



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, religion, gender, age, disability, marital status, national origin, status with regard to public assistance, socioeconomic status, language, sexual orientation, or membership in an organization.

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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. County of Legal Settlement: _____

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

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

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

Guardian Name: _____

Guardian Address: _____

Guardian Phone No.: _____

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

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

FAMILY INFORMATION

Name: _____
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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): _____

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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? _____

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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. Previous Sheltered Workshops Attended: _____

40. Please describe past work experiences: _____

41. What type of work is the Applicant interested in? _____

TRANSPORTATION INFORMATION

42. 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)

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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.

ORGANIZATIONAL EMPLOYMENT SERVICES

Concerned, Inc.'s Organizational Employment Program is designed to help you learn the work and life skills needed to become more independent. The Client Services Coordinator and Production Services Coordinator work together to assist you in meeting your goals in this program. Concerned, Inc. will provide various work contracts that you will be paid for working on. The Production Services Coordinator will assist you in completing these job duties. Some of the different jobs worked on include hand packaging, mail handling, cleaning jobs and assembly work. The Client Services Coordinator is your Advocate and helps you set up your goals and find training in the area in which you would like to find a job.

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. One to 24 hours 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 five roommates and can receive assistance with medications, personal hygiene, healthy living, shopping, etc.

COMMUNITY EMPLOYMENT SERVICES

If you apply for Employment Services and qualify for this service, the Community 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 Community Employment staff along with your county Case Manager 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 don't wish to work, our Adult Day Services program is right for you. Following HCBS Day Habilitation guidelines a structured curriculum of activities and daily living skills classes would be available to you 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.