Application Process

www.christianopportunity.org

It is the policy of COC that all of the people requesting or receiving supports are to be treated equally. No person will be discriminated against based on characteristics protected by applicable federal or state law. COC reserves the right to refuse services to any person based on, but not limited to, the following criteria/conditions:

- The person has a history of threat to the mental or physical welfare of others including but not limited to other people supported, staff and community members.
- The person does not have the financial ability to pay for services or is not eligible for public funding

Application process

Initial contact is made by the applicant, family, or other representative. This contact is directed to the Admissions Coordinator. The initial contact may be made by phone, letter, email, or personal visit. The applicant or representative must submit all of the required application materials.

The application is completed by the applicant/representative and returned to the Admissions Coordinator. In addition to the basic application form the applicant/representative must submit:

a. A current psychological evaluation including diagnosis and IQ range if an intellectual disability is present
b. A psychiatric evaluation if a psychiatric diagnosis is present
c. A neuropsychological evaluation is a brain injury is present
d. A copy of their latest annual service plan if available;
e. A copy of the case management social history and case plan if available;
f. A copy of the Department of Vocational Rehabilitation's evaluation report if applicable;
g. A current photograph;
h. A copy of legal payee documents if applicable;
i. A copy of the guardianship and/or conservatorship documents if applicable; and
j. Signed releases so that information can be obtained from other agencies.
k. Copies of most recent skills assessment tools including case manager assessment, School assessment & previous provider assessments.

Additionally, a physical examination (using the form provided by COC) and TB test completed within the past twelve months will be required before the applicant can begin services at COC, but are not required to be submitted at the time of the application for services at COC. *Please note: The COC Admissions committee may vote before having a completed physical and TB test, they do not have to be submitted with the application. These two items will be required, however, before any individual's start date in their respective program(s) – successfully passing the physical indicating the person is physically suited for the program(s) they applied to and negative TB test results. Positive TB test results would not necessarily preclude a person from participating in COC services, however, a positive TB test result would need further consideration from team members before the person could start in the program.*

In some programs additional information, assessments and evaluations may be required, if applicable, to help determine the level of need before the admissions team can vote on the appropriateness of the service. They include but are not limited to;

- Psychiatric information from a therapist/psychiatrist
- Incident reports from other providers of service
- Current restrictions
- Safety plans, health and nutrition plans
- Assessments from any therapy services (i.e. physical, occupational or speech)
- Crisis Plans

Protocol for the Prevention and Eradication of Bed Bugs

1. Prior to Admission to a residential program at COC, the Admission Coordinator will ensure that the applicant has provided a written signed statement from their landlord/parent/guardian that their current place of residency, be that another provider's residential setting, parent/guardian's home, or their own apartment, has had no evidence of bed bugs in the past year.
    a. If the individual does not submit the written signed statement admission will be placed on hold until the statement is provided. Exceptions may be granted if determined appropriate by the Admissions Team.
    b. If there has been evidence of bedbugs in the past year the applicant must submit a statement from an exterminator that the problem has been rectified, as well as sign an authorization allowing COC to contact the exterminator. If a professional exterminator did not treat the problem COC will contact an exterminator to inspect the apartment for evidence of bugs.
    c. The following will be followed if evidence of bed bugs exists at the time of admission or the landlord does not approve an inspection. If the team determines that the move can take place a plan of action will be developed. It may include any of the following as determined by the level of risk.
        i. The person to be admitted will meet staff at a local Laundromat. All clothes and bedding will be washed on hot. All clothes, bedding, shoes and hats will be dried on hot. Cleaned clothes will be placed in new totes.
        ii. Totes of clothing will be stored and processed following the guidance outlined in 5c
        iii. Bags/boxes will be destroyed and will not be taken to the house. Items including furniture, keepsakes and electronics from the previous residence that cannot be heat treated or washed/dried on hot, may not be brought into the house.
        iv. Checks for any evidence bed bugs will be made at each shift change until the team decides it is no longer necessary.
2. For persons supported living in a COC residence or in an apartment complex/house and receives residential supports checks for evidence of bed bugs will be done on a monthly basis as part as the monthly safety check/safety plan. Mattresses and bed sheets will be examined by the LSA for these checks.
3. Staff will assist p/s in inspecting any new or used clothing purchased before bringing the clothing into the home.
4. Any mattresses, furniture or luggage with fabric parts obtained from a second party, thrift store or garage sale must be inspected by staff prior to it being brought into the residence.

