Hillcrest family services

A ministry of the Iowa Conference of the United Methodist Church and the Synod of Lakes and Prairies, Presbyterian Church (USA)
Accredited by the Joint Commission on Accreditation of Healthcare Organizations

Hillcrest Family Services
Application for Services

In order for us to evaluate an application for Hillcrest Family Services Adult Programs, we would like the following information. Even though some sections may not apply, information on those that do will assist in determining if HFS services will appropriately fill the programming needs of the applicant. If something does not apply, please indicate it on the form.

*** If you are a Case Manager and can supply us with a current Social History, we request that you do so. This may mean that some sections are repetitious to the current Social History content. If so, please state "see Social History" in those areas.****

I. Personal Information

Name: _____ Age: _____ Birth Date: _____
Social Security Number: _____ Marital Status: _____
Address: _____
Home Phone: _____ Work Phone: _____
Name of Person Referring: _____
Relationship to Applicant: _____
Address: _____
Home Phone: _____ Work Phone: _____
Please explain why you are applying to HFS: _____
_____
_____
_____
What services are you interested in receiving from HFS? _____
_____
_____
_____

II. Financial Information

Sources and Amounts:

Employment	$ _____	Rent Assistance	$ _____
SSDI	$ _____	Food Stamps	$ _____
SSI	$ _____	A. D. C.	$ _____
V. A. Disability	$ _____	Other (_____)	$ _____

Please check the following that apply to you:

Medicaid	_____	County Medication Fund	_____
Medicare	_____	Private Insurance	_____

Continued

Client: _____

Who handles your money?
Yourself _____ Name: _____
Guardian _____ Name: _____
Payee _____ Name: _____
Conservator _____ Name: _____

Has a funding source for HFS services (County of legal settlement, DHS, IME) been contacted for funding? ❑ Yes ❑ No
Name of Case Worker: _____
County of Legal Settlement (if Known)_____

III. Background Information
Education:
What are your educational goals? _____
Last grade level completed: _____ Location: _____
Have you received any special training? ❑ Yes ❑ No If so, in what area? _____
_____
Vocational:
What are your vocational goals? _____
_____
Are you currently employed: _____ If so, please complete the following:
Job Title: _____ Employer: _____
Hours: _____ Duties: _____
_____
Is this a paid position? ❑ Yes ❑ No
Do you have concerns about your current employment situation? _____
_____
Please list previous positions:
1. Job Title: _____ Employer: _____
   Dates of employment: _____ Reason for leaving: _____
   _____
2. Job Title: _____ Employer: _____
   Dates of employment: _____ Reason for leaving: _____
   _____
3. Job Title: _____ Employer: _____
   Dates of employment: _____ Reason for leaving: _____
   _____

IV. Psychiatric Information (If applicable)
How many years have you been diagnosed with a psychiatric disorder? _____
What is your current diagnosis? _____
_____
_____

Continued⌜

Client: _____

Are you currently experiencing any type of symptoms? ❑ Yes ❑ No If yes, please describe:

_____

_____

What type of symptoms have you experienced in the past? _____

_____

_____

_____

What are your current medications? _____

_____

_____

Are you compliant with medication orders? ❑ Yes ❑ No
Who is your psychiatrist? _____
Commitment Status: _____ To Where: _____
Do you participate in therapy? ❑ Yes ❑ No Where and with whom? _____

_____

How many times have you been hospitalized for treatment? _____
Please provide the following information for each hospital admission:

Name of Hospital	Admit Date	Discharge Date	Reason for Admission
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Do you have a history of suicidal thoughts and/or attempts? ❑ Yes ❑ No Please explain:

_____

_____

_____

Do you have a history of aggression, violence or being dangerous to others? ❑ Yes ❑ No
Do you have issues regarding sexual or physical abuse? ❑ Yes ❑ No If yes, please explain:

_____

_____

Are you currently using any alcohol or drugs? ❑ Yes ❑ No If yes, what type and how often?

