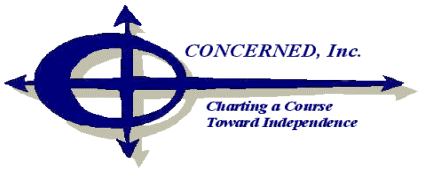

Name: _____
DOB: _____
XIX#: _____

CONCERNED, INC.
APPLICATION FOR SERVICES

Please return to: Concerned, Inc., 1812 Industrial Pkwy., P.O. Box 47, Harlan, Iowa 51537
Phone: (712) 755-5834 Fax: (712) 755-7775 Website: www.concernedinc.com

The mission of Concerned, Inc. is to empower people to obtain their highest level of independence. Upon enrollment into a Concerned, Inc. program, services will be provided without regard to race, color, creed, national origin, age, disability, sex, marital, familial, or parental status, religion, sexual orientation, genetic information, political beliefs, or status with regard to public assistance.

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PERSONAL INFORMATION

1. Name: _____(Last) _____ (First) _____ (Middle)

2. Street Address: _____

City/State/Zip: _____

3. Phone Number: _____ **4.** Date of Birth: _____

5. Social Security Number: _____ **6.** Title XIX Number: _____

7. Medicare Number: _____ **8.** Funding Source (MCO, region, etc.): _____

9. Case Worker Name/Address/Phone No.:

_____

_____

10. IVRS Counselor Name/Address/Phone No.:

_____

_____

11. Does Applicant have a Legal Guardian? (Choose One): _____ YES _____ NO

Guardian Name: _____

Guardian Address: _____

Guardian Phone No.: _____

12. Emergency Contact Name/Address/Phone No.:

_____

_____

13. Referred By Name/Address/Phone No.:

_____

_____

Name: _____
DOB: _____
XIX#: _____

FAMILY INFORMATION

14. Father's Name: _____

Address: _____

Phone Number: _____ Email Address: _____

15. Mother's Name: _____

Address: _____

Phone Number: _____ Email Address: _____

16. List other family members with whom Applicant has interaction with:

a. Name/Address/Phone No.: _____

_____

b. Name/Address/Phone No.: _____

_____

c. Name/Address/Phone No.: _____

_____

17. Is there anyone that the Applicant should not see or visit? _____ If yes, who? _____

_____

MEDICAL INFORMATION

18. Primary Diagnosis: _____Code:_____

19. Please list any/all Secondary Diagnoses:

_____

_____

20. Doctor Name/Address/Phone No.:

_____

_____

Doctor Name/Address/Phone No.

_____

_____

21. Medications taken (Name/Dose/Time Taken):

_____

_____

_____

_____

Name: _____
DOB: _____
XIX#: _____

22. Any known allergies? _____

23. Are there any medical restrictions?

_____

_____

24. Have there been any recent hospitalizations? (If yes, please explain):

_____

_____

25. Please check any of the following conditions that apply to the Applicant:

_____ Respiratory (asthma, emphysema, cystic fibrosis, etc.)
_____ Cardiovascular (heart disease, high blood pressure, etc.)
_____ Gastro-Intestinal (ulcer, colitis, liver, bowel problems, etc.)
_____ Neoplastic Diseases (cancer, tumors, etc.)
_____ Neurological Diseases (MS, Organic Brain Disorder, ALS, etc.)
_____ Tuberculosis
_____ Hearing Problems
_____ Vision Problems
_____ Physical Mobility Problems

Please provide an explanation of all conditions checked above:

_____

_____

_____

26. Does the Applicant have a history of Epilepsy Seizure Disorders? _____ YES _____ NO

27. Which types of seizures has the Applicant experienced in the last 12 months? (Check all that apply):

_____ None
_____ Simple partial (simple motor movements affected, no loss of awareness)
_____ Complex partial (loss of awareness)
_____ Generalized/Absence (Petit Mal)
_____ Generalized/Tonic-Clonic (Grand Mal)
_____ Some type of seizure, but not sure what category.

28. In the past 12 months, how frequently has the Applicant experienced seizures that involve loss of awareness and/or confusion?

_____ None
_____ Less than once a month
_____ About once a month
_____ About once a week
_____ Several times a week
_____ Once a day or more

29. Date of last observed seizure: _____

30. Any other medical areas of assistance that the Applicant may need?

_____

_____

Name: _____
DOB: _____
XIX#: _____

31. Is Applicant on a special diet? _____ YES _____ NO explain: _____

32. Does the Applicant have a DNR (do not resuscitate) order? _____YES _____ NO
* If yes, legal documentation must be attached.

