**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. Guardian/Case Manager email: .

10.Father’s Name: .

 Home Address: .

 .

 Telephone #: .

 Mother’s Name: .

 Home Address: .

 .

 Telephone #: .

11. List family members applicant has interaction with:

 a. .

 Name Phone#

 b. .

 Name Phone#

12. 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

13. 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) : .

14. Why is placement being requested? .

 .

 .

15. Have other potential placement been investigated?

 Yes No If so, list place and location:

 .

 **.**

**B. DISABILITY DESCRIPTION**

16. 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 .

17. From Question 14 enter one letter which represents

 applicant’s primary disability: .

18. What is the applicant’s IQ?: .

18a. Date of last IQ testing: .

19. When was the diagnosis first made? .

**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 potential.**

40. Does applicant like to participate in group activities?

 Yes N o

41. Does applicant initiate interaction with others?

 Yes N o

42. Can applicant attend to task? Yes N o

 Approximately how long? .

43. Is applicant aware of the following?

 self others environment

**F. COGNITIVE/COMMUNICATION**

44. 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: .

45. 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

**D. SENSORY/MOTOR SKILLS**

35. Does applicant wear dentures? Yes No

36. 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

37. How does applicant transfer weight: (Circle One)

 a. Totally independent

 b. Totally dependent

 c. Assisted

38a 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: .

38b 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: .

 .

38c. 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**

39. Is applicant a smoker? Yes N o

20. 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.

21. Does applicant have a psychiatric diagnosis ?

 (e.g. – ADHD, bi-polar, personality disorder, etc.)

 Yes No

**C. MEDICAL**

22. Does applicant have known allergies? Yes No

 If Yes, indicate: .

23. 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.

24. 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: .

25. 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: .

26. Is applicant diabetic? Yes No

 If Yes; is applicant insulin dependent? Yes No

27. Does applicant take any medications? Yes No

 If Yes, list medications and dosages:

 .

 .

 .

 .

28. List the doctor’s name, address and telephone

 number for the above prescribed medications listed:

 .

 .

 .

 .

 .

29. Does applicant receive on-going medication by

 injection? Yes No

30. 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

31. 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: .

 .

32. Circle which best describes the applicant’s sleep

 pattern:

 a. Sleeps through night

 b. Restless

 c. Roams during night

 d. Light sleeper

33. Physical description of applicant:

 Current Height: .

 Current Weight: .

 Identifying Marks: .

34. 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**

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

 **NONE** **OCCASIONALLY**  **FREQUENTLY** **DAILY**

 This Year Less than once Several times Once a day

 a month a week 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)

 .

 .

 .

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

 TOTAL SUPPORT/ASSISTANCE SUPERVISION INDEPENDENT

 Completely Dependent. Requires mainly Starts & Finishes

 Requires hands-on assistance Verbal prompts 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: . Email Address: .

 .

Telephone Number: .