CENTER FOR INDEPENDENCE

creating community opportunities

258 3rd Street S.W.
Phone: 605-352-5698 Huron, South Dakota 57350-2403 Fax: 605-352-1039

Thank you for your interest in the Center For Independence. We are a private non-profit corporation first started in 1976. Our mission is to assist people with Developmental Disabilities to live and work as other citizens do in the community of their choice.

If you would like to fill out an application for services, you will find the application and Notice of Privacy Practices enclosed. Completed applications can be E-mailed using the submit button at the bottom of the application or sent to the address or fax number at the top of this paper. Please be sure to return the Notice of Receipt of Privacy Practices when you send your completed application back. If you would like assistance filling out the application you can reach me at 605-352-5698 to schedule a convenient time to complete the application.
Again, thanks for your interest in the Center For Independence.

Gayle Kludt
Admissions Chairperson

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REQUEST FOR SERVICES

Reason for Referral: ☐ Transition to Adult Services
☐ Other: _________

Applicant Name: ____
(First) (Middle) (Maiden) (Last)

Date of Birth:____________ Sex: ☐ Female ☐ Male

Current Address: ____
(Street) (City) (State) (Zip)

Permanent Address:____
(Street) (City) (State) (Zip)

Home Phone: ______________ Work Phone: ______________ Cell Phone:__________________

Email Address: ____________________________________

Family Contact: ____
(First) (Middle) (Last) (Type of Relationship)

Address: ____
(Street) (City) (State) (Zip) (Email address)

Home Phone: ______________ Work Phone: ______________ Cell Phone:__________________

Additional Contact: ____
(First) (Middle) (Last) (Type of Relationship)

Address: ____
(Street) (City) (State) (Zip) (Email address)

Home Phone: ______________ Work Phone: ______________ Cell Phone:__________________

SCHOOL INFORMATION – Check all that apply

☐ Currently attending school — Date school services projected to end: __________________________
☐ Graduated with signed diploma — Date school services ended: __________________________
☐ Received certificate of completion — Date school services ended: __________________________

School: ____________________________ Contact Person:_________________ Phone:______________

REQUEST FOR SERVICES

LEGAL REPRESENTATIVE/CONSERVATORSHIP – Check all that apply to the applicant if over 18 years old.

☐ Court Ordered Legal Representative and type (medical, limited, etc):______________________________
☐ Court Ordered Conservator and Name if different from Legal Representative: ____________________
☐ Power of Attorney and type: ____
☐ No Legal Representative in place.

Legal Representative's Name: ____
(First) (Middle) (Last)

Address: ____
(Street) (City) (State) (Zip) (Email address)

Home Phone: __________________ Work Phone: ________________ Cell Phone: _________________

SERVICES REQUESTED – Check all that apply

☐ **Educational Services** Requested Start Date:______________________________
- ☐ Integrated Classroom ☐ Self-Contained Classroom

☐ **Employment Services** Requested Start Date:______________________________
- ☐ Day Services ☐ Supported Employment ☐ Community Employment

☐ **Residential Services** Requested Start Date:______________________________
(i.e., independent living skills, community living skills, financial, personal living, etc.)

☐ Live with family	☐ Group Home	☐ 24 hr. support needed
☐ Live alone	☐ Supervised apartment	☐ Daily support needed
☐ Live with roommate	☐ Rent apartment or home	☐ Weekly support needed
	☐ Buy house	☐ Other ____________________

DEVELOPMENTAL DISABILITY DIAGNOSIS – Check all that apply
(If available attach Psychological Evaluation) Please refer to evaluations for formal diagnosis:

IQ:	☐ Mild (52-70)	☐ Downs Syndrome	☐ Fetal Alcohol Spectrum Disorder
	☐ Moderate (36-51)	☐ Cerebral Palsy	☐ Traumatic Brain Injury (Prior to age 22)
	☐ Severe (20-35)	☐ Epilepsy/Seizure Disorder	☐ Cognitive Disability
	☐ Profound (20 or below)	☐ Autism	☐ Other:______________________________
	☐ Borderline (71-85)	☐ Aspergers Disorder	☐ Other:______________________________

FINANCIAL INFORMATION – Check all that apply
To assist in determining applicant's eligibility for services, please list sources and amounts of income:

☐ Medicare Number ______________________ ☐ Medicaid Number _____________________________

☐ Social Security Number __________________	Amount __________	Payee: _______________________
☐ Supplemental Security Income	Amount __________	Payee: _______________________
☐ Social Security Disability Insurance	Amount __________	Payee: _______________________
☐ Veteran's Administration	Amount __________	Payee: _______________________

Other sources of Income and Amount: (e.g.: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, CDs, wages, interest, property owned, etc.)

