MID-STEP SERVICES, INC.
PLACEMENT APPLICATION

Mid-Step Services, Inc. – 4303 Stone Ave. – Sioux City, IA 51106
Telephone: 712-274-2252 Fax: 712-276-0321

Mission Statement: At Mid-Step Services, we are dedicated to providing residential, vocational, educational and recreational services to people with intellectual disabilities in a caring, supportive environment where each individual is encouraged to reach his or her highest

A. IDENTIFYING INFORMATION

Applicant:

1. Name: _____.
   Last First M.
   Address: _____.
   _____.
2. Social Security Number:_____.
3. Title XIX:_____.
4. MCO Provider _____ MCO #_____.
5. Date of Birth:_____ 5a. Sex: _____.
6. County of Legal Settlement:_____.
7. Case Worker/Manager: _____.
   Address: _____.
   _____.
   Telephone #: _____.

8. Does applicant have a Guardian ? ____Yes____No
   If Yes, complete:
   Guardian's Name:_____.
   Address: _____.
   _____.
   Telephone #: _____.

9. Father's Name: _____.
   Home Address:_____.
   _____.
   Telephone #: _____.
   Mother's Name: _____.
   Home Address:_____.
   _____.
   Telephone #: _____.

10. List family members applicant has interaction with:
    a._____.
    Name Phone#
    b._____.
    Name Phone#

11. Indicate Services Requested (Check One):
    _____(ICF/ID) Intermediate Care Facility for Intellectually Disabled
    _____(HCBS) Home & Community Based Services
    _____Supervised Apartments
    _____Work Activity Center
    _____In-Home Services
    _____Other

12. Indicate applicant's place of residence and/or services (Circle One) :
    a. Living with parents
    b. Living with relatives
    c. Intermediate Care Facility for the Intellectually Disabled
    (ICF/ID):_____.
    Name of Facility
    d. Home & Community Based Services
    (HCBS):_____.
    Name of Facility
    e. Supervised Apartments:_____.
    Name of Facility
    f. In-Home Services _____.
    Name of Facility
    g. Work Activity Center_____.
    Name of Center
    h. Other (specify) :_____.

13. Why is placement being requested? _____.
    _____.
    _____.

14. Have other potential placement been investigated?
    ____Yes ___No If so, list place and location:
    _____.
    _____.

B. DISABILITY DESCRIPTION

15. Circle all the developmental disabilities that apply:
    a. Intellectual Disabilities
    b. Autism
    c. Cerebral Palsy
    d. Learning Disability (e.g. – Dyslexia Dysgraphia)
    e. Other Neurological Impairments
    (e.g. – Tourette's Syndrome, Prader-Willi)
    f. Undetermined Developmental Disability
    g. Other _____.

16. From Question 14 enter one letter which represents applicant's primary disability:_____.

17. What is the applicant's IQ?:_____.

17a. Date of last IQ testing: _____.

18. When was the diagnosis first made?_____.

D. SENSORY/MOTOR SKILLS

34. Does applicant wear dentures? _____Yes ____No

35. Does applicant have glasses? _____Yes_____No
Which best describes applicant's vision?
(Circle One)
a. Fully sighted
b. Moderate impairment (has trouble seeing traffic lights, curbs, may be sensitive to bright light)
c. Severe impairment (cannot see faces, line on which to write or mark)
d. Light perception (see only light and/or shadows)
e. Total blindness

36. How does applicant transfer weight: (Circle One)
a. Totally independent
b. Totally dependent
c. Assisted

37a Circle responses that best describes applicant's typical level of mobility:
a. Walks independently
b. Walks independently but with difficulty (no corrective device)
c. Walks only with assistance from another person
d. Uses a walker
e. Uses wheelchair/independent
f. Uses wheelchair/dependent
g. Other forms of locomotion: _____.

37b Indicate whether or not applicant:
a. Can roll from back to stomach? _____Yes _____N o
b. Can pull self to stand? _____Yes _____N o
c. Can walk up and down stairs by alternating feet from step-to-step? _____Yes _____N o
d. Can pick up a small object ? _____Yes _____N o
e. Can transfer an object from hand-to-hand? ____Yes ____N o
Comments: _____.
_____.

