CENTRAL IOWA RESIDENTIAL SERVICES, INC.

111 East Linn St. • P.O. BOX 1356
MARSHALLTOWN, IOWA 50158
Phone (641) 752-5762 • Fax (641) 752-9514

APPLICATION
FOR ADMISSION

PERSONAL INFORMATION

Applicant's Full Name | Birthdate | Current Address

City | State | Zip | Phone #

County of Legal Settlement: _____ County & State Where Born: _____

Religion: _____ Social Security Number: _____

Sex: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Marital Status: ( ) Single ( ) Married

Natural Parents:

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

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

Employer: _____ Employer: _____

Social Security Number: _____ Social Security Number: _____

Cell Phone: _____ Cell Phone: _____

Mother's Maiden Name: _____

Foster or Adoptive Parents:

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

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

Employer: _____ Employer: _____

Cell Phone: _____ Cell Phone: _____

Spouse:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Employer: _____

Cell Phone: _____

Brothers, Sisters, Grandparents or Significant Others:

Name	Address	Phone	Birthdate	Relationship

Persons To Contact In Case of Emergency:

Name	Address	Home Phone	Cell Phone	Work Phone

Persons Not Allowed Visits or Phone Contact:

Name _____ Relationship _____

_____

_____

LEGAL AND FINANCIAL INFORMATION

Legal Information:

Does the Applicant have a Legal Guardian? ( ) Yes ( ) No

If Yes, who is the guardianship:

_____

Name Address Phone Relationship

Does the Applicant have a conservator? ( ) Yes ( ) No

If Yes, who is the Applicant's conservator:

_____

Name Address Phone

*** The Agency will request a copy of Guardianship and/or Conservatorship papers.**

Funding Information:

Does the Applicant receive financial assistance? ( ) Yes ( ) No

SSI _____ Social Security (SS) _____ Parents _____ Other _____

Amount Amount Amount Amount

Has a payeeship for SSI or SS been established? ( ) Yes ( ) No

_____

Payee's Name Address Phone

Time Certificates/CD's ( ) Yes ( ) No Where: _____

Savings Account ( ) Yes ( ) No Where: _____

Checking Account ( ) Yes ( ) No Where _____

Burial Fund ( ) Yes ( ) No Where: _____

Life Insurance ( ) Yes ( ) No

Company: _____ Policy Number: _____

Face Value: _____ Cash Value: _____

Receiving low rent housing? ( ) Yes ( ) No Receiving food stamps? ( ) Yes ( ) No

Trust Fund: ( ) Yes ( ) No Where: _____

MEDICAL COVERAGE

Does the Applicant have Medicaid (Title 19) benefits? ( ) Yes ( ) No

Medicaid Number (Title 19): _____

Does the Applicant have Medicare benefits? ( ) Yes ( ) No

Medicare Number: _____

Does the Applicant have Medicare D Prescription Drug Coverage?

Company: Policy Number:

Does the Applicant have private health insurance? ( ) Yes ( ) No

Company: Policy Number:

Policy Holder: _____

APPLICANT'S NEEDS

Health Needs:

Activity/Equipment/Special Devices

List all activities or limitations the Applicant is restricted from as ordered by a medical doctor:

Does the Applicant have any physical disabilities that require the use of special devices? (Wheelchair, braces, walker, orthopedic shoes, splints, canes, etc.)

Please list:

Diet:

Is the Applicant on a special diet as ordered by a doctor? ( ) Yes ( ) No

Reason for diet: _____

Type of diet: _____ Doctor: _____

Medications:

Name	Dosage	Time Taken	Reason for Medication

Is the person self-medicating? ( ) Yes ( ) No

Allergies:

The Applicant is allergic to: _____

Medications? ( ) Yes ( ) No Food? ( ) Yes ( ) No Other? ( ) Yes ( ) No

Please List: Type of Reaction:

Medical Problems:

Is the Applicant prone to or have any of the following disorders? (Please check if YES)

☐ Asthma	☐ Diarrhea	☐ Strep Throat	☐ Nose Bleeds	☐ Skin Breakdown
☐ Colds	☐ Diabetes	☐ Urinary Tract Infections	☐ Ear Infections	
☐ Constipation	☐ Bladder Infections	☐ Vaginal infections	☐ Other _____	

Other: _____

Does the Applicant consult with a specialist? ( ) Yes ( ) No Doctor: _____

Seizure Disorders:

Does the Applicant have seizures? ( ) Yes ( ) No

Is a protective helmet or head gear required? ( ) Yes ( ) No

Age of seizure onset: _____ Date of last seizure: _____

Type of seizure and frequency: _____

Describe seizures: _____

Illnesses (List year):

Chicken Pox _____ German Measles _____ Pneumonia _____

Measles _____ Polio _____ Croup _____

Mumps _____ Whooping Cough _____ Tuberculosis _____

Scarlet Fever _____ Rheumatic Fever _____ Hepatitis _____

Other: _____

Hospitalization:

List all operations, injuries or illnesses the Applicant suffered which required hospitalization. List admitting doctor, date, hospital address and nature of hospitalization(s):

Doctor | Date | Hospital | Why Applicant was Hospitalized

_____

_____

_____

Immunizations: (The agency will request a copy of immunizations)

List of Current Doctors:

Medical Doctor: _____ Date of Last Exam: _____

Address: _____

Current Dentist: _____ Date of Last Exam: _____

Address: _____

Does the Applicant have dentures? ( ) Yes ( ) No

Current Eye Doctor: _____ Date of Last Exam: _____

Address: _____

Does the Applicant wear glasses? ( ) Yes ( ) No

Current Ear Doctor: _____ Date of Last Exam: _____

Address: _____

Does the Applicant have a Hearing Aide? ( ) Yes ( ) No

List Preferences:

Pharmacy: _____
Name | Address | Phone

Mortician: _____
Name | Address | Phone

RESIDENTIAL NEEDS

What service(s) is the applicant requesting from CIRSI?

