

# 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: \_\_\_\_\_ Caucasian \_\_\_\_\_ African-American \_\_\_\_\_ Asian \_\_\_\_\_ Hispanic  
 \_\_\_\_\_ Native 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
- \_\_\_\_\_ Day Habilitation (day program to assist with life skills)
- \_\_\_\_\_ Vocational Assessment (short term assessment of work skills and interests at various job settings)
- \_\_\_\_\_ 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 \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Physical limitations or mobility impairments \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Sensory impairments \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Speech or language impairments \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Emotional or mental health problems \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Behavioral difficulties \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Serious injuries: \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Special equipment required: \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Please list and describe any hospitalizations or surgeries: \_\_\_\_\_

Describe any on-going health problems: \_\_\_\_\_

List any allergies: \_\_\_\_\_

**Previous Illnesses (List Date: mo/yr)**

Chicken Pox \_\_\_\_\_

Tonsillitis \_\_\_\_\_

Polio \_\_\_\_\_

Hepatitis \_\_\_\_\_

Ear Infections \_\_\_\_\_

Mumps \_\_\_\_\_

Hay fever \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Measles \_\_\_\_\_

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Cardiac \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

**Immunizations:** (circle if received and then list date underneath)  
(Attach physician documentation)

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.

\*If consistently is marked for the first line (completely independent) remaining lines do not need to be completed for that section.

<b>FEEDING</b>	<b>Consistently</b>	<b>Sometimes</b>	<b>Never</b>	<b>Comments</b>
Completely independent *				
Requires physical assistance				
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				

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

<b>GROOMING</b>	<b>Consistently</b>	<b>Sometimes</b>	<b>Never</b>	<b>Comments</b>
Completely independent *				
Totally dependent				
Washes hands				
Washes face				
Brushes teeth				
Combs or brushes hair				
Bathes self independently				
Shaves self				
Shampoos hair				

<b>TOILETING</b>	<b>Consistently</b>	<b>Sometimes</b>	<b>Never</b>	<b>Comments</b>
Cares for self during menstruation *				
Completely independent *				
Requires control briefs				
Scheduled toileting				
Can indicate need				
Wets/soils during the day				
Wets/soils during the night				
Cares for self at toilet				

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

<b>COMMUNICATION</b>	<b>Consistently</b>	<b>Sometimes</b>	<b>Never</b>	<b>Comments</b>
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				

<b>HUMAN SEXUALITY</b>	<b>Consistently</b>	<b>Sometimes</b>	<b>Never</b>	<b>Comments</b>
Demonstrates knowledge of own sexuality				
Demonstrates knowledge of others' sexuality				
Masturbates privately				
Masturbates publicly				
Actively displays interest in same sex				
Actively displays interest in opposite sex				

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

<b>BEHAVIORS</b>	<b>Check if Yes</b>	<b>Comments/Explain</b>
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		
Other significant behaviors		

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:** \_\_\_\_\_