OneVision
Connecting People with Purpose

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:

_____

_____

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_____

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Factors that may affect me receiving services:

_____

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

_____

_____

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_____

Important things I want to be known about me:

_____

_____

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_____

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: Cyndi Reid, Services Coordinator
One Vision
PO Box 622
Clear Lake, IA 50428
O: 641-355-1345 M: 641-525-2981
creid@onevision.org