



Application for Services

APPLICANT INFORMATION:

Name: _____ Date of Birth: _____ / _____ / _____

Address: _____

City/Zip Code: _____ Phone #: (_____) _____ - _____

Gender: _____ Social Security #: _____ - _____ - _____

MCO: _____ MCO ID#: _____

Medicaid #: _____ Medicare#: _____

PERSON MAKING REFERRAL:

Name: _____ Relationship: _____

Email: _____ Phone #: _____

Address: _____

FUNDING TYPE:

ID Waiver BI Waiver Habilitation Fee For Service MEPD ICF/ID

Region/County IVRS Private Pay Other: _____

I have other medical coverage: YES NO If Yes:

Policy type: _____ Company: _____

Policyholder/relationship: _____

DIAGNOSIS: _____

SERVICE(S) I AM INTERESTED IN: Select all that apply

HCBS Daily Site Home (Small residence [5 or less] skill building, support and supervision provided 8 or more hours a day)

ICF/ID (Large residence [10-12 people] active treatment, skill building, supervision provided 24 hours a day)

Hourly SCL in home (intermittent skill building)

indicate hours needed per day: _____ h ; number of days per week _____)

Day Habilitation (skill building activities in the community weekdays)

Vocational (comprehensive employment services from discovery of job interests to support on the job)

Other (please describe): _____

LOCATION I WOULD LIKE TO RECEIVE SERVICES: (Please indicate 1st and 2nd choice)

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 Other (please describe): _____

Reason I am applying for services from One Vision:

Factors that may affect me receiving services:

Things I need help with (Medical, Life Skills, Employment, etc):

Important things I want to be known about me:

Services I currently receive (Residential, 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.

Please complete the following, if applicable:

Payee: _____ **Phone #:** _____

Address: _____

Guardian: _____ **Relationship:** _____

Address: _____

Phone #: _____ **Email:** _____

Case Manager/ Care Coordinator: _____

Address: _____

Phone #: _____ **Email:** _____

Signature of Applicant

Date

(or Person completing form)

Include Social History, Service Assessment, InterRAI or SIS as applicable.

Please return form to: Teal Ferry, Service Coordinator
One Vision
1470 21st Ave N
Fort Dodge, IA 50501
641-525-2981
tferry@onevision.org