|  |
| --- |
| Customized Living and Community Residential ServicesRequest Form |

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

|  |  |
| --- | --- |
| 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 [ ]  NoName and phone number of that provider.ARHMS or Mental Health Case Manager: [ ]  Yes [ ]  NoName and phone number of that provider.Individualized Home Support: [ ]  Yes [ ]  NoName and phone number of that provider.Personal Care Services [ ]  Yes [ ]  NoName and phone number of that provider.  |
| Guardian/Conservator/Power of attorney: [ ]  Yes [ ]  NoMust 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: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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)

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

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

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

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

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

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

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.