

APPLICATION FOR SERVICES

CODE # 9.5

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| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Social Security #:\_\_\_\_\_\_\_\_\_\_\_ |
| City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicaid #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicare #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

MCO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MCO #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case manager/care coordinator name and contact information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have other medical coverage: \_\_\_YES \_\_\_NO

If yes:

Policy type:

Company:

Policyholder:

Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Payee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I am applying for services from One Vision because:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Service(s) I am applying for:

\_\_\_\_\_ Residential (Supported Community Living, Respite)

 \_\_ICF/ID \_\_HCBS Daily Site Home \_\_Hourly SCL in home

\_\_\_\_\_ Vocational (Discovery, Career Exploration, Job Development, Job Coaching)

Where I would like to receive these services:

\_\_\_ Clear Lake

\_\_\_ Mason City, Nora Springs, Charles City, Osage

\_\_\_ Ventura, Garner, Britt, Forest City, Lake Mills

\_\_\_ Fort Dodge, Eagle Grove, Humboldt, Webster City

\_\_\_ Anywhere available

My wants and desires are (living arrangements, goals, employment):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have the following needs:

1. Vocational – Employment:

2. Medical:

3. Life Skills (living, personal & educational):

Factors that might affect me receiving services:

Something important to me that I want you to know: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I am currently receiving the following services (residential, vocational-employment, medical):

My current monthly income is:

Social Security\_\_\_\_\_\_\_\_\_\_\_ SSI\_\_\_\_\_\_\_\_\_\_\_ Wages/Earned Income\_\_\_\_\_\_\_\_\_\_\_

Railroad Pension \_\_\_\_\_\_\_\_\_ VA \_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have a checking/savings account at (bank name/location):

My present balance is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (checking) and $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (savings).

I have an irrevocable burial trust: \_\_\_YES \_\_\_NO

If yes, please provide a copy of the trust agreement.

Signature of Applicant Date

(or Person completing form)

Please return form to: Cyndi Reid, Quality Leader Region I

Referrals/Enrollment

 One Vision

 PO Box 622

 Clear Lake, Iowa 50428

 641-355-1345

 creid@onevision.org

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