Accessible Space, Inc.
HOUSING WITH CARE®

Customized Living (CL) Integrated Community Supports (ICS) and Community Residential Services (CRS) Request Form

Email the completed form to: **services@accessiblespace.org** along with CSSP, IAPP, behavior and substance abuse records, latest provider notes, and signed release of information for health care professionals.

COMPLETE THIS FORM IN ITS ENTIRETY

All Accessible Space, Inc. homes are funded by HUD, and rent is 30% of all income sources.

Date of Application:	Individuals Name:
Date of Birth:	Gender:
Phone:	Address:
MA #:	Other Insurance:
Social Security Number:	Individuals Email:
Diagnosis:	Onset Date:
Height:	Approximate Weight:
Description of injury or condition:	
Emergency Contact Name:	Emergency Contact Phone/Email:
County Waiver Type: ☐ CADI ☐ BI ☐ EW ☐ Other (list) ☐ PRIVATE PAY ☐ Community Residential Services (Waiver Reimagined) County of Financial Responsibility:	**Do you have any of the following?** Names and Phone Number of Provider (s). Relocation Service Coordinator: ☐ Yes ☐ No ARHMS or Mental Health Case Manager: ☐ Yes ☐ No Individualized Home Support: ☐ Yes ☐ No Personal Care Services ☐ Yes ☐ No
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:

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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 ***

- **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. Awake overnight staffing options.
- **Integrated Community Supports (ICS) (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.

Integrated Community Supports (ICS) (Own Apartment)	24-Hour Customized Living (CL) 8 Person Home	Community Residential Services (CRS) 4 Person Home
Check all that apply		
		☐ Falcon Heights*
☐ Roseville*	☐ Grand Rapids*	☐ St. Anthony*
☐ New Brighton**		☐ Coon Rapids Flintwood*
☐ Mounds Views**		☐ Coon Rapids Magnolia*
☐ Brooklyn Park**		☐ Blaine*
☐ Duluth*		☐ White Bear Lake*

How did you hear about us?

☐ Website
☐ Family _____
☐ Case Manager _____
☐ Other _____

Will anyone else be living with the applicant? ☐ Spouse/Partner ☐ Children (age 17 or younger) ☐ Other Adults	
Case Management Information:	**Do you have any of the following?**
Name: **Address:** **Phone:** **Fax:** **Email:**	Behaviors such as shouting, hitting, manipulation ☐ Maladaptive behaviors present ☐ History of behaviors not present ☐ No behaviors Please list behaviors 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 <u>each</u> 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 and ethnicity for grant writing purposes	

Guided Supports Request Form.

The Following is a list of community living service categories, that Accessible Space Inc. either can assist you in or will assist you in finding outside resources if we are unable to provide the assistance ourselves.

*Individuals Name:*_____ *Date:*_____

Community Living

Check each box that applies

☐	Community Mobility, accessing the community.	☐	Asking for help when in the community.
☐	Safety in the community.	☐	Finding volunteer activities in the community.
☐	Community resources, social or leisure activities.	☐	Pedestrian Safety
☐	Accessing public transportation.	☐	Maintaining appropriate social behavior, in the community.
☐	Finding a place of employment.	☐	Finding a place where I can practice my beliefs.
☐	Assistance staying safe in my community.	☐	Support maintaining friendships and family relationships.

Health Safety and Wellness

☐	Scheduling doctors' appointments.	☐	Setting up rides to appointments.
☐	Ordering medications	☐	Picking up medications
☐	Finding a workout gym.	☐	Assistance with hygiene tasks.
☐	Help at doctors' appointments.	☐	Other

Household Management

☐	Planning a special diet.	☐	Making a grocery List.
☐	Grocery Shopping.	☐	Support with accessibility in my living environment.
☐	Support with laundry.	☐	Calling for home maintenance.
☐	Cooking, and safe food handling.	☐	Setting up Cleaning Schedule
☐	Cleaning, home and medical equipment	☐	Other (please list)
☐	Guidance to identify routine household chores and maintenance.	☐	

☐	Getting Mail	☐	Organizing Mail
☐	Organizing Mail	☐	Setting up household budget.
☐	Completing recertification paperwork.	☐	Paying bills
☐	Balancing money checkbook, savings.	☐	Organizing Home, to meet my needs.
Adaptive Skills			
☐	Coordinating services between providers.	☐	Safety at home.
☐	Problem solving.	☐	Support strategies for self-sufficiency.
☐	Support with verbal interactions with others.	☐	Keeping an appointment book, or calendar.
☐	Maintaining appropriate interactions with Staff.	☐	Crisis Prevention skills.
☐	Support with challenging behaviors.	☐	Following housing and lease rules.
☐	Following written directions	☐	Following verbal directions
☐	Other assistance with adaptive skills. Please comment below	☐	Other
Specialized Medical Care			
☐	Catheter Care	☐	Oxygen administration
☐	Monitoring Vital Signs	☐	Monitoring blood sugar
☐	Bowel Program ☐suppository ☐fleet enema, ☐digital stimulation)	☐	Medication Administration
☐	Application of braces or orthotics	☐	Cpap/Bipap use
☐	Superficial wound care	☐	Standing frame
☐	Range of motion	☐	Hoyer Lift * must be electric
☐	Walking programs	☐	Other mechanical lift (what) must be electric
Grooming Personal Cares ADL's			
☐	Bathing	☐	Oral Care
☐	Dressing	☐	Hair Care
☐	Nail Care	☐	Toileting
☐	Skin care	☐	Foot care

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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 Ave W STE 330 N St Paul MN 55114 651-645-7271

Wet Signature of Resident or 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.