Christian Opportunity Center
Supporting PEOPLE. Changing LIVES.

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, which can be extended at the team's discretion. Information contained in other submitted application materials does not need to be filled out.***

Pella/Knoxville/Des Moines
Attn: Admissions Coordinator
Christian Opportunity Center
PO Box 347
Pella, IA 50219
(641) 628-8087 ext. 108

Oskaloosa
Attn: Admissions Coordinator
Christian Opportunity Center
110 B Avenue East
Oskaloosa, IA 52577
(641) 673-9480

Indianola
Attn: Admissions Coordinator
Christian Opportunity Center
1602 N 14th St.
Indianola, IA 50125
(515) 961-3653 Ext 210

Applicant's Name: _____ Date: _____

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

Current Phone #: _____ Email: _____

Gender: _____ Marital Status: _____ Date of Birth: _____

Person Completing Application: _____

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

Current Phone #: _____ Email: _____

Relationship to Applicant: _____

What would you or your family/case manager like COC to help you with, or provide for you? (finding a job, helping with budget, learning to cook, residential home, etc.)

_____
_____
_____

Check the regions you wish to apply for. Please note not all services are available in all regions.

___ Pella/Knoxville (P/K)
___ Oskaloosa (O)
___Indianola (I)
___Des Moines (DM)

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

Vocational:
___ Facility Based Employment (P, O)
___ Community Based Employment (P/K, I, O)
___ Day Habilitation (P, I, O)

Residential:
___Intermediate Care Facility (P, I)
___Supported Community Living – 24 hour (all regions)
___Supported Community Living – hourly (P/K, I, O)

It is the policy of COC not to admit persons to services that 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.

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

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)

Funding/Financial Information:

Do you currently qualify for the funding for COC's services? ____ Yes _____No

What is the source of the funding? (Medicaid, MCO, HCBS/ID Waiver, HCBS/BI Waiver, Habilitation, Region, State, IVRS, Private Pay, etc.)_____
_____

My case manager/social worker/Integrated Health Care Coordinator's name is: _____

Current Phone #: _____ Email: _____

Psychological/Psychiatric/Neuropsychological Evaluation Information:

A **psychological evaluation** is completed by a psychologist and is used to diagnose a Developmental Disability. IQ testing is a portion of the evaluation. 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. A **neuropsychological evaluation** is completed to document a brain injury. The evaluation results will typically determine the source of funding available to an individual.

What evaluation(s) apply to you? _____ Psychological _____ Psychiatric _____Neuropsychological

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

Please list the Axis I diagnosis (Clinical Disorders):

_____

Please list the Axis II diagnosis (Personality Disorders and Intellectual Disability):

_____

Are you currently seeing a psychiatrist and/or therapist? ____ Yes ____No

Previous hospitalizations and/or commitments for mental health treatment:

_____
_____
_____

If committed, was commitment _____voluntary _____involuntary

Medical Information:

What are your current and/or reoccurring medical conditions? (Allergies, heart conditions, high blood pressure, cancer, nervous, respiratory, circulatory, digestive, urinary, or urinary problems, venereal disease or other infectious disease, diabetes, thyroid, pneumonia, or disorder of the lymph system, hepatitis, seizures, etc.)

_____
_____
_____
_____

What kind of support do you need for the medical conditions you listed?

_____
_____
_____

Do you have a history of substance abuse? ____Yes _____No
If yes, please explain: _____
_____

Do you have Diabetes? ____Yes _____No **If so, please fill out the diabetes section.**

Diagnosis: _____Type 1 _____Type 2

Is your diabetes well controlled? ____Yes _____No

Do you suffer from frequent and severe episodes of hypoglycemia and/or hyperglycemia, sometimes referred to as 'brittle' diabetes? ____Yes _____No

Do you test your blood sugar?

a. Do you need any assistance with this? ____Yes _____No
b. If yes, what assistance is needed?_____
   _____

Do you take insulin? ____Yes _____No

c. Do you need any assistance with this? ____Yes _____No
d. If yes, what assistance is needed?_____
   _____

Can you identify when your blood sugar is too high or too low? ____Yes _____No

Medication Information: A medication record from your provider can be attached instead.

Name of Medication Dosage Frequency/Time Purpose Doctor who prescribed

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Please attach additional page as needed.)

What kind of assistance is needed for taking your medications? _____
_____

Educational/Vocational Information:

What is your highest level of education?_____

What other vocational training have you received?_____
_____

Are you currently working? ____Yes _____No
How is your job going? _____
_____

Are you in need of assistance with your current job? ____Yes _____No

Employment History

Employer	Date Started	Date Ended	Job Duties

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	_____	_____	_____
• Overstepping physical boundaries	_____	_____	_____
• Self-injury	_____	_____	_____

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

_____

_____

_____

Communication Needs:

Can you read? ____Yes _____No
Can you write? ____Yes _____No
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 aid? ____Yes ____No

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

Further communication information/instructions: _____

_____

Getting to know you personally:

Please comment on areas in which you do well (your strengths: easygoing, helpful, hard worker, etc.):

_____

_____

_____

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

_____

_____

_____

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)

_____
_____
_____

Previous and Current Residential Programs/Living Arrangements, including dates started and ended:

_____
_____
_____

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)

_____
_____
_____
_____

Toileting:
What assistance do you need? ___No assistance ___Some assistance ___Complete assistance
Please describe the assistance needed. _____
_____

Dressing:
What assistance do you need? ___No assistance ___Some assistance ___Complete assistance
Please describe the assistance needed: _____
_____

Overnight assistance: (Repositioning, brief training, monitoring seizure activity)
Please describe the assistance needed: _____
_____

Personal Hygiene: (Bathing/showering, shaving, washing face/hands, oral care, menstrual care, ear molds)
What assistance do you need? ___No assistance ___Some assistance ___Complete assistance
Please describe the assistance needed: _____
_____

Mobility/Special Equipment Needs:
Do you use a wheelchair? ____Yes _____No
Do you require assistance walking? ____Yes _____No If yes, please explain: _____
_____

Other mobility/special equipment instructions:

_____
_____

Dietary Needs:
What assistance do you need? ___No assistance ___Some assistance ___Complete assistance

Do you require?
Chopped food _____ Blended food _____ Pureed food _____Diet Supplement (i.e. *Ensure)* _____
Special utensils (if so, please list) _____

Do you have difficulty?
Swallowing _____ Chewing _____ Drinking _____
Please explain: _____
_____

Specific diet/diet restrictions prescribed by a doctor:
_____
_____

Signatures:

Signed _____Date_____

How did you learn about COC's Services? (Website, DHS, radio ad, newspaper, friend, or other)
_____
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