APPLICATION FOR SERVICES

Date of Application: _____

Applicant's Full Name: _____

Applicant's Present Address: _____

_____

Phone: _____ **Birthplace:** _____

Birthdate: _____ **Sex:** _____ **Marital Status:** _____

Social Security No.: _____ - _____ - _____ **Medicaid No.:** _____ **Medicare No.:** _____

Case Manager: _____ **County:** _____

___ **Legal Guardian** Name: _____ Phone: _____

Address: _____

___ **Co-Guardian** Name: _____ Phone: _____

Address: _____

___ **Trustee** Name: _____ Phone: _____

Address: _____

___ **Conservator** Name: _____ Phone: _____

Address: _____

___ **Payee** Name: _____ Phone: _____

Address: _____

Current Primary Caregiver or Provider:

Name: _____ Birthplace: _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

Applicant's Parents (if under age 18): Marital Status: M S D W (circle one)

Father's Name: _____ Living? _____ Birthdate: _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

Birthplace: _____ Social Security No.: _____ - _____ - _____

Mother's Name: _____ Living? _____ Birthdate: _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

Birthplace: _____ Social Security No.: _____ - _____ - _____

Rules for acceptance and participation in OHI programs are the same for everyone without regard to race, color, national origin, sex, age, handicap, creed, religion, or political affiliation.

(Turn over)

OPPORTUNITY HOMES, INC.
606 Iowa Avenue, PO Box 166, Decorah, IA 52101 **Phone:** 563-382-8140 **Fax:** 563-382-5049

APPLICATION FOR SERVICES

SERVICE APPLYING FOR: (please check AMOUNT & TYPE below)

AMOUNT:	**TYPE:**		
☐Daily	☐ID Waiver	☐Habilitation	☐Chapter 24
☐Hourly	☐Respite	☐BI Waiver	

State why application is being made: (attach supplementary sheet, if necessary)

_____

_____

_____

_____

_____

Race: _____ **Height:** _____ **Weight:** _____ **Eye Color:** _____ **Hair Color:** _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Diagnosed Epilepsy? Yes ___ No ___ **Type of Seizures:** _____

Allergies: (record in red ink) _____

Medications: (include dosage)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Does applicant self-administer medication? Yes _____ No _____

Please list any special attention needed for management of bowels, bladder, or any aspect of personal care:

_____

_____

_____

_____

_____

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