____

REQUEST FOR SERVICES

SUPPORT NEEDS – Check all that apply (if applicable, attach extra page(s))

☐ cannot walk alone ☐ cannot do steps

☐ Intentionally hurts self

Please describe: ____________________

What appears to cause this? ____________________

What is frequency? ____________________

☐ Physically aggressive towards others
Please describe: ____________________
What appears to cause this? ____________________
What is frequency? ____________________
Is this potentially dangerous to others? ____________________
If yes, explain: ____________________

☐ Disruptive (such as frequent tantrums, screaming, other emotional outbursts)
Please describe: ____________________
What appears to cause this? ____________________
What is frequency? ____________________

☐ Sexual acting out
Please describe: ____________________
What appears to cause this? ____________________
What is frequency? ____________________

☐ Takes other possessions
Please describe: ____________________
What appears to cause this? ____________________
What is frequency? ____________________

☐ Any other concerns such as verbal or physical threats, difficulty relating to peers/authority, etc.
Please describe: ____________________
What appears to cause this? ____________________
What is frequency? ____________________

COMMUNICATION – Check primary means of applicant's expression

☐ Speaks ☐ Sign Language ☐ Gestures ☐ Communication Device
☐ Other (please specify): ____________________

ADAPTIVE EQUIPMENT – Check all of the adaptive devices or equipment the applicant uses:

☐ Hearing Aid	☐ Corrective Lenses	☐ Orthopedic Splints	☐ Manual Wheelchair
☐ Catheter	☐ Colostomy Bag	☐ Orthopedic Shoes/Braces	☐ Electric Wheelchair
☐ G-Tube	☐ Wears Helmet	☐ Walker	☐ Mechanical Lift
☐ J-Tube	☐ White Cane	☐ Gait Belt	☐ Other: ____________

REQUEST FOR SERVICES

MEDICAL INFORMATION and RELATED SERVICES – Check all that apply

☐ Speech/Language ☐ Physical Therapy ☐ Occupational Therapy ☐ Counseling
☐ Psychiatric
☐ Medical Problems: ____________________
☐ Medications: 1. Name: ____________________ Reason: __________
2. Name: ____________________ Reason: __________
3. Name: ____________________ Reason: __________

Required documents to enclose with this application – Check and attach all that apply

☐ IEP (if applicable)
(Multidisciplinary Team Assessment)

☐ Diagnosis Documentation
(Psychological Evaluation and Medical Information)

☐ Court Order for Legal Representation

Criminal Convictions ☐ No ☐ Yes

If yes, please describe: ____________________

I acknowledge this is a request for agency planning purposes. Completion of this form is not a guarantee of services nor is it a commitment on my part to accept offered services.

APPLICANT SIGNATURE: ____________________

PARENT/LEGAL REPRESENTATIVE SIGNATURE: ____________________

DATE: ____________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.
A COPY OF THE COMPLETE NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED FROM THE ADDRESS ABOVE. THE FOLLOWING IS A SUMMARY OF THE NOTICE OF PRIVACY PRACTICES.

Uses & Disclosures of Health Information

The Center for Independence uses health information regarding you in order to provide treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of services.

The Center for Independence may use or disclose identifiable health information about you without authorization for several other reasons. Subject to certain requirements, the agency may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. The agency provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, the agency will ask you for a written authorization before using or disclosing any identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

The Center for Independence may change its policies at any time. When a significant change in policy is made, the agency will change this notice and post the new notice in all agency residences. In addition, a copy of the new notice will be provided to you. You and/or your family members or guardian may request a copy of this notice at any time. For more information about the agency's privacy practices, please contact the person listed below.

Individual Rights

In most cases, you have the right to review or receive a copy of health information that is used to make decisions concerning you. You have the right to receive a list of instances where the agency has disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that the agency correct the existing information or add the missing information. You may request in writing or via other form of communication, that the agency not use or disclose information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. The Center for Independence will consider each request but is not legally required to accept it.

Complaints

If you believe that the Center for Independence has violated your privacy rights, or if you disagree with a decision the agency made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health & Human Services. The person listed below can provide you with the appropriate address.

Our Legal Duty

The Center for Independence is required by law to protect the privacy of your information, to provide this notice about our privacy practices to you and to follow the practices that are described herein.

***If you have any questions or complaints, please contact*:**
Georgia Langbehn, Chief Operating Officer
Center for Independence
258 3rd Street, SW
Huron, SD 57350
(605) 352-1002
email: glangbehn@cfindependence.com

12/15/2006

258 3rd Street S.W.
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Acknowledgment of Receipt of Notice of Privacy Practices

(effective date April 14, 2003)

My signature below acknowledges my receipt of the Center for Independence's Notice of Privacy Practices.

______________________________	______________________________
Date of Individual's or Guardian's Signature	Signature of Individual or Guardian

____
Individual's Name

____
Name of Guardian (if applicable)

____
Service Facilitator Signature/Admissions Chairperson

Routing:
Client Services Officer

revised 9/10/10

If you have difficulty e-mailing the application with the submit button, save the form and e-mail to gkludt@cfindependence.com.