APPLICATION FOR STEPHENS FARM AT ADEO

2774 W. Reservoir Rd
Greeley, CO 80634
970.506.0008

APPLICANT INFORMATION

Applicant's Name:_____
Preferred Name**:** _____
Date of Birth**:** _____
Current Address:_____
City: _____ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____
E-mail:_____
Gender: ( ) M ( ) F Height: _____ Weight: _____
Preferred Language: _____
Preferred Language for Written Communication: _____
Date of Onset of Brain Injury:_____
Explain How Brain Injury was Acquired:_____
_____
Secondary Diagnoses (List all): _____
Name of Primary Care Provider: _____
Address: _____
Phone: _____
Date of last PCP visit: _____
Are you under the care of any other medical professionals? Yes ____ No ____
If yes, please list name of MD and specialty (Cardiology, Neurology, Mental Health, etc.):
_____

_____

_____

_____

Do you currently have a paid or volunteer job? Yes ____ No ____

If yes, is it ( ) full-time ( ) part-time ( ) seasonal
Current employer (if applicable):_____
Level of Education: _____
Marital Status: _____
Children: Yes___ No___
Name of person completing application if other than applicant: _____
Relationship:_____
Home Phone: _____ Cell Phone: _____
E-mail:_____

STATUS PRIOR TO INJURY

Level of Education:_____Job Status:_____
Alcohol or drug abuse history:_____
Had you received treatment for alcohol and/or drug abuse? Yes___ No___
If Yes, where and when_____
Marital Status: _____
Any Children: Yes___ No___
Living Situation: _____
Had you been arrested: Yes___No___
Alleged Offense:_____Date:_____Outcome:_____
Alleged Offense:_____Date:_____Outcome:_____

FAMILY/RESPONSIBLE PARTY'S INFORMATION

Who would you want us to contact on your behalf in case of an emergency (Emergency Room visit, Urgent Care visit or other urgent matters)?

Name: _____
Relationship: _____
Current Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail:_____

Do you have any of the following (please check all that apply)?

( ) Legal Guardian
( ) Conservator
( ) Power of Attorney

If yes, please provide the following information for the individual/s in these roles:

Name:_____
Current Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail:_____

PAYOR INFORMATION

Do you have Medicaid? Yes___ No___ If yes, Medicaid #_____ State: _____
Do you have Home and Community Based Services (HCBS)? Yes___ No___
If yes, in what county? _____ Phone number: _____
Who is your HCBS Case Manager? _____
Do you have Medicare? Yes___ No___ Part A___ Part B___
If yes, list your Medicare #: _____

FINANCIAL INFORMATION

Do you manage your own money? Yes_____ No_____
Representative Payee:_____
Please list the source of your income and amount:

( ) Social Security	Amount_____
( ) SSI	Amount_____
( ) SSDI	Amount_____
( ) Pension	Amount_____
( ) Alimony	Amount_____
( ) Disability Insurance	Amount_____
( ) Other	Amount_____

MEDICAL INFORMATION

Can you manage your own medication organization, schedule and storage? Yes____ No____
If no, which part of your medication management do you need assistance with?
_____

Do you need assistance with taking your medications? Yes____ No____
If yes, which medications (pills, injections, patches, eye drops, etc.)?
_____

Have you had or do you currently experience seizures? Yes____ No____
If yes, what type of seizures? _____
Are they controlled by medication?
Yes____ No____
Have you been injured as a result of a seizure? Yes____ No____
Do you use any safety devices related to seizures? Yes____ No____
If yes, what device? _____
Can you go into the community unassisted and be safe? Yes____ No____
Date of last seizure: _____

Have you ever had a stroke? Yes____ No____
If yes, please provide the date of stroke: _____
Please list any deficits from the stroke (weakness, slurred speech, difficulty swallowing, etc.):
_____

Do you have problems with your vision? Yes____ No____
If yes, please explain: _____
Do you wear glasses or contact lenses? Yes____ No____

Do you have any hearing problems? Yes____ No____
If yes, please explain: _____
Do you use hearing aids? Yes____ No____
If yes, can you manage them yourself? Yes____ No____

Are you incontinent or do you experience episodes of incontinence? Yes____ No____
If yes, please select which type: ( ) Bladder (Urine) ( ) Bowel (Fecal) ( ) Both
How often (times per day on average) do you experience episodes of incontinence?
_____

Are you able to perform your own pericare/incontinence care? Yes____ No____
If no, how much assistance do you need?
( ) Stand by Assist (set up supplies only)
( ) Partial Assist (set up supplies, remove clothing/bedding, assist with positioning, some assistance with hard to reach areas)
( ) Full Assist (supplies, full pericare, clothing/bedding change, repositioning, bath/shower if needed)

