

AREA RESIDENTIAL CARE, INC. APPLICATION FOR SERVICES

Vocational Services Center
2455 Kerper Blvd.
Dubuque, IA 52001
(563) 556-7040

Administrative Offices
1170 Roosevelt St. Extension
Dubuque, IA 52001
(563) 556-7560

Delaware Co. Voc. Services Center
609 Jasper Street
Manchester, IA 52057
(563) 927-2459

*It is the mission of Area Residential Care to empower people with mental disabilities
to achieve their highest quality of life.*

IDENTIFYING INFORMATION:

Name of person seeking services: _____
(Last) (First) (Middle) (Nickname)

Social Security number: _____ Birth date: _____

Current Address: _____ Phone Number: _____
(Street)

_____ County of Legal Residence: _____
(City) (State) (Zip Code)

Sex: _____ Marital Status: _____ Height: _____ Weight: _____

Ethnicity: _____ White non-Hispanic; _____ African-American non-Hispanic; _____ Asian; _____ Hispanic;
 _____ American Indian; _____ Other; _____ Unknown

Religion: _____ (optional)

Name of person supplying information (if different from applicant): _____

Relationship to applicant: _____ Date form completed: _____

Date admission is desired: _____

SERVICES SOUGHT:

Below is a list of services provided by Area Residential Care. Please check all the applicant may be interested in.

Residential

- _____ Community Living Home (5 to 8 residents) _____ Awake night staff, or: _____ Sleeping night staff
- _____ Community Living Home (ICF/MR)
- _____ Apartment Living (site-based – 24 hour/day staff) _____ Awake night staff, or: _____ Sleeping night staff
- _____ Supported Community Living (staff stop in at current living place for training)
- _____ Parental home _____ Own Apartment
- _____ Respite (staff stays with individual in own home while family is away to provide a “break”)

Vocational

- _____ Sheltered Workshop
- _____ Community Based Enclave Work Site (staff always present during work hours)
- _____ Community Based Individual Employment/Job Coaching (staff periodically visit to check on)
- _____ Competitive Placement (just need help finding a job)
- _____ Retirement/Adult Day Program
- _____ Vocational Evaluation (2 to 5 week evaluation of work skills and interests at various job settings)
- _____ Adjustment Services (3 to 5 week training on general job traits)
- _____ Other (please describe): _____

FAMILY INFORMATION:

Emergency Contact Person Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Work Phone Number: _____

Applicant's Father's Name: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date of Birth: _____ Level of Education Completed: _____
 Place of Employment: _____ Phone Number: _____
 Social Security Number: _____ / _____ / _____ Health Concerns: _____

Applicant's Mother's Name: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date of Birth: _____ Level of Education Completed: _____
 Place of Employment: _____ Phone Number: _____
 Social Security Number: _____ / _____ / _____ Health Concerns: _____

Other Family Members Who Are Significant in Applicant's life:

Name: _____ Birth date: _____ Sex: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Involved with applicant? Yes _____ No _____

Name: _____ Birth date: _____ Sex: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Involved with applicant? Yes _____ No _____

Name: _____ Birth date: _____ Sex: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Involved with applicant? Yes _____ No _____

Name: _____ Birth date: _____ Sex: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Involved with applicant? Yes _____ No _____

Applicant's Stepfather: _____
 Address: _____ Phone Number: _____

Applicant's Stepmother: _____
 Address: _____ Phone Number: _____

HEALTH & DISABILITY RELATED INFORMATION:

Applicant's primary diagnosis: _____

Applicant's secondary diagnosis (if any): _____

Date of applicant's most recent psychological exam: _____

Primary Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Dentist: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Hospital Preference: _____ Address: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Does the applicant currently have or has he/she ever had any of the following (if so, please describe):

Seizures or convulsions _____

Describe: _____

Physical limitations or mobility impairments _____

Describe: _____

Sensory impairments _____

Describe: _____

Speech or language impairments _____

Describe: _____

Emotional or mental health problems _____

Describe: _____

Behavioral difficulties _____

Describe: _____

Has the applicant had any serious injuries?: _____

Describe: _____

Please describe any special equipment required: _____

Please list any hospitalizations or surgeries: _____

Describe: _____

Describe any on-going health problems: _____

List any allergies: _____

Previous Illnesses (List Date: mo/yr)

Chicken Pox _____

Ear Infections _____

Measles _____

Tonsillitis _____

Mumps _____

Asthma _____

Polio _____

Hayfever _____

Diabetes _____

Hepatitis _____

Tuberculosis _____

Cardiac _____

Previous Surgeries: _____

Immunizations: (circle if received and then list date underneath)

