Information needed:

- Application
- Copy of Current Psychological
- Copy of Current Supports (ISP/IEP) *(if applicable)*

- Copy of Social Security Card
- Copy of ID Card
- Copy of Birth Certificate
- Copy of Immunization Record
- Copy of current Checking/Savings accounts

- Social Security award Letter (*if applicable)*
- Copy of Medicare/Medicaid cards (*if applicable)*
- Copy of Guardianship papers (*if applicable)*

RELEASE OF CONFIDENTIAL INFORMATION TO LIFEQUEST

This release pertains solely to: ____
(Person's name)

who is currently receiving services from:____

I, ___________________________ ,or ______________________________________
(Individual served) (Guardian, if applicable)

HEREBY authorize the release of necessary confidential information including the findings of physical and psychological examinations, educational, clinical, laboratory, Individual Service Plan and financial information to LifeQuest.

This release will be applicable for two years from the date signed, unless otherwise stated. A photocopy of the signature is as valid as the original signature. The team will review and revalidate at the Annual Meeting each year.

Date: ____________________ ____
(Signature of person receiving services)

Date: ____________________ ____
(Signature of guardian, if applicable)

Date: ____________________ ____
(Signature of witness, if signed by mark above)

South Dakota Request for Developmental Disabilities Services

Reason for Referral: _____

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:____________________

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. ☐ Copies of Legal Documents are attached.

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

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

Home Phone:____________________ Work Phone: ____________________ Cell Phone:________________

South Dakota Request for Developmental Disabilities Services

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
- ☐ Own my Own Business

☐ **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)	☐ Down 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.) ____

COMMUNICATION – Check primary means of applicant's expression

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

South Dakota Request for Developmental Disabilities Services

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

☐ Needs Assistance Walking ☐ Needs Assistance on Stairs

☐ 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: ____________

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: ____________

Previous/Current Placements and dates-

____

____

____

____

____

____

____

____

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

☐ IEP (if applicable) ☐ Support Plan ☐ Diagnosis Documentation

(Multidisciplinary Team Assessment) (Psychological Evaluation and Medical Information)

SUPPORTS I NEED TO KEEP MYSELF & OTHERS SAFE – Check all that apply. (if applicable, attach extra page(s).

☐ 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 concerns
Please describe: ____________________
What appears to cause this? ____________________
What is frequency? ____________________

☐ Takes others 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? ____________________

Legal convictions/history ☐ 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: ____________________

What do others like and admire about me:

Things I like to do and things I am good at:

Things that are important to me and make me happy:

Supports I need-what I am looking for to be successful:

Documentation Checklist for Enrollment to Home & Community Based Service Providers (CSP's, PLANS)

Name: ____

INFORMATION REQUIRED FROM PARENTS:

Date Submitted:

______________ Completed Service Planning PreApplication (if applicable)
______________ Completed Full Application
______________ Authorization for Release of Information (current w/in 12 months)
______________ Copy of Guardianship Documentation (if applicable)
______________ Copy of Certified Birth Certificate
______________ Copy of Social Security Card
______________ Copy of State-Issued Photo ID Card
______________ Copy of Medicaid/Medicare Card(s)
______________ Copy of Medicare D Card (if applicable)

INFORMATION REQUIRED FROM SCHOOL DISTRICT:

Date Submitted:

______________ Adult Psychological Evaluation (**Wechsler Adult Intelligence** Test preferred)
______________ Current ICAP and Summary Printout (with 12 months of enrollment)
______________ Most Recent 3-year Multidisciplinary Evaluation
______________ Updated Medical / Social Assessment
______________ Current IEP
______________ Approved Program Development Request (SF District only)

INFORMATION REQUIRED FROM PRIMARY PHYSICIAN:

Date Submitted:

______________ "Home Community-Based Services (Medicaid) Physician's/Psychologists Statements (DHS-DD-721)
______________ Physical Examination (within 12 months of enrollment)
______________ List of prescription medications signed by primary physician
______________ Current Vaccination Record
______________ TB Risk Assessment (current within 12 months of enrollment)

ADDITIONAL RECOMMENDATIONS:

______________ Tour of agency
______________ Tour of available residential services (when applicable)
______________ Meet with service provider
______________ Prepare/submit updated resume

COMMUNITY SUPPORT PROVIDERS

Ability Building Services (ABS)
909 West 23rd
Yankton, SD 57078-1510
Telephone: (605) 665-2518 / FAX: (605) 665-0206
Executive Director: Gloria Pearson
Admissions: Gigi Healy

ASPIRE
607 North Fourth Street
Aberdeen, SD 57401-2733
Telephone: (605) 229-0263 / FAX: (605) 225-3455
Web Site: http://www.abatc.org
Executive Director: Jennifer Gray
Admissions: Arlette Kellar

ADVANCE (ADV)
PO Box 810
Brookings, SD 57006-0810
Telephone: (605) 692-7852 / FAX: (605) 692-6169
President/CEO: Larry Franklin
Admissions: Marilyn Kruse

