

Application

NOTE: *If you have any questions about the application process, please contact an Admissions Coordinator listed below. All admissions are made on a 30-day trial basis.*

Please mail the completed application with supporting documents to the region that offers the program(s) in which you are interested.

Pella/Knoxville

Teresa Rens
Christian Opportunity Center
PO Box 347
Pella, IA 50219
(641) 628-8087 ext. 108

Oskaloosa

Caree Gordon
Christian Opportunity Center
110 B Avenue East
Oskaloosa, IA 52577
(641) 673-9480

Indianola/Des Moines

Sarah Darr
Christian Opp. Center
1602 N 14th St.
Indianola, IA 50125
(515) 961-3653 Ext 210

www.christianopportunity.org

Special Note:

The following documents must accompany this application before COC will provide services:

1. A current psychological evaluation including diagnosis and IQ range and a psychiatric evaluation if a psychiatric diagnosis is present. COC will accept the AEA/MR Waiver letter for high school students.
2. A copy of the physical examination and TB test completed within the past twelve months.
3. A copy of the most recent habilitation plan (for those currently in a rehabilitation program).
4. A copy of a vocational rehabilitation evaluation report (for those who have been through such an evaluation).
5. A current photograph.
6. Copy of proof of legal payee (if applicable)
7. Copy of guardianship and/or conservatorship legal document (if applicable).
8. Signed copies of "Authorization for Release of Confidential Information".



CHRISTIAN OPPORTUNITY CENTER APPLICATION

Applicant's Name: _____ Date: _____

Current Address: _____ (Street, PO, Box, Rural Route) (City) (State) (Zip)

Current Phone #: _____ E-mail: _____

Date of Birth: _____ Gender: _____ Birthplace: _____

When would you like to begin receiving supports from COC? _____ (day, month, year)

Check all programs you wish to apply for. All programs are explained on the accompanying sheet.

Pella/Knoxville:

Vocational:

- ___ Facility Based Employment & Pre-vocational
___ Community Based Employment
___ Day Habilitation-Pella
___ Adult Rehabilitation Option (ARO) CBE

Oskaloosa

Vocational:

- ___ Facility Based Employment
___ Community Based Employment

Indianola/Des Moines

Vocational:

- ___ Facility Based Employment & Pre-vocational
___ Community Based Employment
___ Day Habilitation-Indianola
___ Adult Rehabilitation Option (ARO) CBE

Residential:

- ___ Intermediate Care Facility
___ Supported Community Living - 24 hour
___ Supported Community Living - hourly
___ Consumer Directed Attendant Care
___ Adult Rehabilitation Option (ARO)

Residential:

- ___ Intermediate Care Facility
___ Supported Community Living - 24 hour
___ Supported Community Living - hourly
___ Adult Rehabilitation Option (ARO)

Applicant Information:

Marital Status: _____

Spouse's Name: _____ Spouse's Maiden Name: _____

Social Security #: _____ Medicare # _____

Medicaid #: _____

Health Insurance Company: _____

Health Insurance Number: _____ Policy Holder: _____

Emergency Contact Name: _____ Phone #: _____

Address: _____

Names and Addresses of Next of Kin:

Father's Name: _____ Phone: _____

Father's Address: _____

Mother's Name: _____ Phone: _____

Mother's Address: _____

Name: _____ **Relationship:** _____

Address: _____ Phone: _____

Legal Guardian's Name: _____

Address: _____ Phone: _____

Physician's Name: _____ Address: _____

Office Phone: _____

Pharmacist: _____ Address: _____

Office Phone: _____

Dentist: _____ Address: _____

Office Phone: _____

Optometrist: _____ Address: _____

Office Phone: _____

Hospital Preferred: _____

Address: _____ Phone: _____

Church Affiliation: _____ Address: _____

Pastor's Name: _____ Phone #: _____

Funding/Financial Information:

My social worker/case manager's name is _____

Phone number: _____

I am currently approved for funding from the following source:

- ____ Medicaid
- ____ HCBS/MR Waiver
- ____ County of legal settlement (Name of County) _____
- ____ State
- ____ Vocational Rehabilitation
- ____ Private – self pay
- ____ Private Insurance
- ____ Adult Rehab Options
- ____ Other: (please state) _____
- ____ I do not have a funding source

Earned Income:

Monthly amount: \$ _____ **Source:** _____

Unearned income – monthly amount:

- _____ Social Security
- _____ Supplemental Security Income
- _____ Social Security Disability Income
- _____ VA Pension
- _____ Title XIX (19)

Other income/financial resources that may impact your funding: _____
(trust fund, stock, bonds, investment)

How is income handled? (i.e. parents manage, or I handle my own)

Name of conservator: _____ **Address:** _____

Name of payee: _____ **Address:** _____

Name of Power of Attorney: _____ **Address:** _____

Psychological Evaluation Information: A psychological evaluation is completed by a psychologist and is used to diagnose a Developmental Disability, including but not limited to, Mental Retardation. IQ testing is a portion of the evaluation. The evaluation results will typically determine the source of funding available to an individual.

*For a person with a Brain Injury diagnosis, documentation of the BI diagnosis is needed which is typically in a neuropsychological report.

Date of most recent psychological evaluation and person who completed this (please include copy of evaluation with this application): _____

Please list the primary disability (disabilities) according to the most recent psychological evaluation: _____

Please list the secondary disability (disabilities) according to the most recent psychological evaluation: _____

What is your IQ according to the psychological evaluation? _____

Psychiatric Evaluation Information: A psychiatric evaluation is completed by a qualified Mental Health Professional and is used to diagnose a mental disorder or mental illness. IQ testing is not generally a part of this evaluation. The evaluation results will typically determine the source of funding available to an individual.

Name of current psychiatrist/therapist: _____

Date of most recent psychiatric evaluation and person who completed this: (please include copy of evaluation with this application: _____

Please list the primary disability(disabilities) according to the most recent psychiatric evaluation: _____

Please list the secondary disability(disabilities) according to the most recent psychiatric evaluation: _____

Please comment on any physical limitations you may have. (Include physical limitations needing adaptive equipment, such as - visual/hearing impairment, use a wheelchair, have dentures, use medications, experience seizures, etc.?)

Medical Information:

Do you have or have you been told you have:

- a. chest pains, heart trouble, heart attack or heart murmur yes no
- b. high blood pressure yes no
- c. cancer or tumors yes no
- d. nervous, respiratory, circulatory, digestive, urinary, or genital-urinary problems yes no
- e. venereal disease or other infectious disease yes no
- f. diabetes, thyroid, pneumonia, or disorder of the lymph system yes no
- g. mental illness yes no
- h. hepatitis yes no
- i. seizures yes no

If yes, please describe the seizures in detail. Tell how long they last, what care you need during and after the seizure. _____

Are you using any tobacco products now? yes no
Do you use alcohol? yes no
Do you have a history of substance abuse? yes no
If yes, explain: _____

Diabetes Information (Complete only if applicable)

Diagnosis Type 1 Type 2 Brittle diabetic Other

Do you take insulin? Yes No

- a. What type? _____
- b. Dosage _____
- c. Administration Time _____
- d. What is your normal method of knowing when to take your medication (clock, timer, beeper, other) _____

Do you take oral medication for your diabetes? Yes No

- a. What type? _____
- b. Dosage _____
- c. Administration Time _____
- d. What is your normal method of knowing when to take your medication (clock, timer, beeper, other) _____

Do you use prepared or predosed disposable syringes? Yes No

Do you draw your own insulin? Yes No

- a. Do you need any assistance with this? Yes No
- b. If yes, what assistance is needed? _____

Can you give the injection to yourself without anyone observing or monitoring you?

Yes No

Can you give the injection to yourself, but need someone there to observe you?

Yes No

Do you need someone else to administer your insulin?

Yes No

Can you identify when your blood sugar is too high or too low? Yes No

What are your symptoms of low blood sugar?

- Shaking Hungry
- Fast Heartbeat Blurred vision
- Sweating Fatigue/weakness (low energy)
- Dizziness Headache
- Anxious Irritable
- Other Please explain: _____

What are your symptoms of high blood sugar?

- Extreme thirst
- Hungry
- Frequent urination
- Blurred vision
- Dry skin
- Drowsiness (feeling tired)
- Other Please explain: _____

Once you have identified your symptoms, do you know what to do if your blood sugar is too high or too low? _____Yes _____No

a. If it is too high, what do you do? _____

b. If it is too low, what do you do? _____

Can you perform the following steps to test your blood sugar?

