Hills & Dales

AG115

APPLICATION FOR SERVICES

NAME: ____
Last First Middle

ADDRESS: ____**D.O.B.**__________________
Street (Including Apt. #) City/State/Zip

PHONE: (_________**)**_______________________ **SOCIAL SECURITY #:** _________-_______-__________

SEX: ☐ female ☐ male **HEIGHT:** __________ **WEIGHT:** __________ **EYES:** __________ **HAIR:** __________

MEDICAID #_____________________**EFFECTIVE DATE:** __________________ **STATE ISSUED:** __________

MCO: ___________________________**MCO #:** _______________________

MEDICARE # ____________________ **EFFECTIVE DATE:** _________________ **STATE ISSUED:** ___________

PRIVATE HEALTH INSURANCE NAME: ____

INSURANCE GROUP #: ______________________ ______**POLICY #:** _____________________________

INSURANCE TELEPHONE #: (______**)** ____________________________________

POLICY HOLDER _______________________**SOCIAL SECURITY # OF POLICY HOLDER:** _____-______-______

PLACE OF EMPLOYMENT: ____

WHO REFERRED YOU TO US? : ____

Type of Service Requested

☐ ICF/ID ☐ Respite ☐ Hourly SCL ☐ 24hr SCL (Dubuque/Davenport) ☐ Day Hab (Dubuque/Davenport)

☐ Applied Behavior Analysis (Autism ABA) ☐ Other ____________________

Employment Services

☐ Discovery ☐ Work Place Readiness ☐ Job Development ☐ Job Coaching ☐ Enclave/Crew

Legal and Financial Information

County of Legal Residence: ____
Is the individual adopted: ☐ yes ☐ no (if yes, please attach adoption record)
Case Manager: _________________________________Telephone No: (______) ________-________________
Address: ____

DHS/County Contact:___________________________ Telephone No: (______) ________-________________
Address: ____

Is ICF/ID placement court ordered: ☐ yes ☐ no
ID Waiver Tier Assignment? __________________________ Date of last SIS Assessment? _____________________
Does the applicant have a legally appointed guardian?: ☐ yes ☐ no ☐ pending ☐ temporary guardian only
If yes, who has legal custody or guardianship? ☐ Mom ☐ Dad ☐ Both Parents ☐ Other
If other than parents please specify: ____
name address phone relationship
Date the custody/guardianship was established: _______________ ***(Please attach court decrees)***
Does the applicant have a legally appointed conservator?: ☐ yes ☐ no ☐ pending ☐ temporary
If yes, who is the applicant's conservator?: ____
name address phone
Date the conservatorship was established: _______________ ***(Please attach court decrees)***

Services Received (Current & Previous)
(eg. Residential placement, Work site involvement, Extended year school programming, Waiver-Community based treatment, Respite, Supported Community Living, Rehabilitative Treatment Support Services (RTSS); BI Waiver).

Agency	Type of Services	Dates
____________________________	______________________________	___/___/___ to ___/___/___
____________________________	______________________________	___/___/___ to ___/___/___
____________________________	______________________________	___/___/___ to ___/___/___

Previous Living Arrangements:
____ ___/___/___ to ___/___/___
____ ___/___/___ to ___/___/___

Family Information & Emergency Contacts

1. Father's Name: ____ ☐Check if deceased
Address: ____
City/State/Zip: ____
Telephone#: (____) _________ Date of Birth ___/___/___ Social Security #: ________-________-_________
Work Phone#: (____)________ Cell Phone#: (____)__________ Fax #:(____)__________
Email Address: __________________________ Military Service ☐ No ☐ Yes What Branch? ____________
May we contact this person to get additional information? ☐ Yes ☐ No

1. Mother's Name: ____ ☐Check if deceased
Mother's Maiden Name: ____
Address: ____
City/State/Zip: ____
Telephone#: (____) _________ Date of Birth ___/___/___ Social Security #: ________-________-_________
Work Phone#: (____)________ Cell Phone#: (____)__________ Fax #:(____)__________
Email Address: __________________________ Military Service ☐ No ☐ Yes What Branch? ____________
May we contact this person to get additional information? ☐ Yes ☐ No

(please list siblings oldest to youngest)
3. Sibling's Name: ____ ☐ Check if deceased
Address: ____
City/State/Zip: ____
Date of Birth ___/___/___ Do you have contact with this brother/sister? ☐ Yes ☐ No

