Dear Applicant,

Thank you for your interest in Genesis Development. Our basic application follows. In addition to the completion of this basic application, we will need the following before we can make a decision as to whether or not we could meet your needs or the needs of your family member:

- A current/updated social history
- At least 1 year's worth of IEPs, IPPs, OAPs, and/or Case Plans
- Last psychiatric and/or psychological evaluations
- A physical within the last year including diagnosis and restrictions
- An assessment does not replace the application

Please send the completed application and the above information to the site of your choice. A completed application is required before consideration of services will be reviewed. After receiving all necessary information, the Admission Committee will meet within 10 working days to address our ability to meet the person's needs. The Chair of the Admissions Committee will contact the Case Manager / Social Worker as soon as the decision is made.

Again, thank you for your interest in Genesis Development. If you have any questions or would like to arrange a tour, please contact the site of your choice to make arrangements.

Belle Plaine
708 12th Street
P.O. Box 95
Belle Plaine, IA 52208
Phone: (319)444-3211
Fax: (319)434-6042

Boone
927 8th Street
Boone, IA 50036
Phone: (515)432-7288
Fax: (515)432-7289

Toledo
1001 C South County Rd.
P.O. Box 315
Toledo, IA 52342
Phone: (641) 484-3561
Fax: (641) 484-2225

Jefferson
401 W. McKinley
P.O. Box 438
Jefferson, IA 50129
Phone: (515)386-3017
Fax: (515)386-4642

Perry
610 Tenth Street
Perry, IA 50220
Phone: (515) 465-7541
Fax: (515) 465-7636

Storm Lake
1607 North Lake Avenue
Storm Lake, IA 50588
Phone: (712)732-5038
Fax: (712)732-3312

Indianola
1809 West 2nd Avenue
Indianola, IA 50125
Phone: (515) 961-6918
Fax: (515) 961-6913

Winterset
115 East Washington
P.O. Box 488
Winterset, IA 50273
Phone: (515)462-9083
Fax: (515)462-9065

Grinnell
925 Broad Street
Grinnell, IA 50112
Phone: (641) 236-0230
Fax: (641) 236-0245

Adel Office
2111 West Greene Street
P.O. Box 221
Adel, IA 50003
Phone: (515) 993-5986
Fax: (515) 993-5988

SERVICES REQUESTED

☐ **Employment Services**

Assistance for individuals desiring full or part time employment in the community. Assistance is based on individual need and could include job-seeking skills, resume writing, interviewing skills, job-keeping skills, job coaching on or off the employment site, and employer accommodations. If community employment is not an option, work activity in a facility-based program may be considered. Individuals are paid based on productivity. Workstations may include recycling, redemption, sub-contracting, janitorial, and box manufacturing.

☐ **Residential Group Living**

☐ **Residential SCL**

Group Living and SCL programs are designed to provide experience in independent living for people with disabilities. Depending upon the individual's needs, these services may provide training and supervision in but not limited to the following areas: personal hygiene, laundry skills, household maintenance, menu planning, cooking, socialization, recreation and leisure skills, money management, medication administration, community mobility, and transportation.

☐ **Discovery**
Adult Day Activity

Discovery offers a wide variety of activities to provide meaningful leisure experiences for those involved. Individuals are encouraged to make their own choices, to integrate with the community, to interact socially and to enjoy the slower pace of their leisure time. It is the purpose of this program to improve the quality of life of the participants by providing experiences that strive toward the least restrictive, most community based setting. It is designed to develop individual potential and raise self-worth and self-sufficiency by providing choices and support.