- a. Inserting the lancet into the lancing device? _____Yes _____No
- b. Prick finger with the lancing device? _____Yes _____No
- c. Put drop of blood onto strip? _____Yes _____No
- d. Read what the glucose monitor tells you? _____Yes _____No
- e. Based on what your level of blood sugar is, do you know what to do?
 _____Yes _____No

COMPLETE THE NEXT SECTION FULLY FOR ALL “YES” ANSWERS ABOVE

(If additional space is needed, please attach a separate piece of paper)

Nature of illness or injury, Treatment, Testing, or Medical Attention, Past Surgeries, etc..	Date Month/ Year	Duration	Diagnosis, Results, Findings or Remaining Effects	Name & Address of Physician or Hospitals

Do you require:

Special utensils (if so, please list) _____

Chopped food _____

Blended food _____

Pureed food _____

Diet Supplement (i.e. *Ensure*) _____

Do you have difficulty:

Swallowing _____ Chewing _____ Drinking _____

Explain: _____

Favorite foods: _____

Which foods do you dislike? _____

Specific diet/diet restrictions prescribed by a doctor: _____

Toileting:

Are you independent in toileting? _____ Do you need to be reminded? _____

Do you have bladder control during the day? _____

Do you have bladder control during the night? _____

Do you have bowel control during the day? _____

Do you have bowel control during the night? _____

Are you on a toileting schedule? _____ If yes, please describe: _____

Do you use incontinent briefs? _____ (If yes) Size: _____ When? _____

Dressing: (Please check correct responses)

Do you need help with dressing? No help Some help Complete help

Which of the following do you need help with? buttons shoes shoe laces socks zippers
shirts pants glasses fasteners contacts hearing aids Other (please state) _____

Personal Hygiene: (Please check appropriate response)

Assistance level: No help Some help Complete help

Which of the following do you need help with? washing face and hands showering brushing teeth
menstrual care bathing shaving ear molds

Communication Needs:

How do you communicate wants/needs? _____ verbally _____ non-verbally

How do you understand and respond to questions? _____

Method of communication: _____ understands and uses speech _____ uses communication board
_____ uses electronic device _____ uses sign language

Further communication information/instructions: _____

Mobility/Special Equipment Needs:

Do you use a wheelchair? _____

Do you require assistance walking? _____ If yes, please explain: _____

Other mobility/special equipment instructions: _____

Comment on areas in which you do well (your strengths). _____

Please comment on areas in which you need help or support:

What would you like COC to help you with, or provide for you? (getting a job, helping with budget, learning to cook, etc.) _____

What would your family/guardian like COC to help you with? _____

History:

Give the history of any schools, vocational programs, residential programs, and/or institutions attended. Include approximate beginning and ending dates for each.

Schools: _____

Did you graduate? _____ What year? _____

Vocational training: _____

Please list any employers you have worked for. Include the type of work performed, and the approximate beginning and ending dates for each:

Previous Residential Programs/Living Arrangements: _____

Current Residential Program/Living Arrangement:

Behavior:

Please discuss your general characteristics and significant psychological conditions: (general attitude toward self and others, temper, withdrawn or outgoing, depressed, social skills, aggression incidents, destruction of property, frequency of incidents and any other pertinent facts about yourself which could help the Admissions Committee as they attempt to best understand your needs).

During what times or activities is particularly close supervision needed? _____

Relationships/Environmental Factors:

Who is part of your life? Relationship with family, significant others, and other support systems: (i.e. where do you receive on-going emotional support? How often do you have contact with your family? What type of contact do you have? (i.e. overnight visit, out to eat, home for weekends)

Past environmental factors affecting development? (poor diet as an infant, abandoned, etc.)

Significant abuse history (physical and/or substance):

Hobbies and leisure time activities, and things I enjoy:

Tell us some great things about yourself – things you must have, must do, what you want to be:

Have you ever been convicted of a criminal charge? If so, please explain briefly:

Date	Place	Violation	Outcome of Case

(Possession of a conviction does not automatically preclude admission to COC)

How did you learn about COC's Services? (Web site, DHS, radio ad, newspaper, friend, or other – please state) _____

Person Completing Application: _____ **Phone :** _____

Address: _____

Relationship to Applicant: _____

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