Options of Linn County
Instructions for Applying for Service

All items in section 1 & 2 must be submitted before an admission decision can be made.

Section 1--FORMS TO FILL OUT

	Application for Service/Med List	Statement signed by person submitting application.
	East Central Region Application	Required of consumers who will request funding from East Central Region MH/DS (i.e. will not have Medicaid funding when services start)
	Health/Therapy/Self-Care Pre-Admission Assessment	Should be completed by someone who knows the applicant well.
	Day Habilitation Personal/Interest Assessment	Should be completed by someone who knows the applicant well.
	Medical exam report	Completed within last year. May use either the form included herein, or a physician's or clinic's form. Must be signed by a physician.
	General Releases of Information	Complete a release for each person or agency with whom Options must communicate, in order to complete this application and to start and continue services(e.g. Case Manager, residential provider, physician)
	HIPAA acknowledgement	Statement signed by the applicant or the legal guardian acknowledging that he or she has been informed of Linn County's Privacy Practices.
	Photo Release/ Out of Facility activity release	Photos and video for advertisement and newsletters. Out of facility activities authorization.

Section 2--DOCUMENTS TO ATTACH TO THE APPLICATION

	Up-to-date social history	Completed within last year.
	Psychiatric evaluation report	Must state the diagnosis that qualifies the applicant for Options service.
	Educational Background	May be included in the social history, but any additional reports from school programs are helpful and may be requested.
	Full SIS Assessment & tier assignment	
	Current case management plan	

Questions about the application or other required forms? Phone 319-892-5800.

Mail application to: **Options of Linn County**
Attn: Intake Coordinator
1240—26th Avenue Ct. SW
Cedar Rapids, IA 52404

Or fax to: 319/892-5849

***NOTE:* <u>ALL</u> ITEMS BELOW MUST BE SUBMITTED BEFORE SERVICE WILL BEGIN:**

	Guardianship court order	If applicable.
	Updated Funding Authorization	Must be available before service may begin.
	Copy of Social Security Card	Must be available before service may begin.
	Picture ID	One of the following: driver's license, government issued ID, school ID or voter's registration card.

Options of Linn County
Application for Service

Funding source(s) ______________________ Tier assigned__________

PERSONAL INFORMATION

Name ______________________ DOB __________ SS No. __________

Address ______________________ City __________ Zip __________

E-mail ______________ Sex ___ Ethnicity ___ Marital Status ______ Ph.______

Emergency contact(s) ______________________ Ph.______

Referring person / agency ______________________ Ph.______

Case Mgr. / agency ______________________ Ph.______

Guardian ______________ Ph. ______________ Ph.______

Residential Provider/Cord. ______________________ Ph.______

Diagnosis qualifying this applicant for service ______________________

Do you have a criminal history—i.e., convictions or pending charges—other than misdemeanor traffic violations? (*MUST BE ANSWERED. Please circle your answer.*) YES NO

MEDICAL

Physician ______________ Phone ______

Psychiatrist ______________ Phone ______

Health insurance:

Date of last tetanus inoculation __________ Allergies ______________

Restrictions and limitations ______________________

Please list medications on Page 2 or on the reverse of this page.

SocSec

Social Security Payee ______________ Address ______________

Monthly Amount SSI--$ SSDI--$ SS--$

EDUCATION

High School ______________ Yr. graduated _____ In spec. educ. classes? _____

HS Work Experience? ______________ College __________ # Yrs. attended ___

______________________ ______________

APPLICANT OR GUARDIAN SIGNATURE DATE

Updated: 9/2018

Options of Linn County
Application for Service

Consumers Name: _________________________DOB. _________ Date: ___________

Please list all medications the applicant currently uses, and check (√) the left column below if a medication is to be administered at Options. Options must be in possession of a physician's written and signed prescriptions (or order) for each medication administered by Options personnel.

	Medication	Strength	Time Administered	Dose	Signed Rx/Order Attached

Options of Linn County
Application for Service

Health/Therapy/Self Care Pre-Admission Assessment

Instructions: Please complete and include this screening tool with other application material when submitted to Options. Please answer YES or NO for each part of each question and add comments and explanations as necessary for clarity.

Consumers Name: __________________________DOB. __________ Date: ___________

1. **Has the consumer ever received any physical, occupational or speech therapy? Yes/No**
   If Yes, when and where was the therapy provided? Date: ____________ Location: ______________

   What were the results? ____

   ____

2. **Does the consumer have problems or difficulty with any of the following?**

Yes	No	
☐	☐	Self-Feeding______________________________
☐	☐	Grooming______________________________
☐	☐	Bathing______________________________
☐	☐	Dressing______________________________
☐	☐	Walking______________________________
☐	☐	Transferring______________________________
☐	☐	Shortness of breath or tiredness due to normal activity ______________________
☐	☐	Sitting in wheelchair for long periods without regularly shifting weight___________
☐	☐	Speech being understood by others______________________
☐	☐	Communicating needs and ideas______________________
☐	☐	Following simple task instructions______________________
☐	☐	Range of motion loss in:
		Upper Extremities______________________
		Lower Extremities______________________
☐	☐	Loss of strength______________________
☐	☐	Loss of fine or gross motor skills______________________
☐	☐	Seizures______________________
☐	☐	Behavior______________________