Black Hills Special Services Cooperative (BHSSC)
PO Box 218
Sturgis, SD 57785-0218
Telephone: (605) 347-4467 / FAX: (605) 347-5223
Web Site: http://www.bhssc.org
Executive Director: Ron Rosenboom
Admissions: Shirley Halverson

Black Hills Special Services Cooperative - Hot Springs
737 University Avenue
Hot Springs, SD 57747
Telephone: (605) 745-3408 / FAX: (605) 745-4474
Executive Director: Ron Rosenboom
Admissions: Shirley Halverson

Black Hills Workshop and Training Center (BHWTC)
PO Box 2104
Rapid City, SD 57709-2104
Telephone: (605) 343-4550 / FAX: 343-0879
Web Site: http://www.bhws.com
CEO: Brad Saathoff
Admissions: Kathy Staton

Community Connections, Inc. (CCI)
PO Box 742
Winner, SD 57580-0742
Telephone: (605) 842-1708 / FAX: (605) 842-0309
Executive Director: Rebecca Carlson
Admissions: Melony Bertram

DakotAbilities (DA)
3600 South Duluth
Sioux Falls, SD 57105-6494
Telephone: (605) 334-4220 / FAX: (605) 334-7976
Web Site: http://www.dakotabilities.com
Executive Director: Robert Bohm
Admissions: Shelley Graham

Dakota Milestones (DM)
PO Box 248
Chamberlain, SD 57325-0248
Telephone: (605) 734-5542 / FAX: (605) 734-4260
Web Site: http://www.dakotamilestones.org
Executive Director: Ronda Schelske
Admissions: Rhonda Schelske

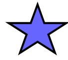
Every Citizen Counts Organization, Inc. (ECCO)
PO Box 450
Madison, SD 57042-0450
Telephone: (605) 256-6628 / FAX: (605) 256-2060
Executive Director: Norman Jerke
Admissions: Karla Kessler

Huron Area Center for Independence (HACFI)
258 3rd Street SW
Huron, SD 57350
Telephone: (605) 352-5698 / FAX: (605) 352-1013
Web Site: http://www.cfindependence.com
Executive Director: Randy Meendering
Admissions: Lisa Tschetter

LifeQuest (LQ)
804 North Mentzer
Mitchell, SD 57301-2198
Telephone: (605) 996-2032 / FAX: (605) 996-0972
Web Site: http://www.lifequestsd.com
Executive Director: Daryl Kilstrom
Admissions: Betty Visscher

LIVE Center, Inc. (LIVE)
PO Box 59
Lemmon, SD 57638-0059
Telephone: (605) 374-3742 / FAX: (605) 374-3238
Executive Director: Randy Schwab
Admissions: Kevin Alton

New Horizons
c/o Human Services Agency
PO Box 1030
Watertown, SD 57201-6030
Telephone: (605) 886-0123 / FAX: (605) 886-5447
Web Site: http://www.humanserviceagency.org
HSA President/CEO: Dr. Charles L. Sherman; ATCO Executive Director: Larry Merxbauer
Admissions: Cyndi Speiker



Northern Hills Training Center (NHTC)
625 Harvard Street
Spearfish, SD 57783-9730
Telephone: (605) 642-2785 / FAX: (605) 642-5069
Web Site: http://www.nhtc.org
Executive Director: Fred Romkema
Admissions: Carl Edwards

OAHE, Inc. (OAHE)
PO Box 503
Pierre, SD 57501-0503
Telephone: (605) 224-4501 / FAX: (605) 224-9619
Web Site: http://www.oaheinc.com
Executive Director: Ann Hoye
Admissions: Kim Kietzman

South Dakota Achieve (SDA)
4100 South Western
Sioux Falls, SD 57105-6699
Telephone: (605) 336-7100 / FAX: (605) 338-0259
Web Site: http://www.achievesd.org
President/CEO: Anne Rieck McFarland
Admissions: Melanie DeBates

Southeastern Directions for Life (SE)
2000 South Summit
Sioux Falls, SD 57105
Telephone: (605) 335-8956 / FAX: (605) 338-9385
Web Site: http://www.southeasternbh.org
Executive Director: Mark Bratt
Admissions: Debbra Anderson

SESDAC, Inc (SESDAC)
1314 East Cherry
Vermillion, SD 57069-1606
Telephone: (605) 624-4419 / FAX: (605) 624-7375
Web Site: http://www.sesdac.org
Executive Director: Gerry Tracy
Admissions: Rennae O'Connor

Volunteers of America/West Oak (VOA)
908 N West Avenue
Sioux Falls, SD 57105
Telephone (VOA): (605) 334-1414 / FAX: (605) 335-3121
Telephone (WO): (605) 367-4293 / FAX: (605) 367-5714
Turning Point Director: Pam Bollinger; West Oak Director: Kris Killeas
Admissions: Kurt Schiferl

