

**SERVICE APPLICATION FORM for BI SERVICES
REM IOWA COMMUNITY SERVICES**

Directions: Complete all information. Please only check one box per item.

Applicant Information

Applicant's Full Name: _____

Urgency: Next Availability Placement in Jeopardy Within 6 months
 Within 1 year Within 2 years No Preference

Current Address: _____

Telephone Number: (____) _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

Title 19 Number: _____ Medicare Number: _____

Gender: Male Female Height: _____ Weight: _____

Marital Status: Single Married Divorced

Primary Diagnosis: Brain Injury

Other Diagnosis: Mental Retardation Mental Illness

Guardianship Status

Own Guardian: Yes No

If no, who is Guardian?: Spouse Parent(s) Siblings County State Other

Name of Guardian: _____

Address: _____

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

Cell Telephone #: (____) _____ Email Address: _____

County of Legal Settlement/ Financial Responsibility

County of Financial Responsibility (if diagnosis of MR): _____

IME Determination Date (if diagnosis of MR): ____ / ____ / ____ Level of Care: _____

Case Manager Name: _____

Telephone Number: (____) _____ Email Address: _____

Has Applicant Applied for BI Waiver: Yes No

If yes, Received Slot: Yes No Waiting List: Yes No

Applied for MR Waiver: Yes No NA

Service(s) Desired

Length of Services Desired: Transitional Long-Term Unknown

If transitional, time frame: _____

Type of Services Desired:

BI Diagnosis Only: 24-hour Waiver Hourly SCL (Supported Community Living)
 CDAC (Consumer Directed Attendant Care) Respite Unknown

MR/BI Diagnosis: ICF/MR RCF/MR/HCBS 24-hour Waiver
 Hourly SCL (Supported Community Living) CDAC (Consumer Directed Attendant Care)
 Respite Unknown

Communities desired:

- Adult ICF/MR (Preference): 1st Available Opening Cedar Rapids Area Cedar Rapids Hiawatha Kalona
 Marion Shelby Washington
 No Preference

- RCF/MR/HCBS: Shelby

- Waiver Services: 1st Available Opening Adel Atlantic
 Cedar Rapids/Marion/Hiawatha Clive
 Council Bluffs Harlan Fort Madison
 Iowa City/Coralville Keokuk Mt. Pleasant
 Mt. Vernon North Liberty Shelby
 Tipton Vinton Waukee West Des Moines
 No Preference Other (document below): _____

- Vocational: Adel Avoca Hiawatha Mt. Vernon

What supports do you currently receive? _____

From whom/where? _____

Roommates with:

• Diagnosis: BI MR Either

Gender: Male Female Either

History of Services (do not include hospitalizations)

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

Has applicant received: Neuro-rehabilitation Nero-behavioral

Has the applicant always lived at home? Yes No

Service

Provider

Dates

Service	Provider	Dates

Vocational services

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

Place of Employment

Provider

Dates

Place of Employment	Provider	Dates

Has the applicant ever been arrested? Yes No

If yes, provide:

Date(s): _____

Reason(s): _____

Outcome(s): _____

Involved Family Information

■ Full Name of: Parents' Father's Mother's Name(s): _____

Address: _____

Home Telephone #: _____ Email Address: _____

- Full Name of: Father's Mother's Name: _____
 Address: _____
 Home Telephone #: _____ Email Address: _____
- Spouse Yes No Name: _____
 Address: _____
 Home Telephone #: _____
- Child's Full Name: _____
 Address: _____
 Home Telephone #: _____
- Child's Full Name: _____
 Address: _____
 Home Telephone #: _____
- Other Full Name: _____ Relationship: _____
 Address: _____
 Home Telephone #: _____

Applicant's Financial Information

- Receive Financial Assistance? Yes No
 If yes, type: SS (Social Security) SSI (Supplemental Social Insurance) VA
 If other, list: _____
- Health Insurance (other than Title 19 or Medicare): Yes No Unknown
 If yes, company: _____
- Burial Account: Yes No Unknown
 If yes, where: _____ Amount: _____
- Life Insurance: Yes No Unknown
 If yes, list company: _____ Amount: _____

Trust Fund: Yes No Unknown

If yes, list where: _____ Amount: _____

Applicant's Health/Medical Information

Physical issues prior to brain injury: Yes No Unknown

If yes, describe: _____

Mental Health issues prior to brain injury: Yes No Unknown

If yes, describe: _____

Disabilities prior to injury: Yes No Unknown

If yes, level of supports and provided by whom? _____

Date brain injury occurred: ____ / ____ / ____ How old was applicant at that time: _____

How did the brain injury occur: Fall Motor Vehicle Assault Unknown Other

If other, describe: _____

Area of brain impacted: Frontal lobe Parietal lobe Temporal lobe Occipital lobe
 Cerebral Cortex

Severity of the injury:

Glasgow Coma Scale scores : _____ Date: ____ / ____ / ____

Length of coma: _____ Duration of post-traumatic amnesia: _____

Neuro psychology evaluation: _____ Date: _____

Physiatrist Consult: Yes No Unknown

Presence of multiple injuries: Yes No

If yes, describe: _____

Sleep habits: _____

Applicant utilizes: Right-hand Left-hand Unknown

Hospitalizations/Surgeries:

Dates Reason

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? Yes- correctable with glasses Yes- not correctable Blind No

Hearing problems? Yes- correctable with hearing aids Adapt by speaking loudly
Deaf No

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

Consistently Sometimes Hx Of NA

Comments

Cognition, Language & Functional Impact					
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Short Attention Span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sequencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Processing / Thinking Delays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced / Lack of Awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reading & Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Initiation/Internal Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Visual-spatial skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social skills/Pragmatics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EATING					
Completely independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs to be fed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swallowing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRESSING					
Completely independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs to be dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GROOMING					
Completely independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs to be done by other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathes self independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathes self with supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TOILETING					
Independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Independent with reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Consistently	Sometimes	Hx Of	NA	Comments
Toileting schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wears briefs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
COMMUNICATION					
Verbal communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech easily understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with signing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates with pictures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL RELATIONS					
Accepts supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoys interaction with peers	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
Needs close supervision (about every 5 minutes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs 1:1 supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHORES & ACTIVITIES					
Helps with household tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does routine chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Goes about neighborhood without supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Makes purchases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoys community activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drives	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
Demonstrates knowledge of others sexuality	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
Sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Display sexually inappropriate behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIOR					
Becomes upset when redirected/corrected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self injurious behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Consistently	Sometimes	Hx Of	NA	Comments
Verbally aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physically aggressive towards peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physically aggressive towards staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physically aggressive towards objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Temper outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wanders within home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Elopes/Runs away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse					
Uses tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses other drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health					
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Leisure activities

Prior to the brain injury:
 Interests: _____

Hobbies: _____

Dislikes: _____

Currently:
 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
 Leon.Bohn@TheMentorNetwork.com