Sibling's Name: ____ ☐ Check if deceased
Address: ____
City/State/Zip: ____
Date of Birth ___/___/___ Do you have contact with this brother/sister? ☐ Yes ☐ No

Sibling's Name: ____ ☐ Check if deceased
Address: ____
City/State/Zip: ____
Date of Birth ___/___/___ Do you have contact with this brother/sister? ☐ Yes ☐ No

(please use an additional sheet of paper if needed)

4. Alternate Emergency Contact:

Name: ____ Relationship: ___________

Address: ____

City/State/Zip: ____

Work Phone#: (____) __________ Cell Phone#: (_____) ___________ Fax #: (_____) _______________

Email Address: _________________________

Education History

1. School Name: ____

Address: ____

City/State/Zip: ____

Dates Attended: From ____/____/____ to ____/____/____

Did you receive any of the following: ☐ Diploma ☐ GED ☐ Certificate of attendance

School Name: ____

Address: ____

City/State/Zip: ____

Dates Attended: From ____/____/____ to ____/____/____

Did you receive any of the following: ☐ Diploma ☐ GED ☐ Certificate of attendance

School Name: ____

Address: ____

City/State/Zip: ____

Dates Attended: From ____/____/____ to ____/____/____

Did you receive any of the following: ☐ Diploma ☐ GED ☐ Certificate of attendance

School Attendance: ( ) Full Days ( ) Half Days

( ) Homebound ( ) None

Ride School Bus? ☐ Yes ☐ No

Have you ever been tested by a psychologist? ☐ Yes ☐ No Results:_____________________

Date of testing:_____/_____/_____

Date of last IQ test (if known): ____/____/____

If yes, by whom? Name: ____

Address:____

City/State/Zip: ____

Current Medical

*Not required for Employment Services

Primary Physician's Name: ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Dentist's Name ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Neurologist's Name: ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Orthopedic Doctor's Name: ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Psychiatrist's Name: ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Counselor's Name: ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Other Specialist's Name: ____
Address:____
City/State/Zip: ____
Date of last exam: ____/____/____ Telephone #: (_____)_______-___________

Employment History

Please list your most recent job first. Include all full-time and part-time employment, including sheltered workshop experiences, as well as military service assignments and volunteer activities. Attach an additional sheet if necessary.

1. Company Name: ____

Address: ____

City/State/Zip: ____

Employment Dates: From ____/____/____ to ____/____/____ Position/Title: ________________________

Supervisor: ____ Work performed: ___________________________

____

Major strengths and contributions in this position: ____

____

May we contact this employer as a reference: ☐ Yes ☐ No

Is this a sheltered workshop? ☐ Yes ☐ No

2. Company Name: ____

Address: ____

City/State/Zip: ____

Employment Dates: From ____/____/____ to ____/____/____ Position/Title: ________________________

Supervisor: ____ Work performed: ___________________________

____

Major strengths and contributions in this position: ____

____

May we contact this employer as a reference: ☐ Yes ☐ No

Is this a sheltered workshop? ☐ Yes ☐ No

Previous employment Services: ____ Provider: _____________________

____ Provider: _____________________

____ Provider: _____________________

If requesting Employment Services what is desired: ____

Hours available

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Transportation available: ____

____

Financial Resources

Is the applicant eligible or have any of the following:

Savings Account ( ) Yes ( ) No
Veterans Benefits ( ) Yes ( ) No
Other SSA Benefits ( ) Yes ( ) No
SSI ( ) Yes ( ) No
Checking Account ( ) Yes ( ) No

Burial Account ( ) Yes ( ) No
Life Insurance ( ) Yes ( ) No
Trust Fund ( ) Yes ( ) No
Conservatorship ( ) Yes ( ) No
Adoption Subsidy ( ) Yes ( ) No
Other: (please describe) ____________________
____

Medical History

Do you have any of the following disabilities?

☐ Intellectual Disability ☐ Autism ☐ Cerebral Palsy ☐ Mental Health/Illness ☐ Personality Disorder

☐ Schizophrenia or Schizoaffective Disorder ☐ other (please specify): _________________________________

Do you have a physical disability? ☐ Yes ☐ No If yes, please explain: ____

Do you use any of the following?

