



VILLAGE NORTHWEST UNLIMITED

330 VILLAGE CIRCLE • SHELDON, IOWA 51201

Phone (712) 324-4873 • Fax (712) 324-4877

www.villagenorthwest.org

APPLICATION FOR SERVICES

DATE OF APPLICATION: ____/____/____

NAME: _____ DOB: _____
Last First M.I.

ADDRESS: _____
Street (Including Apt. #) City State Zip

PHONE: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

SEX: Female Male HEIGHT: _____ WEIGHT: _____ EYES: _____ HAIR: _____

MEDICAID NUMBER: _____ EFFECTIVE DATE: _____ STATE ISSUED: _____

MEDICARE NUMBER: _____ EFFECTIVE DATE: _____ STATE ISSUED: _____

MCO: _____ MCO ID #: _____

HEALTH INSURANCE COMPANY NAME: _____

INSURANCE GROUP NUMBER: _____ POLICY NUMBER: _____

INSURANCE TELEPHONE NUMBER: _____

POLICY HOLDER: _____

SS# OF POLICY HOLDER _____ - _____ - _____ PLACE OF EMPLOYMENT _____

GENERAL INFORMATION

County & State of Legal Settlement: _____ County & State of Birth: _____

CASE WORKER/MANAGER: _____
Name Phone

_____ Address (Include City, State, Zip) Email

Does the applicant have a legal guardian? Yes No Pending Temporary Guardian Only
(Please attach a copy of the court document verifying guardianship.)

GUARDIAN: _____
Name Email

_____ Address City, State, Zip

_____ Guardian DOB Home Phone Work Phone Cell Phone

Has a legal conservator been appointed for the applicant by the courts? Yes No Pending Temporary
(Please attach a copy of the court document verifying conservatorship.)

CONSERVATOR: _____
Name Email

_____ Address City, State, Zip

_____ Home Phone Work Phone Cell Phone

FAMILY INFORMATION

FATHER'S NAME: _____ **DOB:** _____

Address: _____ City/State/Zip: _____

Cell Ph: _____ Work Ph: _____ Home Ph: _____

E-mail: _____ SS#: _____/_____/_____

Military Service: Yes No Which Branch? _____

May we contact this person to get additional information? Yes No

MOTHER'S NAME: _____ **DOB:** _____

Address: _____ City/State/Zip: _____

Cell Ph: _____ Work Ph: _____ Home Ph: _____

E-mail: _____ SS#: _____/_____/_____

Military Service: Yes No Which Branch? _____

May we contact this person to get additional information? Yes No

SIBLING'S NAME: _____ **EMPLOYER:** _____ **DOB:** _____

If married, name of spouse _____

Address: _____ City/State/Zip: _____

Cell Ph: _____ Home Ph: _____ E-mail: _____

Does he/she have contact with applicant? Yes No

SIBLING'S NAME: _____ **EMPLOYER:** _____ **DOB:** _____

If married, name of spouse _____

Address: _____ City/State/Zip: _____

Cell Ph: _____ Home Ph: _____ E-mail: _____

Does he/she have contact with applicant? Yes No

SIBLING'S NAME: _____ **EMPLOYER:** _____ **DOB:** _____

If married, name of spouse _____

Address: _____ City/State/Zip: _____

Cell Ph: _____ Home Ph: _____ E-mail: _____

Does he/she have contact with applicant? Yes No

(Please use additional sheet of paper if needed.)

EDUCATIONAL INFORMATION

SCHOOL: _____

Address: _____ City/State/Zip: _____

Ph: _____ Dates Attended: From _____ To _____

Did applicant receive any of the following? Diploma GED Certificate of Attendance

SCHOOL: _____

Address: _____ City/State/Zip: _____

Ph: _____ Dates Attended: From _____ To _____

Did applicant receive any of the following? Diploma GED Certificate of Attendance

SCHOOL: _____

Address: _____ City/State/Zip: _____

Ph: _____ Dates Attended: From _____ To _____

Did applicant receive any of the following? Diploma GED Certificate of Attendance

FINANCIAL INFORMATION

DOES APPLICANT:

Have cash on hand? Yes No Amount: \$ _____

Have a savings account or investments? Yes No Amount: \$ _____

Have a checking account? Yes No Amount: \$ _____

Receive SSI? Yes No Amount: \$ _____

Receive SSDI? Yes No Amount: \$ _____

Receive Social Security? Yes No Amount: \$ _____

Have eligibility for Veteran's benefits Yes No Amount: \$ _____

Have any burial agreement? Yes No

If yes, is it irrevocable Yes No *(Please attach a copy.)*

Have any life insurance? Yes No

If yes, for burial purposes only? Yes No

Have burial plot? Yes No If yes, location _____

RELIGIOUS HISTORY

Religious preference or affiliation: _____

EMPLOYMENT HISTORY

Please list applicant's most recent job first. Include all full-time and part-time employment, including sheltered employment experience, as well as military service assignments and volunteer activities. Attach additional sheet if necessary.

