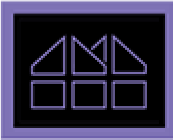


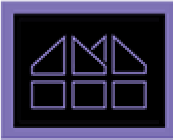
Accessible Space, Inc.

HOUSING WITH CARE®

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 along with CSSP, IAPP, and other relevant records

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	**County of Financial Responsibility:**
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:	



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Facility Contact Name:	
Telephone Number:	Fax Number:

- **Assisted 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.
- **Assisted 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.

24-Hour Assisted Living (own apartment)	**24-Hour Assisted Living (shared house)**	**Community Residential Services (Corporate Adult Foster Care)**
Check all that apply		
☐Minneapolis ***	☐ Minneapolis *	☐ St. Anthony *
☐St. Paul	☐ Grand Rapids *	☐ Falcon Heights *
☐ Roseville *		☐ Coon Rapids *
☐ New Brighton **		☐ Blaine *
☐ Mounds view **		☐ White Bear lake *
☐ Champlain **		
☐ Brooklyn Park **		
☐ Rochester *		
☐ Duluth *		

For all locations you will also need to fill out a housing application.

- ASI housing application *
- NHHI housing application **
- SPPHA housing application ***

Will anyone else be living with the applicant

☐ Spouse/Partner ☐ Children (age 17 or younger) ☐ Other adults

How Did you hear about us?

☐Web Site ☐ Case Manager____________ ☐ Family________________ ☐ Other________

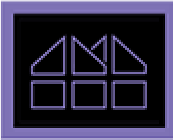
Service needs (mobility)

☐ Ambulatory without aid

☐ Ambulatory with aid of device (what device)

☐ Manual wheelchair

☐ Power wheelchair



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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

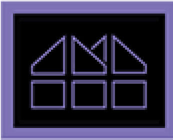
☐Identifying Volunteer Options ☐ Seeking Day Activities ☐ Finding Employment

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)



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Case Management Information:	Do you have any of the following?
Name: **Address:** **Phone:** **Fax** **Email**	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.

Housing History

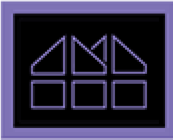
Setting Codes (1) With Parent (2) Rental house, or apartment (3) Hospital (4) Group Home (5) Nursing Home (6) Rehab Facility

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	