OPPORTUNITY LIVING
1890 E MAIN STREET
LAKE CITY, IA 51449
Phone: 712-464-8961 Fax: 712-464-3320

SOCIAL

List facilities in which admission is desired in order of preference:

1_____ 2_____ 3_____

Date Admission Desired:_____ Voluntary or Involuntary Admission:_____

Applicant's Name: _____ Social Security #_____

Current Address: _____ Telephone:_____

_____ Ambulatory: Yes ( ) No ( )

Birth Date: ____/_____/_____ Place of Birth: _____

Sex:_____Height:_____Weight:_____Hair Color:_____Eye Color:_____

Legal Competency Status:_____

Provision for Clothing & Other Personal Needs:_____

Current Status with Facility:_____

Date Admitted:_____ Date Left:_____

Primary Handicap/Diagnosis: _____

Degree of Handicap: _____

Other Handicapping Conditions: _____

Identifying Marks: _____

Medication:_____

Church Affiliation:_____Attends Regularly? Yes ( ) No ( ) Baptized? Yes ( ) No ( )

Marital Status: _____Citizenship Status:_____Race:_____

Language Spoken or Understood:_____

Has the applicant ever been arrested? Yes ( ) No ( ) If YES, give dates, reasons, and outcome:_____

_____

REFERRED FROM: _____ 1) Physician 2) ICF/ID 3) Court 4) Family 5)DHS Co.Soc.Worker 6) Other 7) Unknown

REASON FOR ADMISSION:_____ 1)Need for programming 2)Maladaptive behavior 3) Unable to care for in present living situation 4) Court committed 5) Respite Care 6) Other

PRIOR LIVING: _____ 1) Home 2) SNF 3) ICF 4) ICF/ID 5) Acute 6) RCF 7) RCF/ID 8) Group Home 9) Foster Home 10) Indepdent Living A)Unknown B)Specialty C) Other

ALTERNATIVE RESOURSES EXPLORED PRIOR TO ADMISSION_____ 1) SNF 2) ICF 3) RCF 4) RCF/ID 5) Group Home 6) Independent Living 7) None 8) Other 9) ICF/ID A)Unknown

Attach recent full length photo here

Completed by:_____

Title:_____Date:____/____/____

Previous Placement and services: Residential (State Hospital Schools, Nursing Homes, Private Residential Schools, Foster Homes, Group Homes, Etc.) List most current one first.

PLACEMENT ADDRESS DATES

_____

FAMILY INFORMATION

Father's Name: _____ Social Security Number: _____
First Middle Last

Address: _____ Telephone: _____

Place of Employment: _____ Position: _____

Address: _____ Work Telephone: _____

Birthdate: ____/____/____ Birthplace: _____

Military Service? Yes ( ) No ( ) If YES, what branch? _____

Mother's Name: _____ Social Security Number: _____
First Middle Last

Address: _____ Telephone: _____

Place of Employment: _____ Position: _____

Address: _____ Work Telephone: _____

Birthdate: ____/____/____ Birthplace: _____

Military Service? Yes ( ) No ( ) If YES, what branch? _____

Natural parent's marital status: _____ If remarried, list step-spouse: _____

Source of family income: _____

Sibling's Name: _____ Birthdate: _____

Address: _____ Telephone: _____

Sibling's Name: _____ Birthdate: _____

Address: _____ Telephone: _____

Sibling's Name: _____ Birthdate: _____

Address: _____ Telephone: _____

Sibling's Name: _____ Birthdate: _____

Address: _____ Telephone: _____

Sibling's Name: _____ Birthdate: _____

Address: _____ Telephone: _____

Are there other relatives or friends who will have contact with applicant?

Name: _____ Telephone: _____

Address: _____

Name: _____ Telephone: _____

Address: _____

Is the applicant likely to visit with family or friends on weekends or holidays? _____

Is there anyone who applicant should not see or visit? _____

If applicable, who has legal guardianship (Appointed by District Court to have custody of the person named on this application)?

Mother ( ) Father ( ) Both Parents ( ) Other ( )

If other than parents, please specify:

Name: _____ Address: _____ Telephone: _____

Date of Guardianship: ___/___/___ (Please attach a copy of the guardianship papers.)

If applicable, who has legal conservatorship (Appointed by District Court to handle financial matters of the person named on the application)? Mother ( ) Father ( ) Both Parents ( ) Other ( )
If other than parents, please specify:
Name:_____ Address:_____ Telephone:_____
Date of Conservatorship: ___/___/___ (Please attach a copy of the conservatorship papers.)

FINANCIAL

Does the applicant receive financial assistance? Yes ( ) No ( ) List Payee:_____

SSI: _____ Other:_____
(LIST AMOUNT) (LIST TYPE AND AMOUNT)
Parents:_____ Other:_____
Medicaid Number:_____ Medicare Number: _____
Savings Account: Yes ( ) No ( ) Where:_____
Burial Account: Yes ( ) No ( ) Where:_____
Health Insurance: Yes ( ) No ( ) Company:_____ Policy#_____
Life Insurance: Yes ( ) No ( ) Company:_____ Policy#_____
Face Value:_____Cash Value:_____
Trust Fund: Yes ( ) No ( )

County of Financial Responsibility:_____
Case Worker:_____
Address:_____ Telephone:_____
County of Service if different:_____ Case Worker: _____
Address:_____ Telephone:_____

Other agency involvement: (vocational rehabilitation, private social service agencies, etc.)
Name:_____ Address:_____ Telephone:_____

CONTACT PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name:_____ Telephone:_____
Address:_____

