Options of Linn County
Instructions for applying for service

All items in section 1 & 2 must be submitted before an admission decision can be made.

Section 1-FORMS TO FILL OUT

	Application for Service & Medication List	Statement signed by person submitting application.
	East Central Region Application	Required of consumers who will request funding from East Central Region MH/DS (i.e. will not have Medicaid funding when services start)
	Health/Therapy/Self-Care Pre-Admission Assessment	Should be completed by someone who knows the applicant well.
	Day Habilitation Personal Interest Assessment	Should be completed by someone who knows the applicant well.
	Medical Exam Report	May use either the form included herein, or a physician's or clinic's form. Must be completed within the last year and signed by a physician.
	General Releases of Information	Complete a release for each person or agency with whom Options must communicate, in order to complete this application and to start services(e.g. Case Manager, residential provider, school staff, physician)
	HIPAA Acknowledgement	Statement signed by the applicant or the legal guardian acknowledging that he or she has been informed of Linn County's Privacy Practices.
	Out of Facility Activities Release & Photo Release	Out of facility activities authorization. Photos and video for advertisement, newsletters and website.

Section 2-DOCUMENTS TO ATTACH TO THE APPLICATION

	Up-To-Date Social History	Completed within last year.
	Psychiatric Evaluation	Must state the diagnosis that qualifies the applicant for Options service.
	Educational Background	May be included in the social history, but any additional reports from school programs are helpful and may be requested.
	Full SIS Assessment & Tier Assignment	
	Current Case Management Plan	

Questions about the application or other required forms? Phone 319-892-5800.

Mail application to: **Options of Linn County**
Attn: Intake & Communications Coordinator
1240 26th Avenue Ct. SW
Cedar Rapids, IA 52404

Or fax to: 319-892-5849

ALL ITEMS BELOW MUST BE SUBMITTED BEFORE SERVICES WILL BEGIN

	Guardianship court order	If applicable.
	Updated Funding Authorization	Must be available before service may begin.
	Copy of Social Security Card	Must be available before service may begin.
	Copy of Photo ID	One of the following: driver's license, government issued ID, school ID or voter's registration card.

Updated: 7/19

Options of Linn County
Application for Service

Funding source(s) _____ **Tier assignment** _____

PERSONAL INFORMATION

Name _____ **DOB** _____ **SS No.** _____

Address _____ **City** _____ **Zip** _____

E-mail _____ **Sex** ___ ___ **Marital Status** _____ **Ph.** _____

Emergency contact(s) _____ **Ph.** _____

Referring person/agency _____ **Ph.** _____

Case Mgr./agency _____ **Ph.** _____

Guardian _____ **Ph.** _____ **Ph.** _____

Residential Provider/Coord. _____ **Ph.** _____

Diagnosis qualifying this applicant for service _____

Do you have a criminal history—i.e., convictions or pending charges—other than misdemeanor traffic violations? (*MUST BE ANSWERED. Please circle your answer.*) **YES** **NO**

MEDICAL

Physician _____ **Phone** _____

Psychiatrist _____ **Phone** _____

Health insurance:

Date of last tetanus inoculation _____ **Allergies** _____

Restrictions and limitations

Please list medications on Page 2 or on the following page.

SocSec

Social Security Payee _____ **Address** _____

Monthly Amount **SSI--$** **SSDI--$** **SS--$**

EDUCATION

High School _____ **Yr. graduated** _____ **Special Ed classes?** _____

HS Work Experience? _____ **College** _____ **# Yrs. attended** ___

_____ _____

APPLICANT OR GUARDIAN SIGNATURE DATE

Options of Linn County
Application for Service

Consumers Name: _____DOB: _____ Date: _____

Please list all medications the applicant currently uses and check (√) the left column below if a medication or feeding is to be administered at Options. Options must be in possession of a physician's written and signed prescription or a Dr. order for each medication administered by Options personnel.

	Medication	Strength	Time Administered	Dose	Signed Rx/Order Attached

Options of Linn County
Application for Service

Health/Therapy/Self Care Pre-Admission Assessment

Instructions: Please complete and include this screening tool with other application material when submitted to Options. Please answer YES or NO for each part of each question and add comments and explanations as necessary for clarity.

Consumers Name: _____DOB: _____ Date: _____

1. **Has the consumer ever received any physical, occupational or speech therapy? Yes/No**
   If Yes, when and where was the therapy provided? Date: _____ Location: _____

   What were the results? _____

   _____

2. **Does the consumer have problems or difficulty with any of the following?**

Yes	No	
☐	☐	**Self-Feeding_____**
☐	☐	**Grooming_____**
☐	☐	**Bathing_____**
☐	☐	**Dressing_____**
☐	☐	**Walking_____**
☐	☐	**Transferring_____**
☐	☐	**Shortness of breath or tiredness due to normal activity _____**
☐	☐	**Sitting in wheelchair for long periods without regularly shifting weight_____**
☐	☐	**Speech being understood by others_____**
☐	☐	**Communicating needs and ideas_____**
☐	☐	**Following simple task instructions_____**
☐	☐	**Range of motion loss in:**
		Upper extremities_____
		Lower extremities_____
☐	☐	**Loss of strength_____**
☐	☐	**Loss of fine or gross motor skills_____**
☐	☐	**Seizures_____**
☐	☐	**Behavior_____**