☐ wheelchair ☐ walker ☐ brace(s) (please specify) ______________☐ other (please specify) _______________

Do you experience seizures? ☐ Yes ☐ No If yes, please explain: ____

Describe the type of seizure you experience: ____

How long do your seizures last? ____

In the past year, how frequently have you had seizures? ____

Age of seizure onset? _____________ Date of last seizure: _____/_____/_____

Please list medications that you have taken in the past for your seizures:

____

____

____

____

____

Please indicate any of the following illnesses you have had:

☐ Diabetes ☐ High Blood Pressure☐ Hepatitis ☐ Tuberculosis ☐ Heart Problems ☐ Stomach Problems

☐ Cancer ☐ Substance/Alcohol Abuse ☐ Other (please specify): ____

Have you been in the hospital recently? ☐ Yes ☐ No
If yes, please explain: ____
____
Name of hospital & dates hospitalized: ____
____

Have you had any surgeries? ☐ Yes ☐ No
If yes, please explain: ____
____

Name of hospital & dates hospitalized: ____

____

Do you require a special diet? ☐ Yes ☐ No If yes, please explain: ____

____

Do you have a gastrostomy tube for nutrition/hydration? ☐ Yes ☐ No If yes, please explain: _________________

____

What formula? ____

Do you take anything orally? ____

Do you require staff be trained in special health procedures (i.e. ostomy care, positioning, adaptive devices, etc.)?
☐ Yes ☐ No If yes, please specify: ____

Please list **current** medications, dosages, and reason you are taking them: __________________________________

____

____

____

____

Do you need assistance in taking your medication? ☐ Yes ☐ No If yes, please explain: ______________________

____

Do you have any allergies? ☐ Yes ☐ No If yes, please list known allergies & reactions: ______________________

____

____

____

Name and address of preferred mortician (if none is listed, one will be assigned by the agency):

Name: ____

Address: ____

Sensorimotor Abilities

Do you wear a hearing aid? ☐ Yes ☐ No

When was your last hearing evaluation? ____

By whom? ____

Describe your hearing loss: ____

____

Do you wear glasses? ☐ Yes ☐ No

Describe your visual impairment: ____

Describe your physical mobility: ____

____

Describe your ability to use your upper extremities: ____

____

Describe your communication skills: ____

____

Do you use a communication device? ☐ Yes ☐ No

If yes, explain: ____

Daily Routine

Describe a typical day: ____

____

____

____

Describe leisure activities you enjoy: ____

____

____

Any non-preferred daily activities? ____

Please indicate the amount of supervision required for the following:

Shaving: ____

Bathing: ____

Toothbrushing/Dental Care: ____

Dressing: ____

Toileting: ____

Nail Care: ____

Hair Care: ____

Eating: ____

Food Preferences: ____

Food Dislikes or Allergies: ____

Sleep Habits/Naps: ____

Cleanliness and Neatness: ____

Fears: ____

Cultural Information

Identify cultural practices or traditions important to you: ______________________________

____

____

Behavior

Indicate the frequency of each behavior:

(**Frequently** = several times a week; **Occasionally** = less than once a month)

Self Stimulatory Behavior ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Remove/Tear Own Clothes ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Eat/Drink Inappropriate Items ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Tantrum or Outburst ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Disrupt Others' Activities ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Verbally or Gesturally Abusive ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Self injurious ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Resist Supervision ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Destroy Property ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Display Sexually Inappropriate Behaviors ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Run Away ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Physically Assault Others ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Describe: ____

Steal ☐ Daily ☐ Frequently ☐ Weekly ☐ Monthly ☐ Occasionally ☐ None

Please list medications you have taken in the past for behavioral concerns: ______________________________
____
____

Describe precautions taken in your home to insure or provide safety for you and others (closed or locked doors, restraints, bedrails, alarm system/monitors, night lights, room arrangements, articles placed out of reach, etc.)

____
____
____
____

Legal History

Have you ever been convicted of a crime? ☐ Yes ☐ No
If yes, of what and when? ____
____
____
____

Future Goals

What do you expect to gain from services at Hills & Dales? ____
____
____
____

Applicant: ____ Date: ______/_____/______

Application completion support person: ______________________________________ Date: _____/_____/_____

Relationship to applicant: ______________________________________ Telephone #: (_____) ___________________

PLEASE RETURN TO:

Hills & Dales Child Development Center

1011 Davis Street

Dubuque, IA 52001

Phone: (563) 584-2276

Fax: (563) 557-3822

Revised: 12/12/19hmc, 4/4/18hmc, 3/6/18hmc, 1/26/18hmc, 5/2/17tmr, 7/10/06 tkp, 7/19/06 hmb, 06/06/07 tkp, 8/29/07hmb

Date: 1/20/05 TKP

ATTACHED: Notice of Privacy Practices (AG517)