37c. Does applicant wear hearing aids? _____Yes_____No
Which alternative best describes applicant's hearing? (Circle One)
a. Normal
b. Mild loss (frequent difficulty hearing normal speech)
c. Severe loss (can hear only amplified speech)
d. Profound loss (can't hear even amplified speech; deaf)
e. Can localize sound/speech

E. SOCIAL/BEHAVIORAL ADJUSTMENT/ DEVELOPMENT

38. Is applicant a smoker? ____Yes ____N o

39. Does applicant like to participate in group activities? ____Yes ____N o

40. Does applicant initiate interaction with others? ____Yes ____N o

41. Can applicant attend to task? ____Yes ____N o
Approximately how long? _____.

42. Is applicant aware of the following?
_____self _____others _____environment

F. COGNITIVE/COMMUNICATION

43. Circle which skills the applicant can accomplish:
a. Speak
b. Non-verbal
c. Sign
d. Gesture
e. Use facial expressions
f. Use a communication board
g. Other: _____.

44. Indicate whether or not applicant can perform each of the following skills/tasks/communication directives:
a. Knows how to read and write? ____Yes ____N o
b. Understands the concept of money? ____Yes____N o
c. Understands simple addition/subtraction? ____Yes____No
d. Knows how to use the stove/oven/microwave? ____Yes ____N o
e. Knows how to prepare foods that do not require cooking? _____Yes _____N o
f. Knows how to shop for meals? _____Yes _____N o
g. Knows how to use the telephone? _____Yes_____N o
h. Understands one-step directions (e.g.- "Put on your coat?") _____Yes _____N o
i. Understands two-step directions (e.g. "Put on your coat and then go outside?") _____Yes _____N o
j. Indicates a "Yes" or "No" response to a simple question? _____Yes _____N o
k. Knows how to make the bed? _____Yes _____N o
l. Knows how to clean a room? _____Yes _____N o
m. Knows how to do laundry? _____Yes _____N o
n. Knows safety in crossing streets in the neighborhood? _____Yes _____N o
o. Knows how to use public transportation for a simple direct trip? _____Yes _____N o
p. Knows what leisure time is? _____Yes _____N o

19. From the most recent assessment available, indicate applicant's level of intellectual functioning:
    a. Mild Intellectual Disabilities
    b. Moderate Intellectual Disabilities
    c. Severe Intellectual Disabilities
    d. Profound Intellectual Disabilities
    e. Not determined at this time.

20. Does applicant have a psychiatric diagnosis ?
    (e.g. – ADHD, bi-polar, personality disorder, etc.)
    ___Yes ___No

C. MEDICAL

21. Does applicant have known allergies?___Yes___No
    If Yes, indicate:_____.

22. Does applicant have a history of epilepsy/seizure disorders? ___Yes ___No (Circle what applies)
    a. Simple partial (Simple motor movements affected, no loss of awareness)
    b. Complex partial (Loss of awareness)
    c. Generalized/Absence (Petit Mal)
    d. Generalized/Tonic-Clonic (Grand Mal)
    e. Had some type of seizure, not sure of type.

23. In the past year, how frequently has applicant experienced seizures that involve loss of awareness and/or consciousness? (Circle One)
    a. None
    b. Less than once a month
    c. About once a month
    d. About once a week
    e. Several times a week
    f. Once a day or more
    Date of last observed seizure: _____.

24. Indicate "Yes" or "No" for each of the following medical condition:
___Respiratory (e.g.-asthma, emphysema, cystic fibrosis)
___Cardiovascular(e.g.-heart disease, high blood pressure)
___Gastrointestinal (e.g.-ulcer, colitis, liver/bowel difficulties)
___Genito-Urinary (e.g.-kidney problems)
___Neoplastic disease (e.g.-cancer, tumors)
___Neurological disease (e.g.-MS, Organic Brain Syndrome, ALS, Huntington's disease)
Other: _____.