COMPANY NAME: _____

Address: _____ City/State/Zip: _____

Ph: _____ Employment Dates: From _____ To _____

Position/Title: _____ Supervisor: _____

Duties Performed: _____

Major strengths and contributions in this position: _____

May we contact this employer for a reference? Yes No

COMPANY NAME: _____

Address: _____ City/State/Zip: _____

Ph: _____ Employment Dates: From _____ To _____

Position/Title: _____ Supervisor: _____

Duties Performed: _____

Major strengths and contributions in this position: _____

May we contact this employer for a reference? Yes No

COMPANY NAME: _____

Address: _____ City/State/Zip: _____

Ph: _____ Employment Dates: From _____ To _____

Position/Title: _____ Supervisor: _____

Duties Performed: _____

Major strengths and contributions in this position: _____

May we contact this employer for a reference? Yes No

VOC REHAB: Open file with Voc Rehab Yes No

If yes, name of Counselor _____ Phone # _____

MEDICAL HISTORY

PRIMARY DISABILITY: _____

Secondary Disability: _____

Other Disabilities: _____

MOBILITY DEVICES: (check all that apply) wheelchair walker brace(s)
 other (please specify) _____

SEIZURES: Does applicant experience seizures? Yes No If yes, please explain: _____

Describe type of seizure: _____

Length of seizure: _____ Frequency of seizure: _____

Date of seizure onset: _____ Date of most recent seizure: _____

List all past seizure medications used: _____

Has applicant had any of the following illnesses? (check all that apply)

Diabetes High blood pressure Hepatitis Tuberculosis Heart problems Stomach problems
 Cancer Substance/Alcohol abuse Other (please specify): _____

Has applicant had a recent hospitalization? Yes No

If yes: Name of hospital: _____ Date(s): _____

Reason for hospitalization: _____

Has applicant had any recent surgeries? Yes No

If yes: Name of hospital: _____ Date(s): _____

Reason for hospitalization: _____

Does applicant have any special dietary needs? Yes No If yes, please explain: _____

List all known allergies and reactions: _____

Name and address of preferred funeral home: _____

Does applicant have a Living Will? Yes No (If yes, please attach a copy.)

MEDICAL HISTORY (CONTINUED)

CURRENT MEDICATIONS: (use additional sheet if necessary)

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>PURPOSE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does applicant need assistance taking medication? Yes No If yes, please explain: _____

PHYSICIAN NAME: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Last Exam: _____

DENTIST NAME: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Last Exam: _____

OPTOMETRIST NAME: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Last Exam: _____

NEUROLOGIST NAME: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Last Exam: _____

PSYCHIATRIST NAME: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Last Exam: _____

MEDICAL HISTORY (CONTINUED)

COUNSELOR NAME: _____

Address: _____ City/State/Zip: _____

Ph: _____ Date of Last Contact: _____

OTHER SPECIALIST'S NAME: _____

Address: _____ City/State/Zip: _____

Ph: _____ Date of Last Exam: _____

(Please use additional sheet of paper if needed.)

SENSORIMOTOR ABILITIES

Does applicant wear a hearing aid? Right Ear Left Ear Both Ears None

Date of last hearing evaluation: _____

By whom? _____

Describe hearing loss: _____

Does applicant wear glasses? Yes No **Contacts?** Yes No

Describe visual impairment: _____

Describe ability to use upper extremities: _____

Describe communication skills: _____

Is a communication device used? Yes No If yes, explain: _____

LEGAL HISTORY

Has applicant ever been convicted of a crime? Yes No If yes, when? _____

Explain: _____

Is applicant currently on probation? Yes No If yes, for what? _____

When will probation be completed? _____

Is applicant currently under court appointment? Yes No

BEHAVIOR HISTORY

Indicate the frequency of each behavior over the last 12 months:

(Frequently = several times/week; Occasionally - less than once per month)

	Daily	Frequently	Weekly	Monthly	Occasionally	None
Tantrums or outbursts						
Physically assaults others						
Disrupts others' activities						
Verbally or gesturally abusive						
Self injurious						
Resists supervision						
Steals						
Destroys property						
Displays sexually inappropriate behaviors						
Runs away						
Refuses medication						

Please list medications taken in the past for behavioral concerns: _____

DAILY ROUTINE

Describe a typical day: _____

Any non-preferred daily activities? _____

DAILY ROUTINE (CONTINUED)

Indicate amount of supervision required for the following:

Shaving: _____

Bathing: _____

Tooth brushing / dental care: _____

Dressing: _____

Toileting: _____

Nail care: _____

Hair care: _____

Eating: _____

Food preferences: _____

Food dislikes or allergies: _____

Sleep habits: _____

Cleanliness and neatness: _____

FUTURE GOALS

What are the applicant's goals for the future regarding where he/she wants to live and work? _____

FUTURE GOALS (CONTINUED)

What things are important to the applicant? _____

Application completed by: _____

Relationship to applicant: _____ Phone: _____

PLEASE RETURN COMPLETED APPLICATION TO

**Jerry Postma, Director of Admissions
Village Northwest Unlimited
330 Village Circle
Sheldon, IA 51201**

**Email: jerryp@villagenorthwest.org
Phone: (712) 324-5403
Fax: (712) 324-4877**

Revised 07/2016





DOCUMENT CHECKLIST

The following documents will be required if approved for services. They can be included with the application, but are not required at this time.

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Copy of Guardianship, Conservator & Power of Attorney papers |
| <input type="checkbox"/> | <input type="checkbox"/> | Photo ID (issued by state or school) |
| <input type="checkbox"/> | <input type="checkbox"/> | Copy of Social Security card |
| <input type="checkbox"/> | <input type="checkbox"/> | Copy of Birth Certificate |
| <input type="checkbox"/> | <input type="checkbox"/> | List of Immunizations |
| <input type="checkbox"/> | <input type="checkbox"/> | Copy of Insurance Cards (Front & Back of Medicaid, Medicare, MCO) |
| <input type="checkbox"/> | <input type="checkbox"/> | Burial Agreement |
| <input type="checkbox"/> | <input type="checkbox"/> | Copies of most recent Psychological report |
| <input type="checkbox"/> | <input type="checkbox"/> | Photograph of applicant |