Application for services from Independent Living Services, Inc.

The following items must be attached for the application to be complete:

1. Recent photo
2. Birth certificate (if available)
3. Psychological evaluations and results
4. Current medical information and history
5. High School diploma/Certificate of Completion (if under 21 years)
6. Guardianship papers, if applicable

Please check all the service(s) requested:

_____ Group Home-Supervised Living (waiver, personal care, transportation)
_____ Apartment Complex-Supervised Living (waiver, personal care, transportation)
_____ Intermediate Care-Facility – Individual with Intellectual Disabilities (ICF/IID)
_____ Medicaid Waiver Services in home
_____ Profiles - Adult Developmental Day Treatment Services (ADDT)
_____ Profiles Productions Enrichment Center (Work Center)
_____ Supported Employment

Licensed by the state divisions of Developmental Disabilities and Long Term Care Services

Please contact us if you require this information in another format

Revised 05/2016
APPLICATION FOR ADMISSION
INDEPENDENT LIVING SERVICES, INC.
P.O. BOX 1070
CONWAY, AR 72033
(501) 327-5234

Date Application Received: _____________________ Date of Admission: _____________________

Referral Source: ________________________________________________________________

Name of Applicant (full): ___________________________ Nickname: ______________________

Home Address: _________________________________________________________________

Home Phone: ______________ Cell Phone: ____________ E-mail: ________________________

Date of Birth: ______________ Birthplace: __________________________________________

Gender: _____________________ Marital Status: ________________________________

Social Security #: ____________ Medicaid Number: _________________________________

Medicare #: ________________ Part D Medicare: _________________________________

Third Party Insurance: __________ Third Party Insurance #: _______________________

Name of Parent: ______________ Phone: _________________________________________

Guardian: _____________________ Address: ______________________________________

Legal Status (i.e., competency) __________________________________________________

SERVICES

Indicate the services that have been received, or are now being received by the applicant:

_____ Adult Developmental Day Treatment  _____ HCBS Waiver
_____ Special Education  _____ Residential Services
_____ Regular school classes  _____ Mental Health Center
_____ Work Center  _____ Rehabilitation Services
_____ Supported Employment  _____ Nursing home
_____ ICF/IID  _____ Other: ____________________________

Please use the back of this page to give details of any of the above services that were received or are now being received by the applicant. Include dates, place, type of service.
PERSONAL AND FAMILY INFORMATION

Briefly comment on the following items:
Social skills:

__________________________________________________________________________
__________________________________________________________________________

Abilities/Strengths:__________________________________________________________________________
__________________________________________________________________________

Behavior concerns:__________________________________________________________________________
__________________________________________________________________________

Relationship with family members:__________________________________________________________________________
__________________________________________________________________________

Cultural issues needing consideration:__________________________________________________________________________
__________________________________________________________________________

Please list members of the family below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
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<tbody>
<tr>
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</table>
EMPLOYMENT FACTORS

List any special skills/training the applicant has for employment purposes:

Employer_________________________  Supervisor_________________________
Address_________________________  Phone_________________________
Length of employment_______________  Salary/wage_____________________

Former employer_____________________  Type of work_____________________
Employer_________________________  Supervisor_________________________
Address_________________________  Phone_________________________
Length of employment_______________  Salary/wage_____________________

FINANCIAL RESOURCES
(Answer Yes/No to following)

_________ SSI  _________ Pension/Annuity  _________ Savings
_________ SSDI  _________ Trust  _________ Checking
_________ Rep. Payee

LIABILITY FACTORS

Primary diagnosis (proof must be attached)____________________________________
Secondary diagnosis______________  Physical disabilities_____________________

4
MEDICAL INFORMATION

List any special medical care, diets, or physical limitations pertaining to the applicant’s care.

Is the applicant currently being treated for a medical condition? 

If so, explain in detail condition being treated (use back of form if additional space is needed)

Give Name, Dates of Last Visit and Address to the following:

Medical doctor

Dentist

Optometrist

Orthopedic Specialist

Speech Therapist

Physical Therapist

Occupational Therapist

Neurologist

Counseling Service

Please list other doctors, hospitals, clinics, agencies, etc. (if possible with addresses) that have additional information on the applicant.

Please explain any treatment and/or therapy now being received by the applicant.