Do you have a urinary catheter? Yes____ No____
If yes, what kind (suprapubic, indwelling, condom)? _____
How often is your catheter changed? _____
Are you able to perform your own catheter changes? Yes____ No____

Do you have an ostomy for bowel elimination? Yes____ No____
If yes, are you able to perform your own ostomy care? Yes____ No____
Do you currently use a bowel program? Yes____ No____
If yes, how many times per week? _____
Does your bowel program include digital stimulation? Yes____ No____

Do you have any eating/swallowing concerns? Yes____ No____
If yes, please explain:_____
Have you choked in the past? Yes____ No____
Do you have a history of aspiration pneumonia? Yes____ No____
If yes, provide the date of the most recent episode _____
Do you require your liquids to be thickened? Yes____ No____
Do you require your foods to be chopped, minced or pureed? Yes____ No____
Do you require monitoring while you eat? Yes____ No____

Do you use any communication devices? Yes____ No____
If yes, please explain: _____
What forms of communication do you use? _____

Do you have any chronic respiratory conditions (asthma, COPD, bronchitis, sleep apnea, etc.)? Yes____ No____
If yes, is it controlled with medications? Yes____ No____
Do you currently use oxygen? Yes____ No____
Do you currently use a CPAP machine? Yes____ No____

Do you experience chronic pain? Yes____ No____
If yes, type and location: _____

Do you experience muscle spasms? Yes____ No____
If yes, location and frequency: _____

How do you currently manage your pain (medication, physical therapy, alternate therapies, etc.)?
_____

Do you smoke? Yes____ No____
If yes, how much and how often? _____

Do you drink alcoholic beverages? Yes____ No____
If yes, how much and how often? _____

Do you have a history of alcohol or drug abuse including medical and/or recreational marijuana?
Yes____ No____
If yes, please explain: _____

Have you received treatment for alcohol and/or drug abuse? Yes____ No____
If yes, where and when? _____

Do you use illegal street drugs? Yes____ No____
If yes, what and how often? _____

List any surgeries in the past 12 months: _____
_____

Have you visited the ER in the past 12 months? Yes ☐ No ☐
If yes, how many times: _____
List reason/s for visits: _____

Number of hospital visits in the past 12 months: _____
Date of last admission: _____
Reason for last admission: _____

Do you have any implanted medical devices? Yes ☐ No ☐
If yes, please list type and location _____

Do you have diabetes? Yes ☐ No ☐
If yes, Type 1 or Type 2? _____
Managed with medications? If yes, what kind? _____

Do you take insulin? Yes ☐ No ☐
If yes, how many times per day do you require insulin? _____
Are you able to administer your own insulin injections? Yes ☐ No ☐

Do you require daily blood sugar monitoring? Yes ☐ No ☐
If yes, how many times per day? _____
Can you perform your own blood sugar checks? Yes ☐ No ☐

Do you use an insulin pump? Yes ☐ No ☐
If yes, are you able to manage your own pump refills and maintenance? Yes ☐ No ☐
Are you able to perform diabetic foot checks on your own? Yes ☐ No ☐

Do you have any chronic infections: Urinary, pneumonia? Yes ☐ No ☐

Do you currently have any type of unhealed skin wounds anywhere on your body? Yes ☐ No ☐
If yes, please provide type (surgical, bed sore, etc.), location and date of occurrence:
_____

Can you identify if you are getting sick? Yes ☐ No ☐
Do you require 24hr/day support? Yes ☐ No ☐

Do you go into the community unassisted? Yes ☐ No ☐
Do you receive any mental health supports? Yes ☐ No ☐
If yes, please explain:_____
Which of the following equipment do you use?

( ) Hospital bed
( ) Bedside lift/sling
( ) Electric wheelchair
( ) Electric medication minder
( ) Bedside commode/toilet riser
( ) Adaptive eating device
( ) Fireman's pole
( ) Other DME not listed
( ) Manual wheelchair
( ) Communication device
( ) Shower chair/bench

MOBILITY
Do you need assistance with the use of the above? Yes ☐ No ☐
If Yes, please explain_____
Do you have problems with your balance? Yes ☐ No ☐
Can you go up and down stairs safely and independently? Yes ☐ No ☐
Do you need assistance with the following:

Getting in and out of bed Yes ☐ No ☐
Getting in and out of the shower Yes ☐ No ☐
Getting on and off the toilet Yes ☐ No ☐
Getting up or sitting down in a chair Yes ☐ No ☐

COGNITION

Do you have problems with the following?

