OPPORTUNITIES UNLIMITED
3439 Glen Oaks Blvd
Sioux City, IA 51104
Phone: (712) 277-8295
Fax: (712) 277-8602
www.opportunitiesunlimited.com

APPLICATION FOR BRAIN OR SPINAL CORD INJURY SERVICES

NAME: _____ DATE OF APPLICATION: _____
Last First M.I.

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

PHONE: (_____) _____ - _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

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

MEDICAID NUMBER: _____ EFFECTIVE DATE: _____

MEDICARE NUMBER: _____ EFFECTIVE DATE: _____ STATE: _____

HEALTH INSURANCE COMPANY NAME: _____

INSURANCE GROUP NUMBER: _____ POLICY NUMBER: _____

INSURANCE TELEPHONE NUMBER: (_____) _____ - _____ Ext. _____

POLICY HOLDER: _____

SSN OF POLICY HOLDER: _____ - _____ - _____ EMPLOYER: _____

GENERAL INFORMATION

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

Case Worker/Manager Name: _____

Case Worker/Manager Address: _____ Phone: (_____) _____ - _____

Case Worker/Manager Email Address: _____

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

Please state the guardian's or durable power of attorney's name and address: _____
_____
_____ Guardian's DOB: _____
Home Phone: (_____) _____ - _____ Work : (_____) _____ - _____ Cell: (_____) _____ - _____
Email Address: _____
Has a legal conservator been appointed for the applicant by the courts? ☐ Yes ☐ No ☐ Pending ☐ Temp

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

Please state the conservator's name and address: _____

_____

Home Phone: (____) ____-____ Work: (____) ____-____ Cell: (____) ____-____

Email Address: _____

Does the applicant have a valid driver's license? ☐ Yes ☐ No

Who referred the applicant to Opportunities Unlimited? _____

Has the applicant been in rehabilitation before the present time? ☐ Yes ☐ No

If yes, when and where? _____

_____

FAMILY INFORMATION

Father's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: (____) ____-____ Work: (____) ____-____ Cell: (____) ____-____

Email Address: _____

SSN: ____-____-____ Military Service: ☐ Yes ☐ No Military Branch: _____

May we contact this person to obtain additional information? ☐ Yes ☐ No Email:_____

Mother's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: (____) ____-____ Work: (____) ____-____ Cell: (____) ____-____

Email Address: _____

SSN: ____-____-____ Military Service: ☐ Yes ☐ No Branch: _____

May we contact this person to obtain additional information? ☐ Yes ☐ No Email: _____

Please list siblings in chronological order:

Sibling's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

SSN: ____-____-____ Military Service: ☐ Yes ☐ No Branch: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____ Email: _____

Does this sibling have contact with the applicant? ☐ Yes ☐ No

Sibling's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

SSN: ____-____-____ Military Service: ☐ Yes ☐ No Branch: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____ Email: _____

Does this sibling have contact with the applicant? ☐ Yes ☐ No

Sibling's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

SSN: ____-____-____ Military Service: ☐ Yes ☐ No Branch: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____ Email: _____

Does this sibling have contact with the applicant? ☐ Yes ☐ No

Sibling's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

SSN: ____-____-____ Military Service: ☐ Yes ☐ No Branch: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____ Email: _____

Does this sibling have contact with the applicant? ☐ Yes ☐ No

(Please use an additional sheet of paper if needed)

Spouse's Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

SSN: ____-____-____ DOB: _____ Email: _____

Home Phone: (____) ____-____ Work: (____) ____-____ Cell: (____) ____-____

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

Please list children in chronological order

Child's Name: _____

Address: _____ City/State/Zip: _____

DOB: _____ Do you have contact with this child? ☐ Yes ☐ No

Child's Name: _____

Address: _____ City/State/Zip: _____

DOB: _____ Do you have contact with this child? ☐ Yes ☐ No

Child's Name: _____

Address: _____ City/State/Zip: _____

DOB: _____ Do you have contact with this child? ☐ Yes ☐ No

Child's Name: _____

Address: _____ City/State/Zip: _____

DOB: _____ Do you have contact with this child? ☐ Yes ☐ No

EDUCATIONAL HISTORY

School Name: _____

Address: _____ City/State/Zip: _____

Phone: (_____) _____ - _____ Dates Attended: From _____ To _____

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

School Name: _____

Address: _____ City/State/Zip: _____

Phone: (_____) _____ - _____ Dates Attended: From _____ To _____

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

School Name: _____

Address: _____ City/State/Zip: _____

Phone: (_____) _____ - _____ Dates Attended: From _____ To _____

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

APPLICANT'S FINANCIAL INFORMATION

Does the applicant:

