

HORIZONS UNLIMITED APPLICATION FOR SERVICES

PLEASE CHECK SERVICES REQUESTED:

Work Activity	_____ RCF-MR Group Home/Waiver
Supported Employment	_____ SAIL Program
Partial	_____ INCH/Scattered Site Program
Work Assessment	_____ ICF/MR Placement
Home & Community Based Services	_____ Will live at Home

Proper Name: _____
 Nickname: _____
 Middle Name/Initial: _____
 Last Name: _____
 Address: _____
 City/State: _____
 Zip: _____
 Telephone: _____
 Work Phone No: _____
 Emergency Contact: _____

Date of Birth: _____
 Marital Status: Married Single Divorced
 (Please Circle One)
 Current Living Arrangement: _____
 County of Legal Settlement: _____
 Social Security No.: _____
 Sex: M F (Please Circle One)
 Birthplace: _____
 Father's Name: _____
 Mother's Maiden Name: _____

	Yes	No	Name	Address
Legal Guardian:	_____	_____	_____	_____
Conservator:	_____	_____	_____	_____
Payee	_____	_____	_____	_____

FINANCIAL RESOURCES

Social Security	\$	_____	SSI	\$	_____
V.A. Benefits	\$	_____	*Railroad Retirement Benefits	\$	_____
Earnings	\$	_____	*Other Assistance	\$	_____
*Savings Accounts	\$	_____	*CD's, Burial Funds, Trusts	\$	_____
*Life Insurance Policies	\$	_____			

*This information needed for SSA Pre-Application Form

Health Insurance: _____	Title XIX Number: _____
Medicare No: _____	Medicaid No. _____
DHS Case No: _____	

Medical Concerns: _____

Do you have seizures: _____

Current Medications and Dosages: _____

Are you currently involved with other agencies? Contact Person/Phone No.

DHS (Department of Human Services)	_____	_____
DVRS (Department of Voc. Rehab. Services)	_____	_____
Mental Health Center	_____	_____
Other	_____	_____

ASSISTANCE IS NEEDED IN WHICH OF THE FOLLOWING AREAS OF INDEPENDENT LIVING?

	YES	NO	UNCERTAIN
Meal Planning/Cooking	_____	_____	_____
Housekeeping	_____	_____	_____
Personal Care/Grooming	_____	_____	_____
Laundry/Clothing Care	_____	_____	_____
Management of Personal Finances	_____	_____	_____
Transportation/Community Mobility	_____	_____	_____
Medication Administration/Health	_____	_____	_____
Socialization/Leisure Time	_____	_____	_____
Referred to Additional Services	_____	_____	_____

Explain Briefly Any are Marked “Yes” or “Uncertain”

The following information is necessary prior to finalizing admission to our program. These reports should be included with this application, if available.

	Reports Enclosed	
	Yes	No
A. Medical Report including physical exam done within past year	_____	_____
B. TB Test Done within past year (residential programs only)	_____	_____
C. Dental Report with exam done within past year (residential programs only)	_____	_____
D. Most recent psychological and/or psychiatric report	_____	_____
E. Social History	_____	_____
F. Reports from Other Agencies/Programs	_____	_____
G. Proof of legal guardianship (if applicable)	_____	_____
H. Copy of Birth Certificate/Social Security Card	_____	_____
I. Photo I.D. (optional)	_____	_____

EDUCATIONAL BACKGROUND:

Schools Attended: _____

What are the goals you have set for yourself for the future:

Is there anything not covered on this application form that you think is important for the Work Activity Center to know?

Please return to: Attn: Sharon Manwarren
 Horizons Unlimited
 P.O. Box 567
 Emmetsburg, IA 50536

Telephone: (712) 852-2211
 FAX: (712) 852-480