Measles Mumps Rubella Mantoux Flu DPT Typhoid Polio

Please list any current medications, dosage, and prescribing physician:

Medication	Dosage:	Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATIONAL / RESIDENTIAL / VOCATIONAL HISTORY:

Type of School	Name of School	Location	Program or Level	Year Completed
Grade School				
High School				
Post High School				

Please list below any previous jobs held, or jobs tried as part of vocational exploration / training:

Job Title	Dates Worked	Pay Rate	Brief Description of Job Tasks	Why no longer there?
1.	/	\$		
2.	/	\$		
3.	/	\$		

Please list below any previous residential or in-home services that have been received:

Name of Agency	Location	Service(s) Received	Dates of Service(s)	Why service(s) ended?
			//_ - _/_/_	
			//_ - _/_/_	

Does the applicant have any of the following sources of financial support?

SSI _____	if so, amount: _____
Social Security Disability _____	if so, amount: _____
Veterans Benefits _____	if so, amount: _____
Railroad or Other _____	if so, amount: _____
Other sources of Income _____	if so, amount: _____

Does the applicant have a legal guardian? _____ Name: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date appointed: _____ County: _____

Does the applicant have a legal conservatorship? _____ Conservator: _____
 Current Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Date appointed: _____ County: _____

Does the applicant have a representative payee? _____ Payee: _____

Please complete any of the following that apply:

Name of Medical Insurance Provider: _____

Medicaid Number: _____

Medicare Number: _____

SKILLS CHECKLIST

Check items that best describe applicant.

FEEDING	Consistently	Sometimes	Never	Comments
Requires physical assist to eat				
Throws or plays with food				
Eats with fingers				
Uses cup or glass				
Eats with spoon				
Eats with fork				
Uses knife for spreading				
Uses knife for cutting				
Eats slowly				
Eats rapidly				
Shows good table manners				
Completely independent				

DRESSING	Consistently	Sometimes	Never	Comments
Requires physical assistance				
Resists dressing				
Assists in dressing				
Puts on most clothing indep.				
Buttons clothes				
Ties Shoes				
Chooses own clothing				
Completely independent				

GROOMING	Consistently	Sometimes	Never	Comments
Totally dependent				
Washes Hands				
Washes face				
Brushes teeth				
Combs or brushes hair				
Bathes self independently				
Shaves self				
Shampoos hair				
Completely independent				

TOILETING	Consistently	Sometimes	Never	Comments
Requires control briefs				
Scheduled toileting				
Can indicate need				
Wets/soils during the day				
Wets/soils during the night				
Cares for self at toilet				
Uses toilet independently				
Cares for self during menstruation				

SOCIAL RELATIONS	Consistently	Sometimes	Never	Comments
Needs close supervision				
Avoids interaction with peers				
Enjoys interaction with peers				
Involves self near, not with peers				
Disrupts group activities				

COMMUNICATION	Consistently	Sometimes	Never	Comments
Does not respond to language				
Communicates with gestures only				
Speaks single words				
Uses phrases				
Uses sentences				
Speech easily understood				
Follows simple directions				
Answers questions				
Converses spontaneously				
Talks on telephone				
Prints/Writes				

HUMAN SEXUALITY	Consistently	Sometimes	Never	Comments
Demonstrates knowledge of own sexuality				
Demonstrates knowledge of other's sexuality				
Masturbates privately				
Masturbates publicly				
Actively displays interest in same sex				
Actively displays interest in opposite sex				

CHORES AND ACTIVITIES	Consistently	Sometimes	Never	Comments
Helps with minor household tasks				
Does responsible routine chores				
Goes about neighborhood without supervision				
Makes purchases				
Uses public transportation buses/taxi				

BEHAVIORS	Check if Yes	Comments/Explain
Hyperactive		
Aggressive		
Withdrawn		
Hits/kicks others		
Bites others		
Pulls others hair		
Uses disruptive noises		
Self-stimulates, i.e. rocks back and forth		
Engages in self-injurious behavior		
Abusive of property		
Leaves premises without permission		
Physically abuses others		
Screams		
Eats inappropriate objects/fluids		
Engages in rectal digging		

If other, explain: _____

Does the applicant have a criminal history? _____
 If yes, please explain any criminal charges and related court conditions (ie: probation status, no contact orders, etc):

Application completed by: _____
 Current Address: _____
 City: _____ State: _____

Date: _____
 Phone Number: _____
 Zip Code: _____