5. If there is a confirmed case of bed bugs the following plan will be implemented.

    a. If it is a COC owned home the manager of the program will contact an approved exterminator for immediate treatment of the residence. If they are discovered in an apartment/house not owned by COC the manager of the apartment complex will be contacted.
    b. The individual's clean clothes/bedding will be dried using high heat. Clothing/bedding should be transported to the laundry area utilizing closed trash bags.
    c. Dirty clothing/bedding/shoes will be washed/dried on hot and all processed clothing/bedding/shoes will be stored in an area away from the infestation (basement, garage, storeroom) in plastic totes. Clean items to wear will be obtained from the plastic tote just prior to showering. Used bedding/clothing will be washed immediately after use and returned to the tote.
    d. Staff will not bring bags/purses/bedding/personal effects into or out of the residence. Staff on 24 hour shifts should launder changes of clothing at the residence and place them immediately in their car for storage. Staff should launder the clothing that they are wearing immediately upon getting home from work.
    e. The Program Coordinator will contact parent/guardians if deemed appropriate by the team.
    f. For full disclosure, while the home is in the process of eradicating bed bugs, staff should assist the p/s in notifying any party with whom the p/s wishes to stay overnight, that the home has bed bugs.
    g. Visitors to the residence may be limited as deemed necessary by the Program Manager/Program Coordinator to avoid the spread of the bed bugs

Failure to provide access to information necessary for the development of the Individual Support Plan or delivery of services may be a basis for the denial of services.

At times COC may need to implement a waiting list or potential list due to the lack of staff, funding or other resources.

If the person has received services through COC within the past year and has a current physical on file, the person may not need to go through the application process again. This will be handled on a case-by-case basis.

Timelines for processing the application.

A thirty day timeline for processing the completed application and all supporting documents and making a decision is the goal of the admissions committee. In some cases additional time may be required if additional information is needed. The applicant will be notified if the thirty day time frame needs to be extended.

Notification process for each admission decision.

The Admissions Coordinator will inform the applicant/representative of the admissions decision at minimum by a letter within ten days of the decision. COC's appeal process will be included with denial letters.

Criteria for admission.

General Criteria

Applicants must meet the general program criteria as dictated by the funding source**.**

All sections of the application must be completed and the following general criteria must be met:

1. An individual must have a physician diagnosed and documented physical, mental, or emotional disability.
2. The individual must have attained the age of 16 for admission to vocational services, or the age of 18 for admission to many residential services. Younger individuals are eligible for SCL services. COC encourages individuals to remain in school as long as they can.
3. The individual must be reasonably free of injurious behaviors to self and others, and refrain from destructive acts toward property.
4. The individual must have had a general physical examination and TB test within the past twelve months, using COC's Admissions Physical form when possible. (This does not apply to Transition Students and Division of Vocational Rehabilitation referrals).
5. The individual must be willing to participate in a 120-day evaluation period with the understanding that they may not continue services at COC at the end of the evaluation period depending on various circumstances. The trial period may be extended at the team's discretion. (A team meeting will be held on or before the 90 day point after their admission to the program(s) at C.O.C. if there are indications that a discharge is probable due to the placement(s) not being a good fit after all for the individual. If, however, the admission evaluation period is going well, and there are no indications that the placement is not a good fit for the individual, then no formal 90 day meeting is required. The individual's administrative team members will keep in good contact with each other and the person supported during the evaluation period in order to monitor and communicate the appropriateness of the placement(s).
6. The individual must be able to pay all fees or have adequate public or private funding to meet their needs.
7. People who have a legal county of settlement in COC's primary counties will be given preference.
8. The individual and his or her guardian (if applicable) must consent to admission.
9. All sections of the application must be completed by the individual or responsible person(s).

NOTE: Specific criteria for vocational and residential programs are also required.

CHRISTIAN OPPORTUNITY CENTER
APPLICATION

NOTE: ***If you have any questions about the application process, please contact the Admissions Coordinator in the region you are applying for. All admissions are made on a 120-day trial basis.***

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

Pella/Knoxville	**Oskaloosa**	**Indianola/Des Moines**
Attn: Admissions Coordinator	**Attn: Admissions Coordinator**	**Attn: Admissions Coordinator**
Christian Opportunity Center	**Christian Opportunity Center**	**Christian Opportunity Center**
PO Box 347	**110 B Avenue East**	**1602 N 14th St.**
Pella, IA 50219	**Oskaloosa, IA 52577**	**Indianola, IA 50125**
(641) 628-8087 ext. 108	**(641) 673-9480**	**(515) 961-3653 Ext 210**

Applicant's Name: _____ Date: _____
(Last) (First) (Middle)

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

Current Phone #: _____ County of Residency:_____

Birthplace: _____ Date of Birth: _____

Gender: _____ Email: _____

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

Special Note:
The following documents must accompany this application before COC will process your application:

1. **A current psychological evaluation including diagnosis and IQ range if an intellectual disability is present;**
2. **A psychiatric evaluation if a psychiatric diagnosis is present;**
3. **A neuropsychological evaluation if a Brain Injury (BI) diagnosis is present;**
4. **A copy of their latest annual service plan if available;**
5. **A copy of the case management social history and case plan if available;**
6. **A copy of the Department of Vocational Rehabilitation's evaluation report if applicable;**
7. **A current photograph;**
8. **A copy of legal payee documents if applicable;**
9. **A copy of guardianship and/or conservatorship documents if applicable;**
10. **Signed releases so that information can be obtained from other agencies; and**
11. **A copy of most current Skills Assessments completed by the case manager, schools & previous providers as applicable.**

