Independent Ready Multi-Agency Application

Village Northwest Unlimited: Northwest Iowa Community College: Iowa Vocational Rehabilitation Services: IowaWorks

Demographics

First name: ______________________ Middle Initial: ______ Last Name:________________________

Address: ____

City: _____________________ State: _____________ Zip: ______________ County: ______________

Phone number: _________________________ Email: ____

Date of Birth: __________________________ Age: ______ Social Security #: ___________________

Gender (circle one): Male Female Do not wish to disclose

Race (circle one): White Native Hawaiian or Other Pacific Islander Black or African American
Asian American Indian or Alaska Native Do not wish to disclose

Ethnicity: Are you Hispanic or Latino? Yes No Do not wish to disclose

Are you registered to vote in the state of Iowa? Yes No

Are you a citizen of the United State? Yes No

If no, state type of Visa: __________________________

Is English your native language? Yes No

If No, what is your preferred language? _____________

Do you need an Interpreter? Yes No

Driver's License Information

Do you have a Driver's License? Yes No

If not, do you have a permit? Yes No

Do you have reliable transportation? Yes No

Do you own/are you purchasing a vehicle? Yes No

What is your family size? _________(How many family members, including yourself, related to you by blood, marriage, court decree, or adoption live in your household.)

Are you registered with the Selective Service? Yes No
N/A Male under 18 and/or Female

Does the applicant have a legal guardian? ☐ Yes ☐ No ☐ Pending ☐ Temporary Guardian Only
(Please attach a copy of the court document verifying guardianship.)

Guardian: ____ _________________________________
Name Email

____ ____
Address City, State, Zip

____________________ ____________________ _____________________ ___________________
Guardian DOB Home Phone Work Phone Cell Phone

Has a legal conservator been appointed for the applicant by the courts?
☐ Yes ☐ No ☐ Pending ☐ Temporary

(Please attach a copy of the court document verifying conservatorship.)

Conservator: If name is different from above, please list name, address, and phone number below:
Conservator: ______________________________________ ______________________________
Name Email

_______________________________________ ____
Address City, State, Zip

Emergency Contact Information:
Is there someone outside of your household or relative who would be able to help us contact you?
First name: _________________ Last Name: __________________ Relationship: ________________
Address: ____
City: ____________________ State: ____________ Zip: _____________ County: _____________
Phone number: ________________________ Email: ______________________________________

Who referred you to IVRS? ____________________________ Phone #:_________________________

Did either of your parents graduate from a four-year college? Yes No
Are you a displaced homemaker? Yes No
Are you a single parent? Yes No
Are you a veteran of the US Military?

Education
What best describes your educational background?
☐ In high school and will graduate month ______________ year ________
☐ High school graduate
☐ High school equivalency
☐ Attended another college and not a H.S. graduate
☐ Attended another college and a H.S. graduate
☐ Home school

Highest degree earned at another postsecondary institution
1 = diploma 2= 2-year degree 3= 4-year degree 4= graduate degree 5= certificate
6= none 7= blank-unknown

Enter the name of the high school from which you were or will be graduated. Non-graduates list last high school attended.

Name of school: ____
City, State, Zip: ____

Month & Year of graduation or anticipated graduation: ____

Non Graduate: attended from _______________ to________________
List all collegiate institutions you have attended or are now attending. If you have never attended a colligate institution, write "none". (Transfer students must contact their previous institution for an official transcript.)

Name of each institution attended:
____
____
City and State:
____
____

Dates: from_________ to________
Major or program applying for (this information is necessary to process your application)
Major/Program ____CNC Certification Program____
Applying for term beginning: Fall________ Year_____

National Career Reading Certificates Yes No Level Achieved: __________________________

Other Agency Involvement

Agency			Contact Person & Phone Number
Vocational Rehabilitation	Yes	No	______________________________
PROMISE JOBS Program	Yes	No	______________________________
Probation/Parole	Yes	No	______________________________
General Relief	Yes	No	______________________________
GAP/PACE	Yes	No	______________________________
Other	Yes	No	______________________________

Public Assistance Information

Within the last 6 months, have you received any of the following?

Yes or No:		Assistance Type:	Amount Per Month:
Yes	No	Temporary Assistance for Needy Families (TANF)	$________________
Yes	No	Food Stamps	$________________
Yes	No	Family Investment Plan (FIP)	$________________
Yes	No	Supplemental Security Income (SSI)	$________________
Yes	No	Social Security Disability Insurance (SSDI)	$________________
Yes	No	Aid to Refugees	$________________
Yes	No	General Assistance (GA)	$________________
Yes	No	Free/Reduced Lunches	$________________
Yes	No	Other	$________________

Financial Information

Does Applicant:

Have cash on hand?	☐ Yes	☐ No	Amount: $________________
Have a savings account or investments?	☐ Yes	☐ No	Amount: $________________
Have a checking account?	☐ Yes	☐ No	Amount: $________________
Receive SSI?	☐ Yes	☐ No	Amount: $________________
Receive SSDI?	☐ Yes	☐ No	Amount: $________________
Receive Social Security?	☐ Yes	☐ No	Amount: $________________
Have eligibility for Veteran's benefits	☐ Yes	☐ No	Amount: $________________

Personal Information

Yes	No	Are you pregnant?
Yes	No	Are you a parent?
Yes	No	Are you currently in foster care?
Yes	No	Are you a runaway?
Yes	No	Are you involved with the Adult of Juvenile System?
Yes	No	Did you age out of foster care at age 18 or receive 1 year of TAL (Transition to Adult Living) services after age 14
Yes	No	Are you an English Language Learner?
Yes	No	Is English your native language? If NO, do you have limited ability to speak English? Y N
Yes	No	Do you have chronic health problems including disabilities? Do you have an IEP? Y N
Yes	No	Are you a migrant youth?
Yes	No	Is one or both of your parents incarcerated?
Yes	No	Do you have behavior problems at school?
Yes	No	Do you have family literacy problems?
Yes	No	Are you a victim/witness of domestic violence or other abuse?
Yes	No	Do you have a substance abuse problem?