Reason for Admission _____

_____ _____
(Signature of applicant) (Date)

_____ _____
(Signature of person completing form) (Relationship to applicant)

General Information

Name _____
(last) (first) (middle)

Address _____
(street)

_____
(city) (county) (state) (zip)

Home Phone _____

Cell Phone _____

Email _____

Date of Birth _____

Place of Birth _____

SSN _____

Is placement voluntary? ☐ yes ☐ no ☐ court ordered

Languages spoken _____

Applicants marital status
☐ single ☐ married
☐ divorced ☐ separated
☐ widow(er)

Parents' marital status
☐ single ☐ married
☐ divorced ☐ separated
☐ widow(er)

Father/ Stepfather's (circle one) name

_____

Mother/Stepmother's (circle one) name

_____

Is either parent deceased? ☐ father ☐ mother

Does applicant have a guardian? ☐ yes ☐ no

Name _____

Address _____

_____

Home Phone _____

Cell Phone _____

Email _____

Optional Information *(not required)*

Race _____

Religion _____

Citizenship

Does applicant have Representative Payee or Conservator? ☐ yes ☐ no

If "yes", which? _____

Name _____

Address _____

_____

Phone Number _____

Email _____

Does the applicant receive ☐ yes ☐ no Supplemental Security Income (SSI)? Amount $_____

Does the applicant receive ☐ yes ☐ no Social Security Disability Insurance? Amount $_____

Does the applicant receive ☐ yes ☐ no Food Stamps? Amount $_____

Case manager/Care Coordinator or Social Worker? ☐ yes ☐ no

Name _____

Address _____

_____

Phone _____

Fax _____

E-mail _____

Applicant's current living arrangements
☐ Lives independently
☐ Lives with spouse
☐ Lives with parents
☐ Lives with a family member other than parent or spouse
☐ Lives in group home or Waiver home
☐ Lives in a health care facility
☐ Other (please specify) _____

Medical Information

Diagnosis _____

_____

Age at onset of disability _____

Mechanical aids / allergies _____

_____

_____

Medical insurance? ☐yes ☐no
Please provide number(s)

Medicare _____

Medicaid _____

MCO Name/Number _____

Other _____

Any significant medical concerns? Yes / no

_____

_____

Seizures? ☐yes ☐no

How often? _____

Date of last seizure? _____

Describe seizures _____

_____

_____

Special diet? ☐yes ☐no

Describe _____

_____

Physical disabilities? ☐yes ☐no

Describe _____

_____

_____

_____

Current medications – PLEASE COMPLETE ALL REQUESTED INFORMATION.

1. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

2. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

3. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

4. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

5. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

6. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

7. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

8. Name _____

   Dosage _____ Frequency _____

   For treatment of _____

If more medications, please list on a separate page.

Physician

Name _____

Address _____

_____

Phone _____

Fax _____

Date of Last Appt. _____

Psychiatrist

Name _____

Address _____

_____

Phone _____

Fax _____

Date of Last Appt. _____

Therapist

Name _____

Address _____

_____

Phone _____

Fax _____

Date of Last Appt. _____

Dentist

Name _____

Address _____

_____

Phone _____

Fax _____

Date of Last Appt. _____

Optometrist

Name _____

Address _____

_____

Phone _____

Fax _____

Date of Last Apt. _____

Pharmacy

Name _____

Address _____

_____

Phone _____

Fax _____

Date of Last Apt. _____

Emergency Contact

Name _____

Address _____

_____

Home Phone _____

Cell Phone _____

Email _____

Skills Assessment

This form is to be completed by the case worker or parent as part of the application process. Please circle the frequency that best describes the applicant's ability to perform the skills.

Applicant name _____ Date _____

Completed by _____ Relationship to applicant _____

Communication	never	rarely	sometimes	often
Engages in communication with others. Sign, verbal, written, communication board.	0 ☐	1 ☐	2 ☐	3 ☐
Greets others appropriately.	0 ☐	1 ☐	2 ☐	3 ☐
Uses appropriate manners.	0 ☐	1 ☐	2 ☐	3 ☐
Uses appropriate voice tones.	0 ☐	1 ☐	2 ☐	3 ☐
Basic Skills	never	rarely	sometimes	often
Can tell time by hour and half hour	0 ☐	1 ☐	2 ☐	3 ☐
Knows days of the week, month, and year	0 ☐	1 ☐	2 ☐	3 ☐
Knows address and phone number	0 ☐	1 ☐	2 ☐	3 ☐
Can write name	☐	☐	☐	☐
Can get up independently (with an alarm)	0 ☐	1 ☐	2 ☐	3 ☐
Grooming & Personal Hygiene	never	rarely	sometimes	often
Showers/ bathes independently	0 ☐	1 ☐	2 ☐	3 ☐
Washes / combs hair independently	0 ☐	1 ☐	2 ☐	3 ☐
Applies deodorant independently	0 ☐	1 ☐	2 ☐	3 ☐
Brushes teeth	☐	☐	☐	☐
Shaves (face, legs, underarms)	0 ☐	1 ☐	2 ☐	3 ☐
Changes clothes independently	0 ☐	1 ☐	2 ☐	3 ☐
Manages feminine hygiene (if applicable)	0 ☐	1 ☐	2 ☐	3 ☐

