

Address: _____

Home Telephone #: (____) _____ Work Telephone #:(____) _____

Cell Telephone #: (____) _____

Email Address: _____

County of Legal Settlement/ Financial Responsibility

County of Financial Responsibility: _____

Case Manager: _____

Address: _____

Telephone Number: (____) _____

Email Address: _____

County Administrator (CPC): _____

IME Determination Date: ____ / ____ / ____ Level of Care: _____

Service(s) Desired

- Type of Services Desired: ICF/MR 24-hour Waiver Vocational
 Hourly SCL (Supported Community Living) CDAC (Consumer Directed Attendant Care) Respite
 Habilitation RCF/MR/HCBS Unknown

Communities desired:

- Children ICF/MR (1st Preference): 1st Available Opening No Preference
 Coralville Council Bluffs
- (2nd Preference): No Preference Coralville Council Bluffs
- Adult ICF/MR (1st Preference): 1st Available Opening Cedar Rapids
 Cedar Rapids Area Hiawatha Kalona
 Marion Shelby Washington
 No Preference

(2nd Preference): Cedar Rapids Cedar Rapids Area
 Hiawatha Kalona
 Marion Shelby Washington
 No Preference

- RCF/MR/HCBS: Shelby
- Waiver Services: 1st Available Opening Atlantic Cedar Rapids/Marion/Hiawatha
 Council Bluffs Harlan Fort Madison
 Iowa City/Coralville Keokuk Mt. Pleasant Mt. Vernon
 North Liberty Shelby Tipton
 Vinton Adel No Preference Other (document below)
- Vocational: Adel Avoca Hiawatha Mt. Vernon

Other community(s): _____

History of Services

Residential/ in-home services (e.g. hourly services, 24-hour waiver, ICF/MR, nursing home, etc)

Has the applicant always lived at home? No Yes

Service	Provider	Dates

Vocational services

Has the applicant ever been employed? Yes No NA (if under age 21)

Place of Employment	Provider	Dates

Has the applicant ever been arrested? No Yes

If yes, provide:

Date(s): _____

Reason(s): _____

Outcomes: _____

Family Information

■ Full Name of: Parent's Father's Mother's Other

If Other, Document Relationship: _____

Address: _____

Home Telephone #: _____ Work Telephone #: _____

Email Address: _____

■ Full Name of: Father's Mother's

Address: _____

Home Telephone #: _____ Work Telephone #: _____

Email Address: _____

■ Sibling's Full Name: _____

Address: _____

Home Telephone #: _____ Work Telephone #: _____

■ Sibling's Full Name: _____
Address: _____

Home Telephone #: _____ Work Telephone # _____

■ Sibling's Full Name: _____
Address: _____

Home Telephone #: _____ Work Telephone # _____

Applicant's Financial Information

Receive Financial Assistance? Yes No
If yes, type: SS (Social Security) SSI (Supplemental Social Insurance) VA
 Child Support Other
If other: _____

Health Insurance (other than Title 19 or Medicare): Yes No Unknown
If yes, company: _____

Burial Account: Yes No Unknown
If yes, where: _____
If yes, amount: _____

Life Insurance: Yes No Unknown
If yes, list company: _____
If yes, amount: _____

Trust Fund: Yes No Unknown
If yes, list where: _____
If yes, amount: _____

Applicant's Health/Medical Information

Current Medication(s):

Name	Dose	Frequency	Reason for Taking	Prescribed By

Does the applicant require assistance/supervision when taking medications? Yes No

If yes, describe the assistance/supervision required: _____

Allergies: Yes No Unknown

If yes, what applicant is allergic to and the type of reaction: _____

Diet: General Modified G-tube

If modified, list the type of diet ordered and reason: _____

Physical disabilities that require the use of adaptations (e.g. AFOs {braces}, orthopedic shoes, cane, walker, wheelchair, etc.): Yes No

If yes, list adaptive equipment: _____

Seizures? Yes No History of

If yes or history of, describe type and frequency: _____

Vision problems? No Yes- correctable with glasses Yes- but refuses to wear glasses
 Yes- no correctable Blind

Hearing problems? No Yes- correctable with hearing aids
 Yes- but refuses to wear hearing aids Adapt by speaking loudly
 Deaf

Skill Checklist: (please check items which best describes applicant)

	Consistently	Sometimes	Never	Comments
EATING				
Completely independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs to be fed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eats slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eats rapidly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fussy eater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoys eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eats with fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses cup or glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eats with spoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eats with fork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses knife for spreading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses knife for cutting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Throws or plays with food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shows good table manners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses napkin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRESSING				
Completely independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs to be dressed completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Resists dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Consistently	Sometimes	Never	Comments
Assists in dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tries to dress self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Puts on most of clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Buttons clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zips clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ties shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chooses own clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GROOMING				
Completely independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs complete assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Washes hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Washes face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brushes teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Combs or brushes hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathes self with supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathes self independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shampoos hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TOILETING				
Independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Independent with reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wears briefs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indicates need to toilet/ be changed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinent during day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinent during night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Females- Cares for self during menstrual Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Consistently Sometimes Never Comments

COMMUNICATION				
Understands communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does not understand communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Verbal communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech easily understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speaks freely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speaks incessantly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses phrases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Used single words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Talks on telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with signing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with pictures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with verbal output assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follows simple directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Answers questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Converses spontaneously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Writes by printing/ cursive/ type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL RELATIONS				
Accepts supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoys interaction with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Involves self near, but not with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disrupts group activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Makes close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs close supervision (about every 5 minutes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs 1:1 supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Consistently Sometimes Never Comments

CHORES & ACTIVITIES				
Helps with household tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does routine chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Goes about neighborhood without supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Makes purchases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoys community activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HUMAN SEXUALITY				
Demonstrates knowledge of own sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Demonstrates knowledge of others sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masturbates appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masturbates in areas of home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masturbates in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Actively displays interest in opposite or same sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Display sexually inappropriate behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIOR				
Becomes upset when redirected/corrected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Demands excessive attention from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tells lies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Complains of being persecuted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pretends to be ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Consistently	Sometimes	Never	Comments
Changes mood without reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cries for no apparent reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bosses or manipulates others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoards things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PICA (eats inedible objects) (if displays, list items in comments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self injurious behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Verbally aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physically aggressive towards others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physically aggressive towards objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tears clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Steals others' belongings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Temper outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wanders within home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Elopes/Runs away from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses other drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Removes clothing in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Leisure activities

Interests: _____

Hobbies: _____

Dislikes: _____

Referral to REM Iowa

How did you become aware of REM Iowa services?

- Family / Friends REM TV Ads Newspaper Ads REM Iowa Website
- The MENTOR Network Website County Case Manager Hospital
- Someone that works at REM Iowa Other Provider Other

If other, please document from whom/where: _____

Closing

The information we have asked you to provide is necessary for the effective administration of the services for which you are applying. The information collected will only be used by authorized agency personnel. Use of this information for purposes other than expressed herein will not occur without your prior written approval, unless such other use is specifically authorized by law.

Attach any of the following materials that may be helpful in determining eligibility for service:

- Most recent psychological evaluation
- Most recent education and/or vocational report
- Physical and/or specialty medical examinations
- Other

Completed by:

Applicant Name: _____ Date: ____ / ____ / ____

Parent/Guardian Name: _____ Date: ____ / ____ / ____ .

Name/Title: _____ Date: ____ / ____ / ____

Please return form to: REM Iowa - Attn: Leon
 2205 Heritage Blvd
 Hiawatha, IA 52233
 OR
 Fax Leon Bohn, State Intake Coordinator
 (319) 393-2091