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| Customized Living and Community Residential Services  Request Form |

Fax or Email Filled out form to Jody Parsons IHS Manager at 651-757-3036 [jparsons@accessiblespace.org](mailto:jparsons@accessiblespace.org) along with CSSP, IAPP, behavior, and substance abuse records, or notes

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| --- | --- |
| Date of Application: | Individuals Name: |
| Date of Birth: | Gender: |
| Phone: | Address: |
| MA #: | Other Insurance: |
| Social Security number: | Gross Monthly Income: |
| Monthly Spend down: | Individuals Email: |
| Diagnosis: | Onset Date: |
| Height: | Approximate weight: |
| Description of injury or condition: | |
| Emergency Contact Name: | Emergency Contact Phone, E-mail: |
| County Waiver Type  CADI  BI  EW  Other (what)  Private Pay  Community Residential Services (Waiver Reimagined.)  County of Financial Responsibility: | **Do you have any of the following?**  Relocation service coordinator:  Yes  No  Name and phone number of that provider.  ARHMS or Mental Health Case Manager:  Yes  No  Name and phone number of that provider.  Individualized Home Support:  Yes  No  Name and phone number of that provider.  Personal Care Services  Yes  No  Name and phone number of that provider. |
| Guardian/Conservator/Power of attorney:  Yes  No  Must Provide legal documentation (Please attach) | |
| In the event that we are not able to reach the applicant who may we contact: | |
| Name:  Phone: | Relationship:  Email: |
| Currently living in a health, nursing rehab facility, or group home:  Yes  No | |
| Facility Name: | |
| Facility Address: | |
| Facility Contact Name: | |
| Telephone Number: Fax Number: | |