MEDICAL SECTION

PHYSICIANS

Current Physician:_____ Date of last exam: _____/_____/_____

Addresss:_____Telephone:_____

Current Dentist:_____ Date of last exam: _____/_____/_____

Address:_____ Telephone:_____

Does applicant have dentures? Yes ( ) No ( )

Current Ear Doctor:_____ Date of last exam: _____/_____/_____

Address:_____ Telephone:_____

Does applicant wear hearing aid(s)? Yes ( ) No ( )

Current Eye Doctor:_____ Date of last exam: _____/_____/_____

Address:_____ Telephone:_____

Does applicant wear glasses? Yes ( ) No ( )

Neurologist:_____ Date of last exam: _____/_____/_____

Address:_____ Telephone:_____

Comments:_____

Other Specialist:_____ Date of last exam: _____/_____/_____

Address:_____ Telephone:_____

Reason:_____

CURRENT MEDICATIONS

NAME	DOSE	FREQUENCY	REASON FOR MEDICATION	PRESCRIBED BY

Will the applicant require supervision taking medication? Yes ( ) No ( ) _____

ALLERGIES

Is the applicant allergic to medications? Yes ( ) No ( )

Please list: Type of reaction:

Does the applicant have any food allergies? Yes ( ) No ( )

Please list: Type of reaction:

Does the applicant have any other type of allergies: Yes ( ) No ( )

Please list: Type of reaction:

DIET

Is applicant on a special diet as ordered by a medical doctor? Yes ( ) No ( ) (STATEMENT REQUIRED BY DOCTOR)

Date Started: Type of Diet: Reason for Diet:

ACTIVITY

List all activities or limitations applicant is restricted from as ordered by a medical doctor.

Does applicant have any physical disabilites that require the use of special devices? (Wheelchair, Braces, Walker, Ortho-pedic shoes, Splints, Canes etc.)

HOSPITALIZATIONS

List all operations/illnesses applicant suffered which required hospitalization:

Date Nature of hospitalization Name & address of hospital

Illnesses/Diseases: (List year)

Chicken Pox	_____	German Measles	_____	Pneumonia	_____
Measles	_____	Polio	_____	Croup	_____
Mumps	_____	Whooping Cough	_____	Tuberculosis	_____
Scarlet Fever	_____	Rheumatic Fever	_____	Hepatitis A	_____
Cardiac Problems	_____	Diabetes	_____	Hepatitis B	_____
Cancer	_____				

Other:_____

Is the applicant prone to any of the following? (Please check if YES.)

Asthma	( )	Diarrhea	( )	Urinary Tract Infection	( )
Colds	( )	Nose Bleeds	( )	Vaginal Infection	( )
Constipation	( )	Strep Throat	( )	Weight Gain	( )

Does the applicant have seizures? Yes ( ) No ( )

Age of seizure onset:_____

Date of last seizure:____/_____/_____ Type of seizure:_____

Frequency of seizures: (Number monthly) _____

Date of last blood levels:____/_____/_____ E.E.G._____/_____/_____ CAT Scan:____/_____/_____

Does the applicant have any hearing or vision problems that are uncorrected or uncorrectable? Yes ( ) No ( )

Explain:_____

IMMUNIZATIONS

Type of Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	Booster	Booster
DPT/TD Series							
Polio Series							
Measles (Rubeola)							
German Measles (Rubella)							
Mumps							

Date of last TINE (TB Test):____/_____/_____ Results:_____

Has applicant ever had a positive TINE (TB Test)? Yes ( ) No ( )

Date of last chest x-ray:_____/_____/_____

Date of last Tetnus shot:_____/_____/_____

OTHER

Age menstruation began:_____ Date of last menstrual period:_____/_____/_____

Does applicant have regular montly menstrual cycles? Yes ( ) No ( )

If NO, please comment:_____

Has applicant ever used birth control? Yes ( ) No ( ) Method:_____

Date started: _____/_____/_____ Date discontinued: _____/_____/_____

Has applicant been sterilized? Yes ( ) No ( ) Method:_____ Date____/____/_____

PREFERENCES

Hospital:_____

Address:_____ Telephone:_____

Pharmacy:_____

Address:_____ Telephone:_____

Funeral Director:_____

Address:_____ Telephone:_____

Physician:_____

Address:_____ Telephone:_____

Optometrist:_____

Address:_____ Telephone:_____

Dentist:_____

Address:_____ Telephone:_____

EDUCATION / VOCATION / SOCIAL SECTION

EDUCATIONAL HISTORY (LIST MOST CURRENT FIRST)

Name/address of schools attended Grade Level Dates attended Year graduated

Name/address of program Dates attended Comments

VOCATIONAL HISTORY

Has applicant ever been employed? Yes ( ) No ( ) Sheltered ( ) Competitive ( )

Please list name of current vocational agency or employer:

Agency:_____ From:____/_____/_____To:____/_____/_____

ADDRESS CITY STATE ZIP TELEPHONE

Job responsibilites:_____

Has applicant had any pre-vocational or vocational training? Yes ( ) No ( )

If YES, when and where?_____

OTHER EVALUATIONS

Date of last diagnostic evaluation: _____/_____/_____

Where was the evaluation done?_____

INFORMATION RELEASE

I, _____, herby authorize _____
to release information concerning_____
to_____

I understand that said information will be kept confidential and used only for purposes of evaluation and treatment.

Types of reports requested:

_____ Psychological Evaluation
_____ Medical History
_____ Social History
_____ Individual Program Plan
_____ Speech Evaluation
_____ School Evaluation
_____ Work Evaluation
_____ Other (Specify)_____

Signature:_____
Date:_____
Relation to Client:_____

This release is effective from:____/_____/_____ to:_____/_____/_____