Applicant’s general health:  Good_____    Fair_______    Poor_______

Comment on areas needing “special supervision” or where applicant may be at risk. Address potential or known risk that the applicant may present in new environment.
## MEDICAL HISTORY

### IMMUNIZATION RECORD

<table>
<thead>
<tr>
<th>Disease</th>
<th>Date Original Vaccination</th>
<th>Date Booster Given</th>
<th>Date Reaction Indication</th>
<th>Date Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria (DTP/DtaP/DT)</td>
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<tr>
<td>Pertussis</td>
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<tr>
<td>Typhoid</td>
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<tr>
<td>Whooping Cough</td>
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<td>Polio (IVP or OPV)</td>
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<tr>
<td>Tetanus</td>
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<tr>
<td>Small Pox (Varcella)</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella/Red/3-day/German</td>
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<tr>
<td>Rubella/Hard/10-day Measles</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Chicken Pox</td>
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<tr>
<td>Tuberculin</td>
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<tr>
<td>Flu</td>
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</table>

### INDICATE AGE AT WHICH ANY OF THE FOLLOWING OCCURRED:

- Asthma
- Convulsive Disorder
- Chronic Cough
- Cysts, Tumors
- Diabetes
- Dizziness
- Fainting
- Eye Problems
- Frequent Depression
- Gallbladder problems
- Hay Fever
- Heart Palpitations
- Headaches/Migraines
- Hepatitis B
- High Blood Pressure
- HIV/Aids
- Insomnia
- Jaundice
- Kidney Disease
- Lung Disease
- Frequent Constipation
- Malaria
- Recurrent Head Colds
- Recurrent Diarrhea
- Recent Weight Gain/Loss
- Rheumatic Fever
- High Fever
- Scarlet Fever
- Seizure
- Sinusitis
- Strep Throat
- Stomach/Intestinal Disease
- Tuberculosis
- Venereal Disease
- Herpes
- Weakness/Paralysis

### SURGERIES

- Appendectomy
- Tonsillectomy
- Hernia Repair
- Hysterectomy
- Tubal Legation
- Vasectomy
- Corrective Surgery
- Other: __________________________
LIST ANY CONGENITAL CONDITIONS

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you have severe headaches? __________ How often do headaches occur? ____________

Name of medicine(s) you take for headache _______________________________________

Have you ever had a seizure? _______________ Age of first seizure _________________

Do you know when you are going to have a seizure? (List warning signs) _______________

________________________________________________________________________

Do any of the following cause you to have a seizure? _____________________________

Getting too hot _______________ Physical exercise _______________

Excitement _______________ Crowds _______________

Have you had an EEG? __________ If yes, when? __________ Where ________________

(TO BE ANSWERED BY WOMEN ONLY)

Do you have regular menstrual periods? Yes __________ No __________
(If answered no, please explain) ______________________________________________
________________________________________________________________________

Describe any problems you have with your periods (such as pain, vomiting, etc.) __________

________________________________________________________________________

Are you now, or have you in the past taken birth control pills? _______________________

Date you began taking birth control pills _________________________________________

Date of last menstrual period _______________ Date of last Pap Smear _________________

Name of doctor and clinic where last Pap Smear was done ___________________________

________________________________________________________________________

Date of last Mammogram ________________

Clinic where Mammogram was done _____________________________________________
MEDICATION RECORD

Are you allergic to any medicine?

Describe allergic reaction

List Medication you are currently taking (Prescription and Over the Counter)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Doctor</th>
<th>Starting Date</th>
<th>Why medicine was prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

List Medications you have taken in the past, but are not currently taking.

Do you have any food allergies or other allergies?

List any dietary restrictions or requirements you have.

FAMILY HISTORY

(If Living)

<table>
<thead>
<tr>
<th>AGE</th>
<th>HEALTH</th>
<th>AGE AT DEATH</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

(If Deceased)

<table>
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<tr>
<th>CAUSE</th>
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</table>
Please indicate any blood relative that has or had the following: (Circle and give relationship)

<table>
<thead>
<tr>
<th>Disease</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>Migraine</td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Diabetes</td>
<td>Mental Health Issues</td>
<td></td>
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<tr>
<td>Goiter</td>
<td>Epilepsy</td>
<td>Stomach Ulcers</td>
<td></td>
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<tr>
<td>Asthma</td>
<td>Hay Fever</td>
<td>Rheumatic Heart</td>
<td></td>
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<tr>
<td>Arthritis</td>
<td>Heart Attack</td>
<td>High Blood Pressure</td>
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<tr>
<td>Suicide</td>
<td>Congenital Heart</td>
<td>Kidney Disease</td>
<td></td>
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<tr>
<td>Colitis</td>
<td>Leukemia</td>
<td>Bleeding Tendency</td>
<td></td>
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</tbody>
</table>