25. Is applicant diabetic? ___Yes ___No
    If Yes; is applicant insulin dependent? ___Yes ___No

26. Does applicant take any medications?___Yes ___No
    If Yes, list medications and dosages:
    _____.
    _____.
    _____.
    _____.

27. List the doctor's name, address and telephone number for the above prescribed medications listed:
    _____.
    _____.
    _____.
    _____.
    _____.

28. Does applicant receive on-going medication by injection? ___Yes ___No

29. Which best describes the assistance level applicant requires when taking prescription medication?
    a. No medication.
    b. Total staff support
    c. Partial – staff assistance
    d. Minimal – staff supervision
    e. Independent – responsibility of applicant

30. Indicate whether or not applicant:
    a. Was hospitalized for medical problem in last year?
    ___Yes ___No Date of hospitalization: _____.
    b. Does applicant require direct care staff be trained in special health care procedures (e.g. – ostomy care, positioning adaptive devices) ___Yes___No
    If Yes, specify: _____.
    _____.
    c. Does applicant require special diet planned by dietician, nutritionist or nurse (e.g.- high fiber, low-calorie, low-sodium, pureed, ground, etc.)
    ___Yes ___No
    If Yes, specify: _____.
    _____.

31. Circle which best describes the applicant's sleep pattern:
    a. Sleeps through night
    b. Restless
    c. Roams during night
    d. Light sleeper

32. Physical description of applicant:
    Current Height: _____.
    Current Weight: _____.
    Identifying Marks:_____.

33. Mark any services the applicant currently receives:
    ____Physical Therapist ___Nurse
    ____Speech & Hearing Pathologist ___Psychiatrist
    ____Occupational Therapist
    ____Other; specify: _____.

List the name, address, and telephone number to all that apply above:
_____.
_____.
_____.

G. BEHAVIOR

45. Indicate the frequency of each behavior over the last 12 months: (Check (X) in the appropriate columns)

	NONE This Year	**OCCASIONALLY** Less than once a month	**FREQUENTLY** Several times a week	**DAILY** Once a day or more
a. Has tantrums or emotional outbursts:	_____	_____	_____	_____.
b. Damages own or other's property:	_____	_____	_____	_____.
c. Physically assaults others:	_____	_____	_____	_____.
d. Disrupts other's activities:	_____	_____	_____	_____.
e. Is verbally or gesturally abusive:	_____	_____	_____	_____.
f. Is self-injurious:	_____	_____	_____	_____.
g. Resists supervision:	_____	_____	_____	_____.
h. Runs or wanders away:	_____	_____	_____	_____.
i. Steals:	_____	_____	_____	_____.
j. Eats inedible objects (PICA):	_____	_____	_____	_____.
k. Displays sexually inappropriate behavior:	_____	_____	_____	_____.
l. Disturbs property:	_____	_____	_____	_____.

As a result of any behavior(s) what corrective measures are used? (Please describe)

_____.
_____.
_____.

46. As best you can, indicate how independently applicant typically performs each activity:

	TOTAL SUPPORT/ASSISTANCE Completely Dependent. Requires hands-on assistance	SUPERVISION Requires mainly Verbal prompts	INDEPENDENT Starts & Finishes without prompts/help
a. Toileting/bowels:	_____	_____	_____.
b. Toileting/bladder:	_____	_____	_____.
c. Taking a shower/bath:	_____	_____	_____.
d. Brushing teeth/:	_____	_____	_____.
cleaning dentures:	_____	_____	_____.
e. Chewing/swallowing food:	_____	_____	_____.
f. Feeding self:	_____	_____	_____.
g. Brushing/combing hair:	_____	_____	_____.
h. Selecting clothes appropriate to weather:	_____	_____	_____.
i. Putting on clothes:	_____	_____	_____.
j. Undressing self:	_____	_____	_____.
k. Drinking from a cup or glass:	_____	_____	_____.

Please enclose copies of last evaluation, Individual Educational Plan (IEP), Vocational Staffing (if applicable), Psychological Evaluation or results of last Professional Staffing and a Current Physical Report.

Completed by: _____. Date Completed: _____.
Address: _____.
_____.
Telephone Number: _____.