South Dakota Department of Human Services

Division of Developmental Disabilities
Hillsview Properties Plaza
East Highway 34, c/o 500 East Capitol
Pierre, SD 57501
Telephone: (605) 773-3438

South Dakota Developmental Center
17267 W 3rd Street
Redfield, SD 57469
Telephone: (605) 472-2400

Enter Social History

Applicant's Name: ____
(First) (Middle) (Last)

Social Security Number: ______________________________

Mother's Maiden Name: ____
(First) (Middle) (Last)

Address: ______________________________________ Phone: ____________________

Birthdate: ______________________________ Social Security #: ____________________

If deceased, cause of death: ____

Father's Name: ____
(First) (Middle) (Last)

Address: ______________________________________ Phone: ____________________

Birthdate: ______________________________ Social Security #: ____________________

If deceased, cause of death: ____

Please list siblings:

Name:	Birthdate:	Adress:

Developmental History:

At what age did applicant:

Sit up by self		Walk	
Crawl		Talk	
Stand by self		Toilet indepently	

Social Interactions:

Does the applicant have a close relationship with family? ________ Yes ________ No

Explain: ____

____

____

Check all that best describe applicants interactions with others:

________ Friendly, seeks out others for social contact

________ Gets along with others, but does not seek them out

________ Quiet, withdrawn from others

________ Unusual or repetitive actions, Describe:

____

____

________ Hurts self intentionally-Describe:

____

____

________ Aggressive toward others-Describe:

____

____

Disruptive actions? Describe:

____

____

Takes others' possessions? Describe:

____

____

Has there been a recent event that has affected applicants actions/interactions? Describe:

____

____

Are there any restrictions concerning people in applicant's life when it involves visits or home visits?
Explain:

____

____

____

Describe applicant's living arrangements for the past five years.

____

____

____

Indicate the primary language of the applicant and family.

____

Does the applicant use an alternative communication system? If so, describe:

____

Should the applicante make home visits? __________ Yes __________ No
If yes, How often? For how long?

____

Can the applicant expect visits from family, relatives or friends? ___________ Yes __________ No
If yes, list those the applicant can leave with and for how long.

____

____

Does the applicant have a close relationship with anyone other that family? ______________________________

Name: ____

Does tha applicant have a fear of anyone? Explain:

____

Does tha applicant have a fear of the opposite sex? Explain:

____

What are the applicant's favorite activities? ____

What recreation does the applicant prefer? ____

Does the applicant participate in any organizations? ____________________________________

What is the applicant's favorite food? _____________________ Least favorite food? ____________________

Are there any contraints regarding food for cultural, ethnic or religious reasons?

____

Does the applicant have any personal possesion(s) that have special meaning to them?

____

Does the applicant use tobacco or alcohol? Explain:

____

Does applicant have a fear of anything? Explain:

Any additional information? List here:

Please check how applicant generally relates to others:	Very Good	Good	Fair	Poor	No Contact
Teachers					
Employers					
Parents					
Siblings					
Co-Workers					
Friends					
Relatives					
Persons in authority					
Strangers					
His/Her disability					

Learning Style	Most Effective	Somewhat Effective	Not Effective
Physical Assistance/ Prompts			
Verbal Assistance/ Prompts			
Demonstration			
Verbal Instructions			
Praise			
Constructive Criticism			
Rewards			
Peer Pressure			
Opinion of Others			

Health Services Admissions Checklist

Name of Applicant: ________________________________ DOB: ______________________

Self-Guardian? yes no (if no, please enter guardian name and contact information below)

Guardian Information:

Name	Address	Home Phone	Work Phone	Cell Phone

Allergies: (include meds, food, environmental, animals, soaps, detergents…)

Substance	Reaction

Current Medications:

Name of Medication	Prescribed for (ie; seizures, hayfever, etc)	How many time/day?	Name of Prescriber

*** Pharmacy**: Walgreens Shopko Lewis North Lewis County Fair Kmart WalMart Other: ______________

*Medical Doctor	Address if not in Mitchell	Phone
*Dentist	Address if not in Mitchell	Phone
*Eye Doctor	Address if not in Mitchell	Phone
Specialists?	Address if not in Mitchell	Phone

***If not in Mitchell, will this person consider using Mitchell health care providers & pharmacy? YES NO**

A list of Mitchell health care providers is available.

For the following, please include year of diagnosis or surgery, if possible.

Medical History:

Surgical History:

Brain/Spinal Cord?

Eyes/Ears/Nose/ Throat?

Heart/Lungs/ Other Organs?

Stomach/Bowel?

Bones/Joints/Muscles?

Dietary needs: **√ all that apply**

○ Regular diet	○ All food pureed	○ Diet portions	○ OTHER (see below)
○ Chopped meats	○ Hot/cold sensitivity	○ G-tube	○
○ Soft foods only	○ Diabetic	○ J-tube	○

Other Dietary Needs?

Immunization History:

Please provide a copy of all immunizations. If any reactions were noted to immunizations, please note this on the copy. Thank you!

Will nursing staff be responsible for health appointments? Yes Not at this time