VILLAGE NORTHWEST UNLIMITED

330 VILLAGE CIRCLE • SHELDON, IOWA 51201
Phone (712) 324-4873 • Fax (712) 324-4877
www.villagenorthwest.org

APPLICATION FOR SERVICES

DATE OF APPLICATION:_____/_____/_____

NAME: _____ **DOB:** _____
Last First Middle

ADDRESS: _____ _____
Street (Including Apt. #) City, State, Zip

PHONE: _____ **SOCIAL SECURITY NUMBER:** _____-_____-_____

SEX: ☐Female ☐Male **HEIGHT:** _____ **WEIGHT:** _____ **EYES:** _____ **HAIR:** _____

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:** _____

GENERAL INFORMATION

County & State of Legal Settlement: _____ **County & State of Birth:**_____

CASE WORKER/MANAGER: _____ _____
Name Phone

_____ _____
Address (Include City, State, Zip) Email

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: _____ _____
Name Email

_____ _____
Address City, State, Zip

_____ _____ _____
Home Phone Work Phone Cell Phone

FAMILY INFORMATION

FATHER'S NAME: ____ **DOB:** _____________________

Address: ______________________________________City/State/Zip: _____________________________________

Cell Ph: _________________________Work Ph: ______________________Home Ph: _________________________

E-mail: ____

Military Service: ☐Yes ☐No Which Branch? ____

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: ____________________________________ **MOTHER'S MAIDEN NAME:** _____________________________

Military Service: ☐Yes ☐No Which Branch?____

May we contact this person to get additional information? ☐Yes ☐No

SIBLING'S NAME: __________________ **EMPLOYER:**_______________________________ **DOB:** _______________

If married, name of spouse: ____

Address: ______________________________________City/State/Zip: _____________________________________

Cell Ph: _____________________ Home Ph: _______________________E-mail: ______________________________

Does he/she have contact with applicant? ☐Yes ☐No

SIBLING'S NAME: __________________ **EMPLOYER:**_______________________________ **DOB:** _______________

If married, name of spouse: ____

Address: ______________________________________City/State/Zip: _____________________________________

Cell Ph: _____________________ Home Ph: _______________________E-mail: ______________________________

Does he/she have contact with applicant? ☐Yes ☐No

SIBLING'S NAME: __________________ **EMPLOYER:**_______________________________ **DOB:** _______________

If married, name of spouse: ____

Address: ______________________________________City/State/Zip: _____________________________________

Cell Ph: _____________________ Home Ph: _______________________E-mail: ______________________________

Does he/she have contact with applicant? ☐Yes ☐No

(Please use additional sheet of paper if needed.)

EDUCATIONAL INFORMATION

SCHOOL: _____

Address: _____City/State/Zip: _____

Ph: _____ Dates Attended: From _____ To _____

Did applicant receive any of the following? ☐Diploma ☐GED ☐Certificate of Attendance

SCHOOL: _____

Address: _____City/State/Zip: _____

Ph: _____ Dates Attended: From _____ To _____

Did applicant receive any of the following? ☐Diploma ☐GED ☐Certificate of Attendance

SCHOOL: _____

Address: _____City/State/Zip: _____

Ph: _____ Dates Attended: From _____ To _____

Did applicant receive any of the following? ☐Diploma ☐GED ☐Certificate of Attendance

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: $_____

Have any burial agreement? ☐Yes ☐No ***Attach copies***

If yes, is it irrevocable ☐Yes ☐No ***Attach copies***

Have any life insurance? ☐Yes ☐No

If yes, for burial purposes only? ☐Yes ☐No

Have burial plot? ☐Yes ☐No If yes, location _____

RELIGIOUS HISTORY

Religious preference or affiliation: _____

EMPLOYMENT HISTORY

Please list applicant's most recent job first. Include all full- me and part- me employment, including sheltered employment experience, as well as military service assignments and volunteer activities. Attach additional sheet if necessary.