3. **Does the consumer have a prescribed PT or exercise program? Yes/No**
   If yes, it is effective? Yes/No
4. **Does the consumer use a means of communication other than speech? Yes/No**
   If yes, it is effective? Yes/No

_____ _____ _____
Signature Relationship Date

Options of Linn County
1240 26th Ave. Ct. SW
Cedar Rapids, IA 52404

Day Habilitation Personal/Interest Assessment

General Information

Name: _____ **Date:** _____

Assessment completed by: _____

Seizure History (in the past year): No Known Seizures_____ Controlled seizures _____
Frequency of seizures: ____ Weekly _____ Monthly _____ Less than month ____ None in past year
Description of seizures, including indicator/pre-seizure activity _____
_____
_____

Physical Assessment: _____ Self ambulatory
_____ Needs assistance with ambulation: _____ cane _____ walker _____ crutches _____ wheelchair
Other assistive device needed for ambulation _____
Vision _____
Hearing _____

Self Help: Please use the following rating scale: I = Independent NA = Needs Assistance D = Dependent
_____ Grooming _____ Dressing _____ Eating _____ Toileting
Comments: _____
_____

Communication: Please check the appropriate forms of communication
_____ Verbal communication no issues
- _____ Limited verbal abilities- Describe _____
- _____ Gestures
- _____ Sign Language
- _____ Assistive Technology- Describe _____
  _____

Responds to reinforcers: Check all that apply

- ____ Verbal praise
- ____ Opportunity to select an activity
- ____ A special setting
- ____ Special staff attention
- ____ Other _____
- ____ appropriate physical interaction
- ____ music
- ____ accumulation of chips or objects
- ____ free time

Social Behaviors: Check all that apply

- ____ Socializes with peers
- ____ Interacts appropriately with peers
- ____ Engages in verbal aggression
- ____ Exhibits constant disposition throughout day
- ____ Tolerates nearness of peers
- ____ Interacts appropriately with staff members
- ____ Is physically aggressive
- ____ Interacts appropriately with strangers

Activity Attitudes/Behaviors: Check all that apply

- ____ Is compliant with participation
- ____ Is not agitated by environment
- ____ Requests assistance when needed
- ____ Requests materials when needed
- ____ Accepts assistance from persons other than regular staff
- ____ Performs activities without attention-seeking behaviors
- ____ Participates well in a group
- ____ Energy level is consistent all day

Learning methods: Check all that apply

____ Needs full physical assistance
____ Needs verbal and gestural prompts
____ Needs verbal direction only
____ Needs partial physical assistance
____ Needs demonstration
____ Independently completes tasks

Comprehensive Functional Assessment:

Key: (+) = Consumer performs/responds at least 80% of the time
(-) = Consumer does not perform/respond at least 80% of the time
PI = Consumer is physically incapable of performing skill area
NA = Not Applicable to consumer

____ Has reaching skills
____ Has grasping skills
____ Has releasing skills
____ Can collect own activity materials
____ Can organize own activity areas
____ Can follow safety rules
____ Can transfer learned skills
____ Can read
____ Can recognize some letters
____ Can distinguish colors
____ Has counting skills
____ Can recognize numbers
____ Can complete tasks of one step
____ Can complete tasks of two steps
____ Can complete tasks of three or more steps
____ Can transfer completed items to appropriate area
____ Uses micro switches for activities

General comments:

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GENERAL MEDICAL EXAMINATION REPORT

(Required for Options Facility)

SEND TO: Options of Linn County
1240—26th Avenue Ct. SW
Cedar Rapids, IA 52404

DATE: _____

Name: _____ **DOB:** _____ **Ht.:** _____ **Wt.:** _____

Address: _____

Previous Hospitalizations: (When, Where, Why) _____

_____

_____

_____

Present Complaint, Disability, Problem: _____

_____

Present Medication (If Any) _____

_____

Physical Examination:
Distance Vision: Without Glasses R-20/_____L-20/_____With Glasses R-20/_____L-20/_____
Distance Hearing: R_____ L_____ Comments: _____
20 ft. 20 ft.

_____

Do any of the conditions below exist now or have they existed in the past**?** If yes, please give details here, or on reverse.

Skin? Nose? Throat?	**Yes**	**No**	
Mouth? Eyes? Ears? Lungs?	**Yes**	**No**	
Heart and Circulatory System:	**Yes**	**No**	
Blood Pressure: S____D____Pulse_____	**Yes**	**No**	
Gastro-Intestinal System:	**Yes**	**No**	
Abdominal Organs or Structure?	**Yes**	**No**	
Bones and Muscles?	**Yes**	**No**	
Nervous System:	**Yes**	**No**	

LABORATORY:

URINALYSIS: _____ **SP. GR.** _____ **ALBUMEN**_____ **REACTION**_____**SUGAR** _____
DATE
BLOOD: _____ **HEMOGLOBIN** _____ **COMMENTS:** _____

Date

Options of Linn County General Medical Examination Report, Page 2

Patient name: _____ DOB: _____

DIAGNOSES _____

Characteristics of Major Disability:

Permanent _____ **Temporary** _____ **Stable** _____ **Progressive** _____ **Improving** _____

Duration and Etiology of Major Disability:

Specify type of Specialist, Appliance or Treatment Recommended:

Physical Capacities: Describe Physical or mental Limitations and Precautions of Employability:

RECOMMENDATIONS:

_____ _____ _____

Physician's Signature **Address** **Date**