Memory	Yes☐ No☐
Orientation to time, person or place	Yes☐ No☐
Confusion	Yes☐ No☐
Planning	Yes☐ No☐
Organization	Yes☐ No☐
Judgment	Yes☐ No☐
Initiating activities	Yes☐ No☐

Other (please specify)_____

EMOTIONAL AND BEHAVIORAL ADJUSTMENT

Do you have problems with:

Depression	Yes☐ No☐
Thoughts of suicide	Yes☐ No☐
Paranoia	Yes☐ No☐
Controlling your actions sexually	Yes☐ No☐
Alcohol or drugs	Yes☐ No☐

Do you get angry easily? Yes☐ No☐

If yes what causes this? _____

What are the best ways to help you calm down? _____

_____

How would you rate your frustration tolerance? (mark below)

Never frustrated☐ Sometimes frustrated☐ Always frustrated☐

What causes you to become frustrated?_____

_____

Do you ever verbally lose control?	Yes☐ No☐
Do you ever physically lose control?	Yes☐ No☐

When angry or under stress, do you:

Swear at others	Yes☐ No☐
Threaten others	Yes☐ No☐
Hit, push or physically attack others	Yes☐ No☐
Throw or break things	Yes☐ No☐
Do nothing	Yes☐ No☐
Run away	Yes☐ No☐

Other _____

EMOTIONAL AND BEHAVIORAL ADJUSTMENT

What time do you normally go to bed?_____

What time do you normally get up in the morning?_____

Do you get up at night? Yes☐ No☐

If yes, are you oriented to where you are.

Describe your mood if you get up at night. _____

_____

Are you currently receiving psychotherapies or psychiatric treatment? Yes☐ No☐

If Yes please explain the focus of treatment._____

_____

Name of person providing treatment and phone number:

Name:_____ Phone _____

ACTIVITIES OF DAILY LIVING SKILLS

Mark level of assistance required for each task	Independent	Cues or Supervision	Physical Assistance
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Brushing teeth or cleaning dentures	☐	☐	☐
Brushing and/or styling hair	☐	☐	☐
Shaving	☐	☐	☐
Feeding self	☐	☐	☐
Cooking	☐	☐	☐
Laundry	☐	☐	☐
Cleaning room/apartment	☐	☐	☐
Reading	☐	☐	☐
Writing	☐	☐	☐
Using telephone	☐	☐	☐

Do you drive? Yes☐ No☐

What are your hobbies?_____

_____

MEDICATION SHEET

What allergies do you have? _____

_____

Medications (mg, times per day)	Taken For
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____

If there are more than 15 medications put them on the back of this form.

OTHER INFORMATION NEEDED WITH APPLICATION

1. Physicians History, Current Physical, Neuropsychological evaluation if available.

2. If receiving psychological services, a letter from the person providing services. It should explain the psychological condition of applicant, any concerns the therapist has, and the therapist's recommendation regarding your participation in this program.

Please return to:

Stephens Farm
2774 W. Reservoir Road
Greeley, CO 80634

If you have any questions please call Kortney Campbell, Program Administrator Stephens Farm @Adeo at (970) 506-0008.

VOLUNTARY SURVEY

Government agencies at times require periodic reports on the gender, ethnicity, veteran and other protected status of applicants. This data is for statistical analysis only. **Submission of this information is voluntary and in no way affects the application process.**
Check one: ☐ Male ☐ Female
Are you a veteran of the U.S. Armed Services? ☐ Yes ☐ No
Ethnicity/Race: (check only one) ☐ Black or African American, Not Hispanic or Latino ☐ American Indian or Alaska Native, Not Hispanic or Latino ☐ Asian, Not Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander, Not Hispanic or Latino ☐ Hispanic or Latino ☐ White, Not Hispanic or Latino

Exhibit 3-5: Sample Citizenship Declaration

INSTRUCTIONS: Complete this Declaration for each member of the household listed on the Family Summary Sheet

LAST NAME_____

FIRST NAME_____

RELATIONSHIP TO HEAD OF HOUSEHOLD _____ SEX _____ DATE OF BIRTH _____

SOCIAL SECURITY NO._____ ALIEN REGISTRATION NO._____

ADMISSION NUMBER_____if applicable (this is an 11-digit number found on DHS Form I-94, *Departure Record*)

NATIONALITY _____ (Enter the foreign nation or country to which you owe legal allegiance. This is normally but not always the country of birth.)

