: _____ Date of last exam: _____
Address/Phone: _____

Current Pharmacy: _____
Address/Phone: _____

Current Psychiatrist: _____ Date of last exam: _____
Address/Phone: _____
Reason for the visit: _____

Other Specialist: _____ Date of last exam: _____
Address/Phone: _____
Reason for the visit: _____

ALLERGIES:
Are you allergic to:

Medication? ___Yes ___ No If yes, please explain: _____

Food? ___Yes ____No If yes, please explain: _____

Other? ___Yes ____No If yes, please explain: _____
_____

DIET
Are you on a special diet? ___Yes ___ No If yes please explain: _____
_____
_____

SEIZURES
Do you have seizures? __Yes ___ No Frequency of seizures:_____

Describe a typical seizure: _____

List all activities or limitations you are restricted from as ordered by a medical doctor: _____
_____
_____

Do you have any physical disabilities that require the use of special devices? (Wheelchair, braces, walker, orthopedic shoes, splints, canes, etc.) Please explain: _____
_____
_____

Are you able to communicate medical needs/concerns? __ Yes __ No Please explain: _____
_____
_____

Illnesses Experienced: *Please check all that apply*

-Chicken Pox __ -German measles __ -Pneumonia __-Measles __ -Polio __ -Croup __
-Mumps __ -Whooping Cough __ -Tuberculosis __ -Scarlet Fever __ -Rheumatic Fever __ -Hepatitis __

FEARS:
Do you have any fears that would be important for us to know? (Heights, dogs, enclosed spaces, etc.)
_____
_____

Educational / Vocational/ Employment Information:

Employer / School / Agency: _____

From: _____ to: _____ Address _____

City _____State_____ Zip_____

Job Responsibilities: _____

Reason for Leaving: _____

Employer / School / Agency: _____

From: _____ to: _____ Address _____

City _____State_____ Zip_____

Job Responsibilities: _____

Reason for Leaving: _____

Please complete the following skills check list

Please check the items which best describe your abilities

Eating/Drinking Needs assistance with eating/drinking	**Yes**	**No**	**Comments:** **Prompts/instructions needed**
Able to eat independently			
Uses adaptive devices			
Dressing Needs assistance with dressing			
Able to dress independently			
Personal Hygiene Needs assistance with hygiene			
Completes hygiene tasks independently			
Uses adaptive devices			
Toileting Uses incontinent aids			
Uses a toileting schedule			
Can indicate need to use toilet			
Needs assistance transferring on/off toilet			
Independently cares for menstruation needs			
Medications Needs assistance when taking meds			
Takes meds independently			
Cooperates with taking meds			
Chores & Activities Does household tasks with assistance			
Does household tasks independently			
Does laundry with assistance			
Does laundry independently			
Cooks meals with assistance			
Cooks meals independently			
Requires supervision in public			
Makes purchases with assistance			
Makes purchases independently			
Uses public transportation with assistance			
Uses public transportation independently			
Pursues leisure interests independently			
Sleeping Habits Sleep thought the night			
Has a routine for sleep			

	Yes	No	Comments: Prompts/instructions needed
Sleep walks			
Experiences sleep disorders			
Wakes with alarm independently			
Needs assistance with waking in morning			
Sexuality Displays sexually appropriate behavior			
Is sexually active			
Communication Communicates verbally			
Communicates with devices			
Communicates by signing			
Understands speech			
Follows simple directions			
Talks on the telephone			
Knows how to dial a phone number			
Prints/writes			
Independently asks for help when needed			
Social Relations Interacts with peers			
Interacts with members of opposite sex			
Participates in group activities			
Maintains friendships			
Engages in dating			
Has a significant other			
Prefers to be alone			
Safety Issues Responds to smoke alarms			
Knows how to use basic first aid			
Knows what to do in case of a natural disaster (ex. tornado)			
Behavior Information Hyperactive			
Withdraws			
Makes disruptive noises			
Displays self-stimulating behaviors			
Displays harmful/self-injurious behaviors			
Mistreats property			
Is aggressive/abusive toward others			
Leaves home/work without supervision			
Has a history of substance abuse			
Has been arrested			
Has verbal outburst (swearing or yelling)			

This application was completed by:

Name_____ Phone_____
Relationship to applicant_____