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
___ Habilitation Services

Residential:

___Intermediate Care Facility
___ Supported Community Living – 24 hour
___ Supported Community Living – hourly
___ Habilitation Services

Oskaloosa

Vocational:

___Facility Based Employment
___Community Based Employment
___ Day Habilitation
___ Habilitation Services

Indianola

Vocational:

___ Facility Based Employment & Pre-vocational
___ Community Based Employment
___ Day Habilitation
___ Habilitation Services

Residential:

___Intermediate Care Facility
___Supported Community Living – 24 hour
___Supported Community Living – hourly
___Habilitation Services

Des Moines

Residential:

___Supported Community Living – 24 hour
___Supported Community Living – hourly

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: _____

Date of Birth:_____

Father's Address: _____

Mother's Name: _____ Phone: _____

Mothers Maiden Name: _____

Date of Birth: _____

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/ID Waiver
____ HCBS BI Waiver
____ HCBS Habilitation Services
____ County (Name County) _____
____ State Funding
____ Vocational Rehabilitation
____ Private – self pay
____ Private Insurance
____ 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 (SSDI or SSDAC)
_____ VA Pension
_____ Title XIX (19**)**
_____ Other (ie: adoption subsidy)

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.

Previous hospitalizations and/or commitments for mental health treatment:
_____

If committed, was commitment _____voluntary _____involuntary

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:_____
Name of current 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:_____

Date of most recent neuropsychological evaluation for brain injury _____

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: _____
_____

Have you ever been told you have a lifting restriction?	____yes___no
Have you ever been told you have a standing restriction?	____yes __no

Please explain if you answered yes to the previous 2 questions: _____
_____
_____
_____

COMPLETE THE NEXT SECTION FULLY FOR ALL "YES" ANSWERS FROM PREVIOUS PAGE

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

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

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? (Please circle)

- 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? (Please circle)

- 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

Current Medications: (Please attach additional page as needed)

Name of Medication	**Dosage**	**Frequency/Time**	**Purpose**	**Doctor who prescribed**

Do you administer your own medications? If not, what kind of assistance is needed? _____
_____

Medications no longer used. Explain why they were discontinued:
_____
_____
_____

Allergies: (Describe cause and reaction)
Drug allergies: _____
Food allergies: _____
Insect bites: _____
Other allergies (such as latex) _____

Adaptive Equipment needs: _____
_____
_____
_____

Eating Habits: (please circle the correct response)
Assistance level: No help Some help Total help Describe: _____
_____

Typical Appetite: __Large __Medium __Small

Do you wear dentures? _____Yes ____No

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 describe)
_____

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:

Can you read? ____Yes ____No Can you write? ____Yes ____No

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

Do you have vision impairment? ____Yes No_____ Do you wear glasses or contacts? ___Yes __No

Do you have a hearing impairment? ___Yes ___No Do you wear a hearing aide? ____Yes ____No

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:
_____
_____

Getting to know you personally:
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? _____
_____

IMPULSE CONTROL/SELF_REGULATION

Do you have (or have you previously had) problems with any of the following areas:

	Yes	No	Unsure
• Controlling your temper	_____	_____	_____
• Controlling your emotions	_____	_____	_____
• Destruction of property	_____	_____	_____
• Excessive spending or gambling	_____	_____	_____
• Drug use	_____	_____	_____
• Eating disorders	_____	_____	_____
• Sexual behaviors	_____	_____	_____
• Over stepping physical boundaries	_____	_____	_____
• Self injury	_____	_____	_____

If you answered yes to any of the above, please explain how you are being helped to lessen this behavior:
_____
_____
_____

Are there specific times or activities when particularly close supervision is needed? If so, please explain when these are:
_____
_____
_____

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)

_____
_____

Do you identify strongly with any religious or ethnic sector?_____

Do you celebrate any family traditions? _____
_____

How would you describe your lifestyle? _____
_____

How would you describe your work ethic? _____
_____

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

_____
_____

Significant abuse history (domestic violence, physical, sexual, emotional and/or substance):

_____
_____

How do you manage peer pressure?_____
_____

Do you feel comfortable in social situations? _____
_____

Do you meet and communicate with new people easily? _____

What is your socioeconomic status? _____

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

(A conviction does not automatically preclude admission to COC, but is subject to review by the Admissions Committee)

Are you presently or have you ever been listed on the Sex Offender Registry? ____Yes _____No

Have you been convicted of any crime that will result in you being listed on the Sex Offender Registry in the future? _____ Yes _____ No

It is the policy of COC not to admit persons to services who are presently, or have ever been listed on the Sex Offender Registry. Anyone who is added to the Sex Offender Registry while receiving services at COC will be discharged from services.

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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