Health / Safety / First Aid	never	rarely	sometimes	often
Can take medication independently (without any supervision)	0 ☐	1 ☐	2 ☐	3 ☐
Communicates health needs to staff	0 ☐	1 ☐	2 ☐	3 ☐
Handles basic emergencies	0 ☐	1 ☐	2 ☐	3 ☐
Laundry / Clothing Care	never	rarely	sometimes	often
Sorts laundry	☐	☐	☐	☐
Operates washer	☐	☐	☐	☐
Operates dryer	☐	☐	☐	☐
Folds and hangs clothes	0 ☐	1 ☐	2 ☐	3 ☐
Can make clothing purchases	0 ☐	1 ☐	2 ☐	3 ☐
Housekeeping Skills	never	rarely	sometimes	often
Can vacuum	☐	☐	☐	☐
Can make bed daily	0 ☐	1 ☐	2 ☐	3 ☐
Can change sheets	☐	☐	☐	☐
Can dust	☐	☐	☐	☐
Washes and dries dishes	0 ☐	1 ☐	2 ☐	3 ☐
Can empty trash	☐	☐	☐	☐
Can clean bathroom	0 ☐	1 ☐	2 ☐	3 ☐
Meal Preparation	never	rarely	sometimes	often
Sets table	☐	☐	☐	☐
Can operate appliances	0 ☐	1 ☐	2 ☐	3 ☐
Can prepare simple foods	0 ☐	1 ☐	2 ☐	3 ☐
Safety conscious in kitchen	0 ☐	1 ☐	2 ☐	3 ☐

Skills Assessment Continued…

Banking and money management	never	rarely	sometimes	often
Recognizes coins and values	0 ☐	1 ☐	2 ☐	3 ☐
Performs cash transactions	0 ☐	1 ☐	2 ☐	3 ☐
Recognizes differences between wants and needs	0 ☐	1 ☐	2 ☐	3 ☐
Community mobility	never	rarely	sometimes	often
If lost, is able to get help	0 ☐	1 ☐	2 ☐	3 ☐
Obeys traffic signals/signs	0 ☐	1 ☐	2 ☐	3 ☐
Can travel independently in the community	0 ☐	1 ☐	2 ☐	3 ☐
Can make appointments independently	0 ☐	1 ☐	2 ☐	3 ☐
Uses community resources independently	0 ☐	1 ☐	2 ☐	3 ☐

Behaviors	never	rarely	sometimes	often
Generally accepted by peers	0 ☐	1 ☐	2 ☐	3 ☐
Handles frustration / anger appropriately	0 ☐	1 ☐	2 ☐	3 ☐
Accepts constructive criticism	0 ☐	1 ☐	2 ☐	3 ☐
Displays self abusive behavior	0 ☐	1 ☐	2 ☐	3 ☐
Exhibits aggressive behaviors (verbally or physically) to others	0 ☐	1 ☐	2 ☐	3 ☐
Runs away	☐	☐	☐	☐
Is sexually appropriate with others	0 ☐	1 ☐	2 ☐	3 ☐
Leisure skills	never	rarely	sometimes	often
Engages in age-appropriate skills	0 ☐	1 ☐	2 ☐	3 ☐
Participates in at least 2 community activities	0 ☐	1 ☐	2 ☐	3 ☐
Can initiate 2 individual leisure activities	0 ☐	1 ☐	2 ☐	3 ☐

