First Resources Corp.

A Resource For The Community

Disability Services Application

Application Date: _____

Referral Source Contact: (Name, Phone, Email): _____
_____

Service Area	Desired Location	Services Requested
Adult Day Service		☐ Adult Day Hab ☐ Adult Day Care
Employment		☐ Job Development ☐ Discovery ☐ Job Coaching ☐ Small Group Employment
Residential Services		☐ SCL Hourly ☐ Habilitation Hourly (UA/UB) ☐ Site Home ☐ Individual Respite ☐ Group Respite
RCF		

Applicant Information

_____
First Name **Middle Name** **Last Name**

Address (Street, City, State, Zip): _____

_____

Primary Phone # (_____)_____
Social Security #:_____

Date of Birth: _____ **Age:** _____ **Male____ Female____**

Marital Status: **Single_____** **Married_____** **Divorced_____**

Does the person have a legal guardian? ___ Yes ___No
Is the person under a mental health committal? ___ Yes ___No
Does the person have a case manager or care coordinator? ___ Yes ___No
Is the person on probation? ___ Yes ___No
Is the person on the Sexual Offender Registry? ___ Yes ___No
List any founded and or pending criminal charges: _____
_____
_____

Current Information

Where does the person live?

___ Alone ____ Currently in hospital ____ With Family
___ In a SCL/Hab Home ____ Currently in Jail ____ Other

List funding source(s) _____

Is the person being or recently been discharged from another provider? ___ Yes ___No
If yes, please describe:

List current place of employment: _____
What is the work schedule? _____
What is the current wage? _____

List any work limitations the person has: _____
_____

List primary form of transportation: _____

List primary emergency contact (Name/Phone #)? _____
_____

Financial/Educational Information

Primary Language: _____**Highest Grade Achieved**_____
List any educational accommodations received:_____
_____

Does the person get SSI or SSDI? **___ Yes ___No ____ Application in process**
If yes, how much per month? _____

Does the person get food stamps? **___ Yes ___No**
Does the person have a representative payee? **___ Yes ___No**
Does the person have a power of attorney? **___ Yes ___No**
Does the person have a conservator? **___ Yes ___No**
Does the person have a burial plan or estate? **___ Yes ___No**

Medical Information

Primary Disability: _____

Other Disabilities: _____

Is there a "Do Not Resuscitate" Order? **____ Yes ____ No**
Is the person an Organ Donor? **____ Yes ____ No**
Is there a history of seizures? **____ Yes ____ No**
Is the person diabetic? **____ Yes ____ No**
If yes, can they self-administer the insulin? **____ Yes ____ No**
Allergies- please list _____

Please list your current medications (or attach a med list):

What help is needed with medication supports? _____
_____

Please list insurance info below

- **Amerigroup # _____**
- **Iowa Total Care # _____**
- **Medicare _____**
- **Dental _____**
- **Private _____**

Describe any accessibility or balance issues the person may have: _____

Support Team Information			
Type of Support	**Name/Dr**	**Town**	**Contact #**
Guardian/POA			
Case Manager/IHH			
Family Member			
Doctor			
Psychiatrist			
Therapist			
Pharmacy			
Service Provider			
Court Advocate			
Payee			
Other			

Thank you for your interest in FIRST RESOURCES CORP!

Please submit completed applications to referral@firstresources.us **or fax to 641-684-4223.**
Please call 641-682-8114 for any questions.

In order to speed up the application process, please send a copy of the following information:

Social History

Current Individual Plan

Copy of guardianship papers

Required RCF Admissions Paperwork

FOR OFFICE USE ONLY:

- Date received: _____
- Date of Admissions Review: _____
- Date Sent for Review: _____
- Sent to: _____
- Date Decision Made: _____
- Admission Decision?
    - If yes, date admitted: _____
    - Put on Wait list: Yes No
    - If no, why: _____

    _____