**PERSONAL HABITS**

<table>
<thead>
<tr>
<th>Circle Yes/ No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Do you regularly smoke? Cigarettes ___ Pipe ___ Cigars ___ How long ______</td>
</tr>
<tr>
<td>Yes</td>
<td>Do you usually drink over 6 cups of coffee per day?</td>
</tr>
<tr>
<td>Yes</td>
<td>Do you regularly drink alcohol? 1 oz./ 2 oz./ 4 oz./ over 6 oz. per day</td>
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<tr>
<td></td>
<td>Beer: 1 bottle per day ____ 2 bottles per day ____ Over 5 bottles per day ____</td>
</tr>
<tr>
<td>Yes</td>
<td>Do you have difficulty falling asleep?</td>
</tr>
<tr>
<td>Yes</td>
<td>Do you awaken early in the morning without apparent cause?</td>
</tr>
</tbody>
</table>

Write in names of diseases you have had which required hospitalization:

___________________________________________
___________________________________________
___________________________________________
___________________________________________

Describe any serious injuries or accidents:

___________________________________________
___________________________________________
___________________________________________

List any injury that limits your ability to lift, walk, or participate in physical activities:

___________________________________________
___________________________________________
___________________________________________

Do you wear glasses? __________________________ How long? __________________________

Do you wear a hearing aid? _____________________ How long? _________________________

**Information completed by:**

Name __________________________ Relationship __________________________

Agency __________________________ Title __________________________

Signature of Parent/Guardian/Applicant __________________________ Date __________
RELEASE STATEMENT

I fully understand and agree that I assume all risks in case of personal injury and I authorize Independent Living Services, Inc. to call a physician in case of emergency treatment.

_____  _____

I authorize ILS to give me First Aid measures as deemed necessary.

_____  _____

In case of emergency, notify:

__________________________

Relationship: ________________  Phone No. _____________________

Authority is hereby granted to ILS to use my photograph and name in news releases and stories for/in relation to the agency.

_____  _____

Permission is granted for me to attend field trips with the agency.

_____  _____

I understand ILS may use physical restraints to insure my safety and well being in a crisis situation.

_____  _____

I fully understand and agree to hold ILS harmless in the event of accident or injury to me or my personal property and will further agree to indemnify the facility for any losses incurred by such acts of negligence or injury.

_____  _____

Residential only:

Authority is hereby granted to authorized personnel of the facility to supervise, counsel and advise me in the proper handling of my personal finances. However, neither the facility nor the personnel can be or will be directly responsible for my misuse of my money.

_____  _____

___________________________________  ______________________
Signature of Parent/Guardian/Applicant  Date

This release expires one year from date of signature.
INDEPENDENT LIVING SERVICES, INC.
INFORMED CONSENT FOR SERVICES

NAME:_______________________________________ DATE OF BIRTH:_________

I understand as a participant in ILS’ programs, I am eligible to receive a range of services. The type and extent of services I may receive will be determined following an initial assessment and through discussion with me and my Interdisciplinary Team. The goal of the assessment process is to determine the best possible services and treatment for me.

I understand all information shared with the staff at ILS is confidential and no information will be released without my consent. During the course of treatment at ILS, it may be necessary for my case manager to communicate with other staff at ILS regarding my services. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand there are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, the staff is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion a person is being sexually, physically, or verbally abused or is at risk of such abuse, the staff is legally required to take steps to protect the person and to inform the proper authorities.
- When any incident occurs that requires mandatory reporting to Developmental Disability Services.
- When a valid court order is issued for medical records, the case manager and the agency are bound by law to comply with such requests.

I understand ILS services are provided by a range of professional staff.

I understand while services at ILS may provide significant benefits, it may also pose some risks. These risks may include such things as: industrial grade equipment operation, manipulation of the body through physical and occupational therapy, general risks all individuals have when living in the community.

If I have any questions regarding this consent form or about the services offered at ILS, I may discuss them with my case manager. I have read and understand the above. I consent to participate in the assessment and services offered to me by ILS. I understand I may stop services at any time.

___________________________________________ ____________________
Signature of Parent/Guardian/Applicant Date