Have cash on hand?	☐ Yes	☐ No	Amount: $ _____
Have a savings account or investments?	☐ Yes	☐ No	Amount: $ _____
Have certificate(s) of deposit?	☐ Yes	☐ No	Amount: $ _____
Have stocks or bonds?	☐ Yes	☐ No	Amount: $ _____
Have a checking account?	☐ Yes	☐ No	Amount: $ _____
Need assistance with a checking account?	☐ Yes	☐ No	
Have a special needs trust?	☐ 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 a burial agreement?	☐ Yes	☐ No	
If yes, is it irrevocable?	☐ Yes	☐ No	(If yes, please attach a copy)
Have any life insurance?	☐ Yes	☐ No	
If yes, is it for burial purposes only?	☐ Yes	☐ No	

APPLICANT'S EMPLOYMENT HISTORY

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

Company Name: ____

Address: ______________________________ City/State/Zip: ______________

Business Phone: (______) ______-______ Dates: From __________ To __________

Position/Title: ____________________ Supervisor: ____________________

Work Performed: ____

____

May we contact this employer as a reference? ☐ Yes ☐ No Is this a rehabilitation facility? ☐ Yes ☐ No

Company Name: ____

Address: ______________________________ City/State/Zip: ______________

Business Phone: (______) ______-______ Dates: From __________ To __________

Position/Title: ____________________ Supervisor: ____________________

Work Performed: ____

____

May we contact this employer as a reference? ☐ Yes ☐ No Is this a rehabilitation facility? ☐ Yes ☐ No

Company Name: ____

Address: ______________________________ City/State/Zip: ______________

Business Phone: (______) ______-______ Dates: From __________ To __________

Position/Title: ____________________ Supervisor: ____________________

Work Performed: ____

____

May we contact this employer as a reference? ☐ Yes ☐ No Is this a rehabilitation facility? ☐ Yes ☐ No

Company Name: ____

Address: ______________________________ City/State/Zip: ______________

Business Phone: (______) ______-______ Dates: From __________ To __________

Position/Title: ____________________ Supervisor: ____________________

Work Performed: ____

____

May we contact this employer as a reference? ☐ Yes ☐ No Is this a rehabilitation facility? ☐ Yes ☐ No

APPLICANT'S MEDICAL HISTORY

Does the applicant have a brain injury? ☐ Yes ☐ No Date of Injury: _____

Does the applicant have a spinal cord injury? ☐ Yes ☐ No Date of Injury: _____

Was the brain injury or spinal cord injury a result of: ☐ Motor vehicle accident ☐ Stroke ☐ Tumor

☐ A blow to the head ☐ Diving Accident ☐ Other (please specify) _____

Do you have a physical or any other accompanying disability? ☐ Yes ☐ No

If yes, please explain: _____

Please indicate if the applicant uses any of the following:

☐ Wheelchair ☐ Cane ☐ Splints ☐ Other (please specify) _____
(Please indicate if the applicant owns the item(s) he/she uses.)