Occupational Experience (please include date, place and job title of last employment)

_____

_____

_____

_____

_____

Completed by (signature): _____ Date: _____

THIS RECORD IS CONFIDENTIAL

GENESIS DEVELOPMENT GENERAL MEDICAL EXAMINATION

SECTION I (To be filled out by the Program Coordinator or referring agency)

(Last Name) (First Name)

☐ S ☐ M ☐ W ☐ D ☐ Sep

(DOB) (Race) (Sex) (Marital Status)

MEDICAID NUMBER_____ MEDICARE NUMBER _____

Home Address: Street & Number City or Town County State

Allergies (Known) _____

Guardian _____

Signature _____ Date _____

SECTION II (To be filled out by the Physician)

Diagnosis(es): _____

History of Disability (Onset, course, treatment to date) _____

Systemic Review _____

PHYSICAL EXAMINATION:
Present Disabilities, Mental Attitude, Physique, Gait, Bodily Vigor, etc. _____

Resultant Problems: **Height** _____ft. _____in. **Weight**_____lbs. **Temperature** _____F.

Eyes: Right _____ Left _____ **Ears:** Right _____ Left _____

Nose _____ **Throat**_____ **Mouth** _____

Neck _____ **Lymphathic System** _____ **Breasts** _____

*Client Name:*_____ *Date of Birth:*_____ *Title XIX #:*_____

Lungs: Right _____ Left _____ **Circulatory System:** Heart _____ Pulse Rate _____

Blood Pressure_____ **Cyanosis** _____

Abdomen: _____ **Hernia:** _____

Genito-Urinary: _____ **Ano-Rectal:** _____

Nervous System: _____ **Skin:** _____

Feet: _____ **Varicose Veins:** _____

Orthopedic Impairments: _____

Urinalysis: Date _____ **Specific Gravity** _____ **Reaction** _____

Albumen _____ **Sugar** _____ **Microscopic** _____

NUTRITIONAL STATUS: Special Diet ☐ YES ☐ NO

If yes,explain: _____

_____

_____

PHYSICAL ACTIVITIES: any limitation(s)?: yes / no (circle one) If yes, please describe

_____

_____

_____

WORKING CONDITIONS: any limitation(s)?: yes / no (circle one) If yes, please describe

_____

_____

_____

RECOMMENDATIONS:

Is examination by specialist advisable for completeness of diagnosis or prognosis?

_____

_____

Refraction _____ X-ray of Chest _____ Other diagnostic procedures (specify) _____

Prosthetic Appliances (specify) _____

Hospitalization (specify type and approximate duration) _____

_____

REMARKS:

Medications (1) _____ (2) _____ (3) _____

Referrals (1) _____ (2) _____ (3) _____

The results of this examination have been discussed and explained to the patient.

Date _____ Physician _____

Address _____

Genesis Development

Criminal Conviction Disclosure Form

Name

Last	First	Middle

Address

Street or P.O. Box	City	State	Zip Code

Birthdate

Month	Day	Year

Have you ever been convicted of any criminal offense other than a minor traffic violation?

Yes ☐ **No** ☐

A conviction includes the initial plea, verdict, or finding of guilt, plea of no contest, or pronouncement of sentence by a trial court, even if that conviction may not be final or sentence actually imposed, until appeals are exhausted. Minor traffic violations are those under $1000 not involving alcohol, dangerous drugs, or controlled substances

If you answered yes, provide the following details: Date of arrest, city and state where arrested, name and location of court where case was heard, details of the violation of which you were convicted, dates of imprisonment, dates of period of probation, conditions of probation, name and address of probation officer, amount of fine paid.

_____

_____

_____

_____

_____

_____

Are you or have you ever been required to register as a sex offender?

Yes ☐ **No** ☐

I hereby certify that all statements, answers, and representations on this form, and any attachments, are true, complete and accurate. I understand this information will be used to assist Genesis Development in providing appropriate services and supports.

_____ _____

Signature of person receiving services (or guardian) Date