3. **Does the consumer have a prescribed PT or exercise program? Yes/No**
   If yes, it is effective? Yes/No
4. **Does the consumer use a means of communication other than speech? Yes/No**
   If yes, it is effective? Yes/No

_____________________________ _____________________________ _________________

Signature **Relationship** **Date**

Updated: 9/2018

Options of Linn County
1240 26th Ave. Ct. SW
Cedar Rapids, IA 52404

Day Habilitation Personal/Interest Assessment

General Information:

Name: ______________________________________ Date: __________

Assessment completed by: ____

Seizure History (in the past year): No Known Seizures_________ Controlled seizures ______
Frequency of seizures: ____ Weekly _____ Monthly _____ Less than month ____ None in past year
Description of seizures, including indicator/pre-seizure activity. ______________________________
____
____

Physical Assessment: _____ Self ambulatory
_____ Needs assistance with ambulation: _____ cane _____ walker _____ crutches _____ wheelchair
Other assistive device needed for ambulation ____
Vision ____
Hearing ____

Self Help: Please use the following rating scale: I = Independent, NA = Needs Assistance, D = Dependent
_____ Grooming _____ Dressing _____ Eating _____ Toileting
Comments: ____
____

Communication: Please check the appropriate forms of communication.
_____ Verbal, communication no problem
_____ Limited verbal abilities- Describe ____
_____ Gestures
_____ Sign Language
_____ Assistive Technology- Describe ____
____

Responds to reinforcers of: Check all that apply
____ Verbal praise
____ Opportunity to select an activity
____ A special setting
____ Special staff attention
____ appropriate physical interaction
____ music
____ accumulation of chips or objects
____ free time
____ Others (list) ____

Social Behaviors: Check all that apply

____ Socializes with peers
____ Interacts appropriately with peers
____ Engages in verbal aggression
____ Exhibits constant disposition throughout day
____ Tolerates nearness of peers
____ Interacts appropriately with staff members
____ Is physically aggressive
____ Interacts appropriately with strangers

Activity Attitudes/Behaviors: Check all that apply

____ Is compliant with participation
____ Is not agitated by environment
____ Requests assistance when needed
____ Requests materials when needed
____ Accepts assistance from persons other than regular staff
____ Performs activities without attention-seeking behaviors
____ Participates well in a group
____ Energy level is consistent all day

Learning methods: Check the ones that apply

____ Needs full physical assistance
____ Needs verbal and gestural prompts
____ Needs verbal direction only
____ Needs partial physical assistance
____ Needs demonstration
____ Independently completes tasks

Comprehensive Functional Assessment:

Key: (+) = Consumer performs/responds at least 80% of the time
(-) = Consumer does not perform/respond at least 80% of the time
PI = Consumer is physically incapable of performing skill area
NA = Not Applicable to consumers

____ Has reaching skills
____ Has grasping skills
____ Has releasing skills
____ Can collect own activity materials
____ Can organize own activity areas
____ Can follow safety rules
____ Can transfer learned skills
____ Can read
____ Can recognize some letters
____ Can distinguish colors
____ Has counting skills
____ Can recognize numbers
____ Can complete tasks of one step
____ Can complete tasks of two steps
____ Can complete tasks of three or more steps
____ Can transfer completed items to appropriate area
____ Uses micro switches for activities

General comments:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

GENERAL MEDICAL EXAMINATION REPORT

(Required for Options Facility and Enclave Services)

SEND TO: **Options of Linn County**
1240—26th Avenue Ct. SW
Cedar Rapids, IA 52401

DATE: ____________________

Name: _____________________________________ **DOB:** _____________ **Ht.:** ______ **Wt.:** ______

Address: ____

Previous Hospitalizations: (When, Where, Why) ____

____

____

____

Present Complaint, Disability, Problem: ____

____

Present Medication (If Any)____

____

Physical Examination:
Distance Vision: Without Glasses R-20/_____L-20/_____With Glasses R-20/_____L-20/_____
Distance Hearing: R_____ L_____ Comments: ____
20 ft. 20 ft.

____

Do any of the conditions below exist now or have they existed in the past? If yes, please give details here, or on reverse.

Skin? Nose? Throat?	**Yes**	**No**	
Mouth? Eyes? Ears? Lungs?	**Yes**	**No**	
Heart and Circulatory System:	**Yes**	**No**	
Blood Pressure: S____D____Pulse_____	**Yes**	**No**	
Gastro-Intestinal System:	**Yes**	**No**	
Abdominal Organs or Structure?	**Yes**	**No**	
Bones and Muscles?	**Yes**	**No**	
Nervous System:	**Yes**	**No**	

LABORATORY:

URINALYSIS: _________ **SP. GR.** _________ **ALBUMEN**_________ **REACTION**________**SUGAR** ________
DATE
BLOOD: _________ **HEMOGLOBIN** _________ **COMMENTS:** ____
Date

Options of Linn County General Medical Examination Report, Page 2

Patient name: ____ DOB: _________________________

DIAGNOSES ____

Characteristics of Major Disability:

Permanent _______ **Temporary** _______ **Stable** _______ **Progressive** _______ **Improving** _______

Duration and Etiology of Major Disability:

____

____

____

____

Specify type of Specialist, Appliance or Treatment Recommended:

____

____

____

____

Physical Capacities: Describe Physical or mental Limitations and Precautions of Employability:

____

____

____

RECOMMENDATIONS:

____

____

____

______________________________ ________________________ __________

Physician's Signature **Address** **Date**