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| **For all locations, you will also need to fill out a housing application.**   * ASI housing application \* * NHHI housing application \*\* * SPPHA housing application \*\*\* | |  |  |  | | --- | --- | --- | | 24-Hour Customized Living (own apartment) | 24-Hour Customized Living (shared house with 5 other people) | Community Residential Services (Corporate Adult Foster Care) 4 bed group home | | Check all that apply | | | | St. Paul \*\*\* | Minneapolis \* | St. Anthony \* | | Roseville \* | Grand Rapids \* | Falcon Heights \* | | New Brighton \*\* |  | Coon Rapids Flintwood \* | | Mounds view \*\* |  | Coon Rapids Magnolia \* | | Champlin \*\* |  | Blaine \* | | Brooklyn Park \*\* |  | White Bear Lake \* | | Rochester \* |  |  | | Duluth \* |  |  | | Bloomington\*\* |  |  |   How Did you hear about us?  ☐Web Site ☐ Case Manager\_\_\_\_\_\_\_\_\_\_\_  ☐ Family\_\_\_\_\_\_\_\_\_\_\_\_☐ Other\_\_\_\_\_\_\_\_\_\_\_\_ |
| * **Customized Living (shared house):** Consumer self-directed services for persons with a physical disability and/or BI or similar cognitive disability in a shared house with private bedroom, access to staff 24 hours per day. * **Community Residential Services (Adult Foster Care Home):** Supportive services for persons with a physical disability, BI and/or severe cognitive disability in a shared home with private bedroom. Both asleep and awake overnight staffing options. * **Customized Living** **(own apartment):** Consumer self-directed services for persons with a physical disability and/or a BI or similar cognitive disability in an apartment setting with access to staff 24 hours per day. |
| **Will anyone else be living with the applicant**  Spouse/Partner  Children (age 17 or younger)  Other adults | |
|  |  |
| **Service needs (mobility)**  Ambulatory without aid  Ambulatory with aid of device (what device)  Manual wheelchair  Power wheelchair | |
| **Please check any of the following that you require assistance with. ASI does not guarantee that all of these services are available through our service program.**  **Grooming Personal cares ADLs**  Bathing Oral Care (Including Dentures) Dressing  Hair Care Nail Care (Fingers/ Toes)  Toileting (Including Bowel Program)  Skin Care  Foot Care (Ointments, Lotions, Powders, Etc.)  Repositioning Transfers (is a Hoyer or other mechanical lift needed needed?)  Yes  No  ROM I Exercise Program  Mobility inside the Home Opening Doors  Eating/Drinking Menu Planning  Cooking  **Supportive Needs CRS HOMES ONLY**  Retrieving Mail  Organizing Mail  Completing Forms/Applications  Set Up Household Budget Assistance with Communication/Telephone  Making Appointments  Arranging Transportation  Protecting Self from Abusive Situations  Staff Support in Community/Escort Services  Grocery Shopping  **Vocational Needs**  Identifying Volunteer Options  Seeking Day Activities  Finding Employment  **Social Skills**  Cues/Prompting to Initiate Tasks  Maintaining Appropriate Social Behavior  Maintaining Verbal Appropriateness  Maintaining Appropriate Sexual Conduct  Controlling Physical Aggression  Maintaining Sobriety  Following Directions  **Health**  Medication Management (set up, pass, reminders)  Applying Topical Medications  Wound Care  Monitoring Blood Sugar  Self-Injections  Catheter or Colostomy Care  Other /Please List) | |
| **Case Management Information:**  **Name:**  **Address:**  **Phone:**  **Fax**  **Email** | **Do you have any of the following?**  Behaviors Such as shouting, hitting, manipulation  Maladaptive Behaviors Present  Maladaptive Behaviors Not Present  History of behaviors not present  Please list behaviors  Click or tap here to enter text.  Substance Abuse  Prescription Drug Abuse  Illegal Drug Abuse What?  Alcohol Abuse  Solvent Abuse |
| **Housing History**  **Setting Codes (1) With Parent (2) Rental house, or apartment (3) Hospital (4) Group Home (5) Nursing Home (6) Rehab Facility** | |
| Current Housing Code: | Former Housing code: |
| Length of residency: | Length of residency: |
| Name of facility/property: | Name of facility/property: |
| Reason for moving: | Reason for moving: |
| **Medical History** | |
| List Hospitals, Rehabilitation Centers, Nursing Homes, etc. from which you have received recent medical treatment. **IMPORTANT! Please fill out a corresponding "Authorization for Release of Protected Information" form (attached) for each vendor/provider/contact you list below.** | |
| Dates of Stay: | Dates of Stay: |
| Facility Name: | Facility Name: |
| Address: | Address: |
| Phone: | Phone: |
| Fax: | Fax: |
| Primary Physician | |
| Facility Name: | Address: |
| Phone: | Fax: |
| Psychiatrist Name | |
| |  |  | | --- | --- | | Facility Name: | Address: | | Phone: | Fax: | | |
| Psychologist Name: | |
| |  |  | | --- | --- | | Facility Name: | Address: | | Phone: | Fax: | | |
| \* ASI uses race, ethnicity for grant writing purposes | |

**Authorization for Release of Protected Information**

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Individuals Name: Phone: Date of Birth:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individuals Address:

**I authorize the disclosure and use of health information as described below: Who may disclose (give out) this information: Print name, address and phone number of facility, provider, agency or individual you are authorizing to release information)** (Note: If date is not specified, this authorization expires twelve (12) months from the date this form is signed)

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Name: Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

**Information to be disclosed:**

Time Period \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_ This authorization expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | Entire medical record (includes all listed below) |  | Verbal communication (includes all records listed below) |
|  | Behavior records |  | Most recent physical & History |
|  | Chemical health records |  | Most recent discharge summary records |
|  | Psychology/Psychiatric records |  | Medication information |
|  | Neuropsychological evaluation records |  | Daily narratives and progress notes |
|  | Other: |  |  |

**The purpose for which this information may be disclosed:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | At the request of the individual listed above |  | Provision of service |  | Determining care needs |
|  | Developing Care Plan |  | Care Coordination |  | Other |

**Who may receive and use this information:**

Accessible Space, Inc. (ASI) 2550 University Avenue West, Suite 330 North St. Paul, MN 55114 651-645-7271

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Signature of Resident or Resident’s Legal Representative: Date:

**If signed by Resident’s Representative:**

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Print Representative’s Name: Relationship to Resident:

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that:**

I may revoke this authorization at any time by notifying, in writing, the facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. I have the right to inspect or request a copy of the health information to be disclosed. If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed. I do not have to sign this form.