Advantages In Life, Inc.
1403 Sugar Grove Avenue
Suite C
Dallas Center, IA
50063
Phone: (515) 987-9826
Fax: (515) 209-2125

ADVANTAGES IN LIFE, INC.
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APPLICATION FOR SERVICES

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Service Application *Date Received by AIL*_____

Thank you for your interest in services with Advantages In Life, Inc. We look forward to working with you!

We request the following information (as applicable) be submitted with the fully completed Application for Services as part of our referral process to assist us in determining the service needs of the applicant. Upon receipt of the AIL Application for Services and required documents, your member's Application will be reviewed by AIL's Administrative Admissions Team and you will be contacted within 72 business hours to confirm receipt.

Requested documents:

- Current Social History
- List of current medications (regularly scheduled and prn) & diagnoses
- SIS assessment/InterRAI
- CASH/LOCUS
- Current Person-Centered Service Plan (PCSP)
- Incident reports for prior 6 months
- Most recent Psychiatric Evaluation/Psychological assessment
- Contact information for involved family/support/Guardianship info.

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Applicant's Full Name:

Telephone:

Current Address:

Date of Birth:

Gender Identification:

MEDICAID #:

Social Security #:

Primary Diagnosis:

Secondary Diagnoses: (MENTAL HEALTH & MEDICAL)

Is this placement in jeopardy: (check or highlight one) YES *NO*

Placement needed by date:

Has the applicant ever received services outside of the home? (check or highlight one)
YES NO

If yes, list most current provider: (name, address, phone number)

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NAME
AGENCY NAME
PHONE NUMBER
ADDRESS
CONTACT
Medicaid Eligibility Established: (check or highlight one) Yes
NO
If no, date eligibility process was:
Initiated:
Completed:

HCBS Eligibility Established: (check or highlight one) Yes NO
If no, date eligibility process was:
Initiated:
Completed:

***Financial Information & Financial Resources*:**

- *SSI* *Amt/mo. - $*
- *SSDI* *Amt/mo. - $*
- *VA Benefits* *Amt/mo. - $*
- *Other* *Amt/mo. - $*

Type of Support Requested: (check or highlight one)

- Supported Community Living_____
- 24-hour Habilitation Services_____

  AIL Service Models available: (Check service(s) member is interested in)

  - SCL/HAB HCBS 24/7community living sites is a service where members live in their own home with one to three roommates and have dedicated staff that work shifts to provide support. (Hours of service provided are reflective of the hours authorized in services tier components)

    _____

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- Host Home is a service where individuals live in private family homes and receive specialized assistance from a dedicated caregiver.

_____

Current MCO assigned or other funding source: (Check or highlight applicable source)
Wellpoint
Iowa Total Care
Molina
HHS/FFS

Funding Type: (Check applicable source) and identify tier and authorization dates)
ID Waiver, Tier:
Authorization date: (beginning to end)

Habilitation, Tier:
Authorization date: (beginning to end)

Additional Contact Information

Guardian

Guardian name:

Guardian Relationship:

Guardian Telephone:

Guardian Email:

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Case Manager

Case Manager/Care Coordinator:

Case Manager/Care Coordinator Telephone:

Case Manager/Care Coordinator Email:

Advanced Placement Team

Advanced Placement Team Contact Name:

Advanced Placement Team Telephone:

Advanced Placement Team Email:

Health/Medical Information:

Please list any adaptive equipment used (cane, walker, wheelchair/type, other)

Please list any specialized Medical Needs: (blind, deaf, hearing impaired, T2D, T1D, seizure disorder, dialysis, feeding tube, wound care)

Member History: (yes or no) circle or highlight Yes or No

- Current Court Committal>
  Yes/No

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- Has member been arrested, awaiting charges, on probation, parole? Yes/No
- Has member been accused/convicted of sexual abuse? **Yes/No**
- Does the member have a history of cruelty to animals? **Yes/No**
- Does the member have a history of attempted suicide? **Yes/No**
- Does the member have a history of self-harming? **Yes/No**
- Does the member have a history of fire setting? **Yes/No**
- Does the member have a history of cutting, swallowing, and/or insertion of foreign objects or strangulation? **Yes/No**

The information in this Application for Services that we have asked you to provide is necessary to assist AIL to make a thorough and comprehensive determination regarding services needs and will assist AIL in the administration of effective and person-centered services. The information collected will only be used by authorized AIL personnel. Use of this information for purposes other than expressed within the contents of this application will not occur without your prior written approval unless other use is specified or requested.

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Completed by:

Date:

Relationship to applicant:

Please email completed applications and required application documents to: Jennifer.roberts@advantagesinlife.com, or drop it off at our main office at 1403 Sugar Grove Ave., Suite C., Dallas Center,IA 50063. Please utilize this last page to type any information that you feel is relevant and necessary to complete this referral.

Thank you very much for your interest in Advantages In Life, Inc!