33. Please list any adaptive equipment Applicant uses: _____

_____

34. Does adaptive equipment require maintenance: _____ YES _____ NO

If yes, explain: _____

35. Name/Address/Phone Number of preferred pharmacy: _____

_____

FINANCIAL INFORMATION

36. Does Applicant receive any of the following (Check all that apply):
_____ SSI – Amount: $_____ monthly
_____ SSDI – Amount: $_____ monthly
_____ Social Security: $_____ monthly
_____ Earned Income: $_____ monthly
_____ Other Income: source _____ & $ _____ monthly

37. Does Applicant have a Representative Payee? (Name/Address/Phone No.):

_____
_____

EMPLOYMENT/VOCATIONAL INFORMATION

38. Current Employer (Name/Address/Phone No.):

_____
_____

39. Please describe past work experiences:

_____
_____

40. What type of work is the Applicant interested in?

_____
_____

TRANSPORTATION INFORMATION

41. What method does Applicant use to get to and from work?
_____ Has driver's license _____ Has a car and insurance _____ Needs insurance
_____ Utilizes SWITA van _____ Relies on Agency Transportation _____ Family provides transportation
_____ May be able to get driver's license with training _____Walks independently (Street Safe)

Name: _____
DOB: _____
XIX#: _____

EDUCATIONAL INFORMATION

42. Middle/High Schools Attended/Attending (Name/Address/Phone No.):

_____

_____

43. Has Applicant graduated from High School? _____ YES _____ NO

44. Has Applicant received a GED? _____ YES _____ NO

45. College/Trade/Business Schools attended (Name/Address/Phone No.):

_____

_____

46. Applicant's reading abilities:

_____ Reads independently _____ Limited reader _____ Non reader

47. Applicant's money skills:

_____ Knows bills _____ Knows change _____ Keeps own checkbook
_____ Needs assistance with checkbook _____ Requires dual checking

MISCELLANEOUS INFORMATION

48. How many hours per day is Applicant interested in working? _____

49. How many days per week is Applicant interested in working? _____

50. Is there any other information that Applicant would like to share with us?

_____

_____

Please answer these optional questions:

Sex: ☐ Male ☐ Female

Ethnic Origin:
☐ Hispanic or Latino
☐ American Indian/Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Other _____

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APPLICANT'S SIGNATURE OR MARK: _____

SIGNATURE OF PERSON COMPLETING APPLICATION: _____

DATE: _____

==========

FOR OFFICE USE ONLY:

Date Application Received: _____ **Date of Intake Team Meeting:** _____

Date of Referral Meeting: _____

Name: _____
DOB: _____
XIX#: _____

An important part of the Application Process is deciding which services you would like to receive from Concerned, Inc. Listed below are the names and a brief description of each service offered at Concerned, Inc.
Please take a moment and read each description. Then place an "X" beside each service you may be interested in receiving, or would like additional information about.

_____ **HOURLY BASED SERVICES**

Hourly Based Services are in place and the Hourly Services Coordinator can help you navigate this program. This program is for children or adults who need support to remain in the community. The Hourly Services Program consists of the following major components:

- **Supported Community Living (SCL) –** For any child or adult who meets the criteria. Services can be provided daily to support individuals with their daily living skills in their home or community such as grocery shopping, attending doctor's appointments, and guidance with other daily living activities.
- **Respite –** For any adult or child living at home with family or guardians. Provides short-term relief to the individual's caregiver.

_____ **RESIDENTIAL BASED SERVICES (Site)**

Residential Based Services (Site) are in place and the Site Services Coordinator can help you navigate this program. This program is for people ages eighteen and older who need support with their daily living skills in a residential setting. Persons using this service live in a residence with two to three roommates and can receive assistance with medications, personal hygiene, healthy living, shopping, etc.

_____ **SUPPORTED EMPLOYMENT SERVICES**

If you apply for Employment Services and qualify for this service, the Supported Employment personnel will assist you in preparing for and getting a job in the community. The Employment Specialist will take you to explore and possibly even try out a job of your choice. Once you get a job offer, the Employment Specialist will then help you learn your new job duties. The Supported Employment staff along with your county Case Manger or Iowa Vocational Rehabilitation Counselor will make contacts with you and your employer for as long as you keep your job and funding is available.

_____ **ADULT DAY SERVICES**

Adult Day Services offers you the choice not to work. Whether you are ready to retire, physically or mentally unable, or you just do not wish to work, our Adult Day Services program is right for you. Following HCBS Day Habilitation guidelines you choose a community activity for the day through this program to help you develop or maintain your independence. The Adult Day Coordinator will work with you to get the following services in place: Adult Day Care or Day Habilitation Services, Assistive Devices, and In-Home Respite Care (a relief to caregivers).

_____ **REPRESENTATIVE PAYEE SERVICES**

This service assists you with managing your money. Staff will help you with check writing, paying your bills, and manage other aspects of your personal income based on what your needs and level of independence with these tasks are.

Revised: 6/5/06, 11/10/06, 1/30/07, 4/01/2008, 5/9/08, 1/9/2012, 10/1/2019, 2/8/24