_____

_____

What type of substance abuse treatment have you or do you receive, if any? _____

_____

_____

Continued⌜

Client: _____

V. Medical History

Do you have a general practitioner? ❑ Yes ❑ No Who? _____
When and where was your most recent physical exam? _____
Do you have a dentist? ❑ Yes ❑ No Who? _____
When and where was your most recent dental exam? _____
Do you have medical concerns or medical conditions? ❑ Yes ❑ No If yes,
please explain: _____

_____

_____

Are you on any medication for physical reasons? ❑ Yes ❑ No If yes, please explain: _____

_____

_____

Do you have any allergies? ❑ Yes ❑ No If yes, please describe: _____

_____

Do you have any speech, language or hearing needs? ❑ Yes ❑ No If yes, please explain:

_____

_____

Please describe some identifying information:
Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____
Identifying features: _____

VI. Community Information

Do you have concerns about your current housing needs? ❑ Yes ❑ No Please explain:

_____

_____

_____

Which would best describe your current living situation?

_____ Living on your own
_____ With spouse or significant other
_____ With friends or roommate
_____ With children
_____ With parents
_____ With other relatives
_____ In a facility (Please describe) _____
_____ Other (Please explain) _____

Please list the agencies and community supports you are currently utilizing (such as family, significant other, DHS, therapist, doctor, etc.):

Contact person: _____
Relationship: _____
Address: _____
Phone: _____

Continued

Client: _____

Contact person: _____
Relationship: _____
Address: _____
Phone: _____

Contact person: _____
Relationship: _____
Address: _____
Phone: _____

Contact person: _____
Relationship: _____
Address: _____
Phone: _____

Contact person: _____
Relationship: _____
Address: _____
Phone: _____

Contact person: _____
Relationship: _____
Address: _____
Phone: _____

VII. Recreation

Are you satisfied with your social life? ❑ Yes ❑ No If not, what areas would you like to see changed? _____

_____

Please check any area you would like assistance with or have concerns about:

_____ Talking to new people
_____ Starting conversations
_____ Transportation to activities
_____ Learning about community events
_____ Getting along with others
_____ Affording activities
_____ Maintaining friendships
_____ finding someone to do things with
_____ Finding time for recreation activities

VIII. Independent Living Skills

Do you know how to cook? ❑ Yes ❑ No Please give examples of meals you can prepare:

_____

Do you have trouble shopping for groceries? ❑ Yes ❑ No If so, please describe what areas are difficult: _____

_____

Continued

Client: _____

Do you have adequate money management skills? ❑ Yes ❑ No What is most difficult for you in budgeting your money: _____

_____

_____

Do you have any problems maintaining your personal hygiene? ❑ Yes ❑ No If so, please describe: _____

Are you able to maintain clean living quarters? ❑ Yes ❑ No What areas would you like to improve on? _____

_____

Do you have any problems with transportation? ❑ Yes ❑ No If yes, please describe: _____

_____

_____

IX. Treatment Goals

From the list below, please identify any areas you feel HFS could provide some assistance or you would like to learn more about:

_____ Learning about my psychiatric illness
_____ Managing my psychiatric illness
_____ Monitoring symptoms of illness or side effects of medication
_____ Making friends or getting along with people
_____ Learning to do personal laundry
_____ Filling prescriptions
_____ Taking medications
_____ Making and keeping appointments
_____ Learning cleaning skills
_____ Shopping for groceries
_____ Learning to cook
_____ Learning more about nutrition
_____ Budgeting money
_____ Scheduling leisure/recreational activities
_____ Maintaining religious/spiritual practices
_____ Using public transportation
_____ Maintaining personal hygiene
_____ Seeking help with personal crisis
_____ Maintaining daily routine
_____ Dealing with government agencies and arranging for services
_____ Applying for financial resources
_____ Maintaining personal safety
_____ Seeking help in dangerous situations
_____ Transportation
_____ Increasing daily structure

Continued⌜

Client: _____

Please comment on any of the areas identified above: _____

_____

_____

_____

Please list other goals you would like to address: _____

_____

_____

Please list what you believe to be your personal strengths:_____

_____

_____

This application was completed by: _____

Date completed: _____

******If the application was completed by someone other than the applicant, please list contact information below:

Name_____

Relationship to individual_____

Address/Agency_____

_____

Phone and Fax Number(s)_____