|  |  |
| --- | --- |
| **VODEC Office Use:** | |
|  | BSP Received |
|  | Completed Application Received |
|  | Current Dental |
|  | Current ICP/IEP Received |
|  | Current Physical |
|  | Social History Received |

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**Application for Services**

A completed application along with the Applicant's social history, current ICP/IEP, Behavioral Services Plan, Behavioral and Special Needs questionnaire must be received by Vodec at 612 South Main Street in Council Bluffs, Iowa 51503 or by email to daryn@vodec.org. Once all documents have been received, Vodec will review each document for admission. Admission is subject to vacancy, approval, funding and eligibility requirements. All notifications of decisions regarding services will be communicated to applicants via telephone or in writing. It is the policy of Vodec to be an Affirmative Action Equal Opportunity Employer for all qualified applicants for employment without regard to race, color, religion, sex, age, national origin or disability.

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| **Applicant or Legal Representative Signature** | | | |  | **Date** | | |
| **Applicant’s Information** |  | |  | | |  |  |
| **Name** | **Street** | | **City** | | | **State** | **Zip** |
| **Phone** | **Best time to call?** | | **Date of Birth** | | | **Age** | **\_\_ Male**  **\_\_ Female** |
| **Cell Phone** | **Social Security Number**  **Medicaid Number** | | |
|  | | | | | | | |
| **Services Requested** | | **How did you hear about Vodec?** | | | | | |
| **Applicant's Primary Disability**  **(Please check one**) | | **Funding Source**  **(Please check one)** | | | | | |
| \_\_\_ Autism | | \_\_\_ ID Waiver | | | | | |
| \_\_\_ Asperger's Syndrome | | \_\_\_ BI Waiver | | | | | |
| \_\_\_ Behavior Disorder | | \_\_\_ Hab Services | | | | | |
| \_\_\_ Blind | | \_\_\_ Private Pay | | | | | |
| \_\_\_ Brain injury | | \_\_\_ School Pay | | | | | |
| \_\_\_ Chronic Mental Illness | | \_\_\_ Voc Rehab Pay | | | | | |
| \_\_\_ Deaf/Hard of Hearing | | \_\_\_ Other: | | | | | |
| \_\_\_ Down Syndrome | |
| \_\_\_ Intellectual Disability | |
| \_\_\_ Physical Disability | |
| \_\_\_ Other: | | For Habilitation Services, list the corresponding diagnosis code | | | | | |

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| **Contact information** | | |
| **Contact Information** | **Case Manager/Service Coordinator Name**  **Case Manager/Service Coordinator Company** |
| Mailing Address |
| Primary Phone  Secondary Phone  Fax |
| Type of Service(s) provided: \_\_\_ Current \_\_\_ Previous |
| Date of Service from:  Date of Service to: |
|  |
| **Legal Guardian's Name** |
| Mailing Address |
| Primary Phone |
| Secondary Phone |
| **Is Legal Guardian an emergency contact for this individual?**  **\_\_ Yes \_\_No** | |
| **Conservator's Name** |
| Mailing Address |
| Primary Phone |
| Secondary Phone |
| **Is Conservator an emergency contact for this individual?**  **\_\_ Yes \_\_No** | |
| **Power of Attorney's Name** |
| Mailing Address |
| Primary Phone |
| Secondary Phone |
| **Is Power of Attorney an emergency contact for this individual?**  **\_\_ Yes \_\_No** | |
| **Payee’s Name** |
| Mailing Address |
| Primary Phone |
| Secondary Phone |
| **Is Payee an emergency contact for this individual?**  **\_\_ Yes \_\_No** | |
| **Additional Contacts**  **If Applicable** | **Voc Rehab Counselor’s Name** | |
| Mailing Address | |
| Primary Phone | |
| Secondary Phone | |
|  | |
| **Teacher’s Name** | |
| Mailing Address | |
| Primary Phone | |
| Secondary Phone | |
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