Does the applicant experience seizures? ☐ Yes ☐ No If yes, please explain: _____

Describe the type of seizure: _____

Length of seizure: _____

Frequency of seizure: _____

Date of seizure onset: _____ Date of most recent seizure: _____

Please list all past seizure medications used: _____

_____

Please indicate if the applicant has had any of the following illnesses:

☐ Diabetes ☐ High blood pressure ☐ Hepatitis ☐ Tuberculosis ☐ Heart problems ☐ Cancer

☐ Stomach Problems ☐ Substance/Alcohol abuse ☐ Other (please specify)_____

Has the applicant had a recent hospitalization? ☐ Yes ☐ No

If yes, please explain: _____

Name of hospital and dates hospitalized: _____

Has the applicant had any recent surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Name of hospital and dates hospitalized: _____

Does the applicant have any special dietary needs? ☐ Yes ☐ No

If yes, please explain: _____

Does the applicant require tube feeding: ☐ Yes ☐ No If yes, please explain: _____

Do you require staff be trained in special health procedures? ☐ Yes ☐ No

If yes, please explain: _____

Do you require staff be trained in special health procedures (i.e. ostomy care, positioning, adaptive devices, ect.)? ☐ Yes ☐ No If yes, please explain: _____

Please list applicant's current medications, dosages, and purpose for each medication: _____

_____

_____

_____

_____

Does the applicant require assistance in taking medication? ☐ Yes ☐ No

If yes, please explain: _____

Please list known allergies and reactions: _____

_____

Name and address of preferred funeral home (if none listed, one will be chosen by OU): _____

_____

Does the applicant have a living will? ☐ Yes ☐ No (If yes, please attach a copy)

Physician's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Optometrist's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Dentist's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Neurologist's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Physiatrist's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Psychiatrist's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Counselor's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

Other Specialist's Name: _____

Address: _____ City/State/Zip _____

Date of last exam: _____ Phone: (_____) _____ - _____

SENSORIMOTOR ABILITIES

Does the applicant wear a hearing aid? ☐ Yes ☐ No ☐ Left Ear ☐ Right Ear ☐ Both

Date of last hearing evaluation? _____ By Whom? _____

Describe hearing loss: _____

Does the applicant wear glasses? ☐ Yes ☐ No

Describe visual impairment: _____

Describe physical mobility: _____

_____

Describe ability to use upper extremities: _____

_____

Describe communication skills: _____

_____

Is a communication device used? ☐ Yes ☐ No

If yes, please explain: _____

BEHAVIOR HISTORY

Indicate the frequency of each behavior over the last 12 months:

(Frequently = Several times per week **Occasionally** = less than once per month)

Tantrums or outburst	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Physically assaults others	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Disrupts others' activities	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Verbally or gesturally abusive	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Self injurious	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Resists supervision	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Steals	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Destroys property	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Displays sexually inappropriate Behaviors	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Runs away	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None
Refuses medications	☐ Daily	☐ Frequently	☐ Weekly	☐ Monthly	☐ Occasionally	☐ None

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

_____

_____

_____

DAILY ROUTINE

Describe a typical day: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Any non-preferred daily activities? _____

_____

_____

_____

Please indicate the amount of supervision required for the following activities of daily living:

Shaving: _____

Bathing: _____

Tooth brushing/dental care: _____

Dressing: _____

Toileting: _____

Nail care: _____

Hair care: _____

Eating: _____

Food preferences: _____

Food dislikes or allergies: _____

Sleep habits: _____

Cleanliness and neatness: _____

LEGAL HISTORY

Has the applicant ever been convicted of a crime? ☐ Yes ☐ No

If yes, of what and when? _____

_____

Is the applicant currently on probation? ☐ Yes ☐ No

If yes, for what? _____

When will probation be completed? _____

Is the applicant currently under court appointment? ☐ Yes ☐ No

RELIGIOUS HISTORY

Please list religious preference or affiliation: _____

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: _____ Date: _____

Relationship to applicant: _____ Phone: (_____) _____-_____

PLEASE SUBMIT APPLICATION TO:

Opportunities Unlimited

Attn: Director of Residential Services

3439 Glen Oaks Blvd

Sioux City, IA 51104

Phone: (712) 277-8295 Fax: (712) 277-8295

MATERIAL TO BE SUBMITTED WITH THIS APPLICATION IF AVAILABLE

- ☐ Most recent psychological report
- ☐ Most recent education and/or vocational report
- ☐ Most recent social history
- ☐ Most recent physical examination
- ☐ Other medical specialty reports
- ☐ Copy of guardianship/conservatorship papers
- ☐ Other pertinent information
- ☐ Recent snapshot
- ☐ Copy of Medicaid, Medicare, or private insurance card