Insurance Information

Medicaid Number: _______________Effective Date: _____________ State issued: ___________________

Medicare Number: ____________________ Effective Date: _____________ State Issued: ____________

MCO: ______________________________ MCO ID #: ____

Health Insurance Company Name: ____

_Insurance Group Number: ___________________ Policy Number: _______________________________

Insurance Telephone Number: ____

_Policy Holder: ____

SS# of Policy Holder: _______-______-________ Place of Employment: ___________________________

Family Information

Father's Name: ____ DOB: _____________________
Address: _____________________________________City/State/Zip: ____________________________
Cell Ph: ________________________Work Ph: _____________________Home Ph: ________________
E-mail: ____
May we contact this person to get additional information? ☐ Yes ☐ No
Mother's Name: ____ DOB: ____________________
Address: _____________________________________City/State/Zip: ____________________________
Cell Ph: ________________________Work Ph: _____________________Home Ph: ________________
E-mail: ____
May we contact this person to get additional information? ☐ Yes ☐ No

Medical History

Primary Disability: ____
Secondary Disability: ____
Other Disabilities: ____
Mobility Devices: (check all that apply) ☐ wheelchair ☐ crutches ☐ brace(s) ☐ splints
☐ other (please specify) ______________________________
Seizures: Does applicant experience seizures? ☐ Yes ☐ No If yes, please explain:
____
____
Describe type of seizure: ____
Length of seizure: ______________________________ Frequency of seizure: ______________________
Date of seizure onset: __________________________ Date of most recent seizure: ________________
List all past seizure medications used: ____
____
____

Has applicant had any of the following illnesses? (Check all that apply)
☐ Diabetes ☐ High blood pressure ☐ Hepatitis ☐ Tuberculosis ☐ Heart problems
☐ Stomach problems ☐ Cancer ☐ Substance/Alcohol abuse ☐ other (please specify): ____________

Has applicant had a recent hospitalization? ☐ Yes ☐ No
If yes: Name of hospital: ________________________________ Date(s):___________________
Reason for hospitalization: ____
Has applicant had any recent surgeries? ☐ Yes ☐ No
If yes: Name of hospital: ________________________________ Date(s):___________________
Reason for hospitalization: ____
Does applicant have any special dietary needs? ☐ Yes ☐ No If yes, please explain:
____
List all known allergies and reactions:

____

Current Medications: (use additional sheet if necessary)

MEDICATION	DOSAGE	PURPOSE
____________________________________	____________________	__________________________
____________________________________	____________________	__________________________
____________________________________	____________________	__________________________
____________________________________	____________________	__________________________
____________________________________	____________________	__________________________

Does applicant need assistance taking medication? ☐ Yes ☐ No If yes, please explain:
____

Physician Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Phone: ______________________________________ Date of Last Exam: ___________________________

Dentist Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Phone: ______________________________________ Date of Last Exam: ___________________________
Eye Doctor Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Phone: ______________________________________ Date of Last Exam: ___________________________

Neurologist Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Phone: ______________________________________ Date of Last Exam: ___________________________

Psychiatrist Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Phone: ______________________________________ Date of Last Exam: ___________________________

Counselor Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Ph: ____ Date of Last Contact: _________________________

Other Specialist Name: ____
Address: _______________________________________City/State/Zip: _____________________________
Ph: ____ Date of Last Exam: ___________________________

Does the applicant have food dislikes or allergies: ____
____

(Please use additional sheet of paper if needed.)

Legal History

Has applicant ever been convicted of a crime? Yes No If yes, when?______________________

Explain: ____

Is applicant currently on probation? Yes No If yes, for what? ____________________________

When will probation be completed? ____

Is applicant currently under court appointment? Yes No

Application completed by:

____

Printed Name

Signature: ____ Date:____________________

Relationship to applicant: ___________________________________ Phone: _____________________

APPLICATION CHECKLIST

The following documents will be required if approved for services.
They can be included with the application, but are not required at this time.

YES	NO	
☐	☐	_______ Copy of Guardianship, Conservator & Power of Attorney papers
☐	☐	_______ Photo ID (issued by state or school)
☐	☐	_______ Copy of Social Security card
☐	☐	_______ Copy of Birth Certificate
☐	☐	_______ List of Immunizations
☐	☐	_______ Copy of Insurance Cards (Front & Back of Medicaid, Medicare, MCO)
☐	☐	_______ Copies of most recent Psychological report
☐	☐	_______ Photograph of applicant

If you have additional questions about the 2-year Independent Ready program contact:

Ryan Groeneweg, Ed.S., BCBA
Director of ACT Center
Village Northwest Unlimited
330 Village Circle
Sheldon, IA 51201

Phone: 712-324-5417
Email: ryang@villagenorthwest.org

Once the application has been submitted, it will be reviewed by multiple agencies EDIT NEEDED