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**

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application for Service &amp; Medication List</td>
<td>Statement signed by person submitting application.</td>
</tr>
<tr>
<td>East Central Region Application</td>
<td>Required of consumers who will request funding from East Central Region MH/DS (i.e. will not have Medicaid funding when services start)</td>
</tr>
<tr>
<td>Health/Therapy/Self-Care Pre-Admission Assessment</td>
<td>Should be completed by someone who knows the applicant well.</td>
</tr>
<tr>
<td>Day Habilitation Personal Interest Assessment</td>
<td>Should be completed by someone who knows the applicant well.</td>
</tr>
<tr>
<td>Medical Exam Report</td>
<td>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.</td>
</tr>
<tr>
<td>General Releases of Information</td>
<td>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)</td>
</tr>
<tr>
<td>HIPAA Acknowledgement</td>
<td>Statement signed by the applicant or the legal guardian acknowledging that he or she has been informed of Linn County’s Privacy Practices.</td>
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</table>

**Section 2-DOCUMENTS TO ATTACH TO THE APPLICATION**

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

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Guardianship court order</td>
<td>If applicable.</td>
</tr>
<tr>
<td>Updated Funding Authorization</td>
<td>Must be available before service may begin.</td>
</tr>
<tr>
<td>Copy of Social Security Card</td>
<td>Must be available before service may begin.</td>
</tr>
<tr>
<td>Copy of Photo ID</td>
<td>One of the following: driver’s license, government issued ID, school ID or voter’s registration card.</td>
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Updated: 7/19
Options of Linn County
Application for Service

Funding source(s) ________________________________ Tier assignment __________________

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

Physician ____________________________ Phone ____________
Psychiatrist ____________________________ Phone ____________
Date of last tetanus inoculation _________ Allergies ____________________________
Restrictions and limitations

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

Social Security Payee ____________________________ Address ____________________________
Monthly Amount SSI--$ SSDI--$ SS--$

High School ____________________________ Yr. graduated _____ Special Ed classes? _____
HS Work Experience? ____________________________ College ____________________ # Yrs. attended __________

_________________________________ APPLICANT OR GUARDIAN SIGNATURE ________________ DATE ____________________________

Updated: 7/19
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.**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Time Administered</th>
<th>Dose</th>
<th>Signed Rx/Order Attached</th>
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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 __________

Updated: 7/19
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 ______ appropriate physical interaction
____ Opportunity to select an activity ______ music
____ A special setting ______ accumulation of chips or objects
____ Special staff attention ______ free time
____ Other ________________________________

Social Behaviors: Check all that apply
____ Socializes with peers ______ Tolerates nearness of peers
____ Interacts appropriately with peers ______ Interacts appropriately with staff members
____ Engages in verbal aggression ______ is physically aggressive
____ Exhibits constant disposition throughout day ______ Interacts appropriately with strangers

Activity Attitudes/Behaviors: Check all that apply
____ Is compliant with participation ______ Accepts assistance from persons other than regular staff
____ Is not agitated by environment ______ Performs activities without attention-seeking behaviors
____ Requests assistance when needed ______ Participates well in a group
____ Requests materials when needed ______ Energy level is consistent all day
Learning methods: Check all that apply

- Needs full physical assistance
- Needs partial physical assistance
- Needs verbal and gestural prompts
- Needs demonstration
- Needs verbal direction only
- 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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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 __________

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

Updated: 7/19