MYEP Application for Services

407 Highland Court, Iowa City, IA 52240

Phone: 319-341-0060 Fax: 888-883-1235

www.myep.us

Name of Person Completing Application:	**Relationship to Applicant:**	**Date of Application:**

Applicant Information

Last Name:	First Name:	MI:	Medicaid ID#: SS #	Date of Birth:	Age:

Sex: ☐ Male ☐ Female	Height:	Weight:
Current Address:	City:	State/Zip Code:

County of Residence:	
Home Phone:	Cell Phone:
Primary Disability/Diagnosis (degree and type):	Other Diagnoses and Conditions:

This applicant receives funding through (check all that apply):

☐ Intellectual Disability HCBS Waiver ☐ Brain Injury HCBS Waiver ☐ HCBS Habilitation ☐ Region funding

Managed Care Organization (MCO): ☐ Amerihealth Caritas Iowa ☐ UnitedHealthCare ☐ Amerigroup Iowa ☐ Other: _____

Primary Language and Method of Communication (check all that apply):
☐ Speaks English ☐ Understands English ☐ Non-verbal ☐ Uses Assistive Communication Device(s)
Comments on communication method(s):

Supervision Information

What level of supervision is necessary? ☐ Continual supervision ☐ Can be left alone ☐ Requires supervision in public

If the applicant can be left alone, for how long and under what circumstances?

Services Information

Programs/Services Desired (check all that apply):

☐ Residential Program (ages 17+) ☐ SCL daily ☐ Home Based Habilitation Daily ☐ Region funded SCL Daily	Adult Day Program (ages 16+) ☐ Day Habilitation

Contact Information

Mother's Contact Information:

Last Name:	First Name:	
Current Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Father's Contact Information:

Last Name:	First Name:	
Current Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Legal Decision Maker: ☐ Mother ☐ Father ☐ Both Parents ☐ Other

If the legal decision maker is someone other than one or both parents, complete contact information below:

Last Name:	First Name:	
Current Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Work Phone:

This person is a ☐ Court Appointed Guardian ☐ Attorney-in-fact ☐ Other (specify):

Please attach a copy of guardianship papers, if applicable, to this application

Case Manager/Social Worker Contact Information:

Last Name:	First Name:	
Office Address:	City:	State/Zip Code:
Work Phone:	Email Address:	

Additional Pick-up/Drop Off Contacts/Information

Other than the individuals identified above, to whom may MYEP release the person?

Name (First, Last):	Relationship:	Phone Number:
Name (First, Last):	Relationship:	Phone Number:
Name (First, Last):	Relationship:	Phone Number:

Are there any individual who are not supposed to have contact with the person? ☐ Yes ☐ No

If yes, specify:

Name (First, Last):	Relationship:
Name (First, Last):	Relationship:
Name (First, Last):	Relationship:

Other Community Agencies Involved	
Agency Name:	Contact Person:
Address:	City/State:
Work Phone:	Email Address:

Agency Name:	Contact Person:
Address:	City/State:
Work Phone:	Email Address:

Agency Name:	Contact Person:
Address:	City/State:
Work Phone:	Email Address:

School Contact Information	
School Name:	Contact Person:
Address:	City/State:
Work Phone:	Email Address:

School Name:	Contact Person:
Address:	City/State:
Work Phone:	Email Address:

Signature of person completing general applicant/contact information: _____
Date: _____

Medical Contact/History Information	
Current Doctor (First, Last Name):	Date of Last Exam (if known):
Address:	City/State:
Phone:	

Current Pharmacy:	Contact Person (if any):
Address:	City/State:
Phone:	

Current Dentist (First, Last Name):	Date of Last Exam (if known):
Address:	City/State:
Phone:	

Preferred Hospital:	
Address:	City/State:
Phone:	

Specialist (First, Last Name):	Specialty:
Date of Last Exam:	Reason for visit:
Address:	City/State:
Phone:	

Specialist (First, Last Name):	Specialty:
Date of Last Exam:	Reason for visit:
Address:	City/State:
Phone:	

Medical Information

Medications

Prescribed medications ☐ Yes (complete below) ☐ No

Medication Name	Dosage	Frequency	Purpose/Reason

Over-the-counter medications ☐ Yes (complete below) ☐ No

Medication Name	Dosage	Frequency	Purpose/Reason

Special Considerations while attending MYEP

Are there any activities from which the person should be exempted or during which special considerations should be made for health reasons? ☐ Yes ☐ No

If yes, please list below:

Activity restriction/special consideration:	Reason:
Activity restriction/special consideration:	Reason:
Activity restriction/special consideration:	Reason:

Immunizations:

Date of Last Tetanus Shot (required): _____/_____
Month Year

Please attach school or physician immunization record if possible: ☐ Is attached ☐ Unable to attach

If no immunization record is available to attach, please sign below indicating that the person's/child's immunizations are up-to-date:

Signature of parent or legal representative:_____Date:_____

Allergies	
Is the person allergic to:	
Medications? ☐ Yes ☐ No	If yes, explain:
Food? ☐ Yes ☐ No	If yes, explain:
Other? ☐ Yes ☐ No	If yes, explain:

Diet
Is the person on a special diet or does s/he have any dietary restrictions? ☐ Yes ☐ No If yes, please explain:

Seizures	
Does the person have seizures? ☐ Yes ☐ No	Frequency of seizures:
Describe a typical seizure:	
If there is a specific seizure protocol for staff to follow, please attach to this application.	

Other
Does the person have physical disabilities that require the use of special devices (e.g. wheelchair, braces, walker, orthopedic shoes, splints, canes, etc.)? ☐ Yes ☐ No If yes, please explain:
Is the person able to communicate medical or health needs/concerns? ☐ Yes ☐ No Please explain:

By signing below, you are indicating that the information contained in this application is accurate and complete to the best of your knowledge:

_____ _____

Signature of person completing health history: *Date:*

If the applicant is new to MYEP services, or has not continuously received services throughout the past year, please also complete the skills assessment

EQUAL HOUSING OPPORTUNITY