COMPANY NAME:____

Address: ______________________________City/State/Zip: ______________________

Ph: ____________________ Employment Dates: From ___________ To _____________

Position/Title: __________________________ Supervisor: ______________________

Duties Performed: ____

Major strengths and contributions in this position: ______________________________

____

May we contact this employer for a reference? ☐Yes ☐No

COMPANY NAME:____

Address: ______________________________City/State/Zip: ______________________

Ph: ____________________ Employment Dates: From ___________ To _____________

Position/Title: __________________________ Supervisor: ______________________

Duties Performed: ____

Major strengths and contributions in this position: ______________________________

____

May we contact this employer for a reference? ☐Yes ☐No

COMPANY NAME:____

Address: ______________________________City/State/Zip: ______________________

Ph: ____________________ Employment Dates: From ___________ To _____________

Position/Title: __________________________ Supervisor: ______________________

Duties Performed: ____

Major strengths and contributions in this position: ______________________________

____

May we contact this employer for a reference? ☐Yes ☐No

VOC REHAB: Open file with Voc Rehab ☐Yes ☐No

If yes, name of Counselor: ________________ Phone # ______________

MEDICAL HISTORY

PRIMARY DISABILITY: _____

Secondary Disability: _____

Other Disabilities: _____

MOBILITY DEVICES: (Circle all that apply) wheelchair walker brace(s)

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? (circle 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: _____

_____

Name and address of preferred funeral home: _____

_____

Does applicant have a Living Will? ☐Yes ☐No If yes, please explain:_____

MEDICAL HISTORY (CONT)

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: _____

OPTOMETRIST 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: _____

MEDICAL HISTORY (CONT)

COUNSELOR NAME: _____

Address: _____City/State/Zip: _____

Ph: _____ Date of Last Contact: _____

OTHER SPECIALIST'S NAME: _____

Address: _____City/State/Zip: _____

Ph: _____ Date of Last Exam: _____

(Please use additional sheet of paper if needed.)

SENSORIMOTOR ABILITIES

Does applicant wear a hearing aid? ☐Right Ear ☐Left Ear ☐Both Ears ☐None

Date of last hearing evaluation: _____

By whom? _____

Describe hearing loss: _____

Does applicant wear glasses? ☐Yes ☐No **Contacts?** ☐Yes ☐No

Describe visual impairment: _____

Describe ability to use upper extremities: _____

_____

Describe communication skills: _____

_____

Is a communication device used? ☐Yes ☐No If yes, explain: _____

_____

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

BEHAVIOR HISTORY

Indicate the frequency of each behavior over the last 12 months:
(Frequently = several times/week; Occasionally - less than once per month)

	Daily	Frequently	Weekly	Monthly	Occasionally	None
Tantrums or outbursts						
Physically assaults others						
Disrupts others' activities						
Verbally or gesturally abusive						
Self-injurious						
Resists supervision						
Steals						
Destroys property						
Displays sexually inappropriate behaviors						
Runs away						
Refuses medication						

Please list medications taken in the past for behavioral concerns: _____

_____

_____

DAILY ROUTINE

Describe a typical day: _____

_____

_____

_____

_____

_____

Any non-preferred daily activities? _____

_____

_____

DAILY ROUTINE (CONT)

Indicate amount of supervision required for the following:

Shaving: _____

Bathing: _____

Tooth brushing/dental care: _____

Dressing: _____

Toileting: _____

Nail care: _____

Hair care: _____

Eating: _____

Food preferences: _____

_____

Food dislikes or allergies: _____

_____

Sleep habits: _____

_____

Cleanliness and neatness: _____

_____

FUTURE GOALS

What are the applicant's goals for the future regarding where he/she wants to live and work?

_____

_____

_____

_____

What things are important to the applicant?

_____

_____

_____

_____

_____

_____

_____

_____

Application completed by: _____

Relationship to applicant: _____ **Phone:** _____

PLEASE RETURN COMPLETED APPLICATION TO

Jerry Postma, Director of Admissions
Village Northwest Unlimited
330 Village Circle
Sheldon, IA 51201

Email: jerryp@villagenorthwest.org
Phone: (712) 324-5403
Fax: (712) 324-4877

Revised 11/2021

DOCUMENT 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)
☐	☐	Burial Agreement
☐	☐	Copies of most recent Psychological report
☐	☐	Photograph of applicant