SAVE VERIFICATION NO._____
(to be entered by owner if and when received)

INSTRUCTIONS: Complete the Declaration below by printing or by typing the person's first name, middle initial, and last name in the space provided. Then review the blocks shown below and complete either block number 1, 2, or 3:

DECLARATION

I, _____ hereby declare, under penalty of perjury, that I am _____
(print or type first name, middle initial, last name):

_____ 1. A citizen or national of the United States.

Sign and date below and return to the name and address specified in the attached notification letter. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

_____ _____
Signature Date

Check here if adult signed for a child: _____

_____ 2. A noncitizen with eligible immigration status as evidenced by one of the documents listed below:

NOTE: If you checked this block and you are 62 years of age or older, you need only submit a proof of age document together with this format, and sign below:

If you checked this block and you are less than 62 years of age, you should submit the following documents:

a. Verification Consent Format (see Sample Verification Consent Form in

Exhibit 3-6).

AND

b. One of the following documents:

(1) Form I-551, **Permanent Resident Card**

(2) Form I-94, *Arrival-Departure Record*, with one of the following annotations:

(a) "Admitted as Refugee Pursuant to section 207";

(b) "Section 208" or "Asylum";

(c) "Section 243(h)" or "Deportation stayed by Attorney General"; or

(d) "Paroled Pursuant to Sec. 212(d)(5) of the INA."

(3) If Form I-94, *Arrival-Departure Record*, is not annotated, it must be accompanied by one of the following documents:

(a) A final court decision granting asylum (but only if no appeal is taken);

(b) A letter from an DHS asylum officer granting asylum (if application was filed on or after October 1, 1990) or from an DHS district director granting asylum (if application was filed before October 1, 1990);

(c) A court decision granting withholding or deportation; or

(d) A letter from an DHS asylum officer granting withholding of deportation (if application was filed on or after October 1, 1990).

(6) A receipt issued by the DHS indicating that an application for issuance of a replacement document in one of the above-listed categories has been made and that the applicant's entitlement to the document has been verified.

(7) *Other acceptable evidence. If other documents are determined by the DHS to constitute acceptable evidence of eligible immigration status, they will be announced by notice published in the *Federal Register*.*

If this block is checked, sign and date below and submit the documentation required above with this declaration and a verification consent format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

If for any reason, the documents shown in subparagraph 2.b. above are not currently available, complete the Request for Extension block below.

_____ _____
Signature Date

Check here if adult signed for a child: _____

REQUEST FOR EXTENSION

I hereby certify that I am a noncitizen with eligible immigration status, as noted in block 2 above, but the evidence needed to support my claim is temporarily unavailable. Therefore, I am requesting additional time to obtain the necessary evidence. I further certify that diligent and prompt efforts will be undertaken to obtain this evidence.

_____ _____
Signature Date

Check if adult signed for a child: _____

_____ 3. I am not contending eligible immigration status and I understand that I am not eligible for financial assistance.

If you checked this block, no further information is required, and the person named above is not eligible for assistance. Sign and date below and forward this format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who is responsible for the child should sign and date below.

_____ _____
Signature Date

Check here if adult signed for a child: _____

INTERMOUNTAIN DATA CORP

911 28th Avenue **Phone: (970) 356-1925 & Fax: (970) 352-3142**
Greeley, CO. 80634 **National: 1 800 524-1160 & Fax: 1 888 352-3142**

Authorization for release of Credit and/or Criminal Information

The purpose of this release is to verify the information given on and by the prospective applicant.

TYPE OR PRINT CLEARLY **CLIENT: A D E O**

Last Name _____ First _____ Middle _____

Maiden or AKA: _____ Yrs. Married _____ Other Name(s) used _____.

Social Security # _____ Date Of Birth _____How long have you lived in this State?_____

Driver's Lic. # _____ State of Issue _____ Home Phone # _____

Current Address_____
How Long? _____ (Street number and name) (City) (State) (Zip Code)

Previous Address_____
How Long? _____ (Street number and name) (City) (State) (Zip Code)

Have you lived in another State? _____ If so, list other states and dates of residence _____

Employer Information:

Current Employer Name _____ Salary $_____ Phone _____

Landlord Information:

Current Landlords Name _____ Phone _____

Previous Landlords Name _____ Phone _____

Bank Information: _____ Phone _____Acct # _____
(Name of Financial Institution or Branch)

Conviction Information: (Use additional paper if necessary)

Have you ever been convicted of a crime? _____ Yes _____ No If yes, give dates, charges and Police department: _____

I hereby authorize, without reservations, any and all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, military services and persons to release information they may have about me to the person or company for which this form has been filed, or their agent **Intermountain Data Corp.** This releases the aforesaid parties from any and all liability and responsibility for collecting the above information. I acknowledge that an electronic facsimile (fax) or photographic copy shall be as valid as the original. I further understand that failure to provide information requested on this application or any misrepresentation, intentional or not of any kind shall be cause for my application to be denied.

_____ _____
(Applicant's Signature) (Today's Date)

B25 - 0607
(Client Account Number)