Respite ( ) Yes ( ) No

Adult Day Care ( ) Yes ( ) No

Payee ( ) Yes ( ) No

Supported Community Living Hourly ( ) Yes ( ) No

Supported Community Living Daily ( ) Yes ( ) No

Please list other residential programs which have provided the Applicant services:

Program | From | To

Reasons the Applicant left program: _____

_____

_____

FOR CHILDREN

Educational Needs:

Is the Applicant attending a local school program? ( ) Yes ( ) No If so, teacher's name: _____

Name/Address of School | Grade/Level | Dates Attended | Year Graduated

_____

FOR ADULTS

Vocational:

Is the Applicant attending a local Career Development Center (CDC)? ( ) Yes ( ) No

Is the Applicant employed by Mid Iowa Workshops (MIW)? ( ) Yes ( ) No

Does the Applicant have other local employment? ( ) Yes ( ) No

_____

Employer | Address | Phone | Supervisor

OTHER NEEDS

Counseling:

Is the Applicant currently receiving psychological or psychiatric services? _____

If yes, please list the name of the psychologist or psychiatrist, agency or clinic:

_____

Psychologist or Psychiatrist | Agency | Address and Phone

How often does the Applicant receive services: _____

Why does the Applicant receive services: _____

SKILLS CHECKLIST

Mark Yes if the Applicant completes the following skills on his or her own. Mark the designated columns if reminders, instruction, or physical assistance are needed:

Eating Skills	Yes	Reminders/Instruction	Physical Assistance
Uses Cup or Glass			
Uses Spoon, Fork, Knife			
Displays proper table manners			

If used, please describe feeding instructions: _____

_____

_____

List any special equipment or devices used (tubes, etc.): _____

Dressing Skills	Yes	Reminders/Instruction	Physical Assistance
Puts on clothes			
Snaps/Buttons			
Ties Shoes			
Chooses clothing according to season/weather			
Coordinates clothing			

Grooming Skills	Yes	Reminders/Instruction	Physical Assistance
Washes Hands/Face			
Brushes Teeth			
Combs or brushes hair			
Bathes or showers			
Shampoos			
Shaves			
Cares for self during menses			

Daily Living Skills	Yes	Reminders/Instruction	Physical Assistance
Makes bed/Keeps room clean			
Launders clothing/hangs, folds			
Prepares simple meals			
Helps clean house			
Tells time			

Please list household chores, yardwork, etc. the Applicant does on a routine basis: _____

Toileting Skills	Yes	Reminders/Instruction	Physical Assistance
Uses bathroom when needed			
Cares for self at toilet			

Does the Applicant have wetting accidents? ( ) Yes ( ) No

Does wetting occur during the ( ) Day ( ) Night ( ) Both

Does the Applicant have soiling accidents? ( ) Yes ( ) No

Does soiling occur during the ( ) Day ( ) Night ( ) Both

Does the Applicant have a stoma? ( ) Yes ( ) No

Does the Applicant have catheter? ( ) Yes ( ) No

Please mark the following category that best describes the Applicant's communication and social skills:

Communication Skills	Yes	No	Sometimes	Help or needs encouragement
Uses language board				
Uses picture/word cards				
Uses gestures				
Uses signs				
Uses sentences				
Speech is easily understood				
Follows 1-2 step directions				

Please indicate how the Applicant is being helped to better communicate or understand others at home: _____

Community Living Skills	Yes	Reminders/Instructions	Physical Assistance
Crosses street safely			
Rides bike and is aware of bicycle safety measures			
Uses public transportation (buses, taxis)			
Shops and makes purchases			
Uses bank			
Manages money/Pays bills			

Does the Applicant need supervision in public (i.e., when shopping, on activities, etc.)? ( ) Yes ( ) No

Does the Applicant have a driver's license? ( ) Yes ( ) No

Does the Applicant own a motor vehicle? ( ) Yes ( ) No

Social Skills	Yes	No	Sometimes	Needs help or encouragement
Participates in family or residential activities				
Participates in a program or school activities				
Has friends of the same age				
Gets along well with peers				
Gets along well with parents/staff				
Dates				
Willing to help				
Will do what is asked				
Accepts criticism				
Asserts self when necessary				

Please list the activities (both at home and in the community) the Applicant enjoys: _____

What kind of supervision is needed during free-time at home? _____

BEHAVIORAL INFORMATION

	Yes	No	If yes, How Often?
Leaves without permission			
Runs away			
Borrows others possessions without permission			
Steals			
Abuses or destroys property			
Uses abusive language (swears)			
Physically abuses others (hits, kicks, etc.)			
Displays self abusive behaviors (scratches self, etc.)			
Displays self stimulatory behaviors (rocking, etc.)			
Plays with or sets fires			
Displays Obsessive Behaviors			

Other behavior problems please list: _____

What might cause the Applicant to engage in problem behavior(s): _____

_____

_____

_____

DATA COLLECTION NOTIFICATION

The information we have asked you to provide will be used to determine your appropriateness for the services for which you are requesting. The information collected will only be used by authorized agency personnel. Use of this information for purposes other than explained herein will not be made without your prior written approval, unless such other use is specifically authorized by law. You also have a right to review any information which is maintained by this agency about you.

Applicant: _____ Date: _____

Parent/Guardian: _____ Date: _____

If you are approved for services, the information will then be used to complete a social history.