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# 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.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

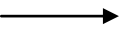
**Mother's Name:** \_\_\_\_\_ Living? \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

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## 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)

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**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)

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**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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