

APOLLO COUNSELING AND RESOURCE CENTER, LLC
APPLICATION FOR SERVICES

NAME:
MEDICAID/INS:
PROGRAM:
REF. DATE:
DOB:

APPLICANT INFORMATION:

NAME _____ DATE _____
SERVICE(S) APPLYING FOR _____ DATE OF LAST ASSESSMENT/ ADMINISTERED BY _____
FUNDING: _____ MEDICAID _____ PRIVATE PAY _____ PRIVATE INSURANCE (PLEASE FILL OUT BELOW)
MEDICAID #: _____
_____ WAIVER (please circle): CMH MR BI ELDERLY HIV/AIDS PD IH
_____ REMEDIAL SERVICES (please circle): ADULT CHILD _____ DHS

PRIVATE INSURANCE(ONLY IF APPLICABLE)

POLICY HOLDER: _____ GROUP: _____
POLICY NUMBER: _____ INS NAME: _____
PERSON RESPONSIBLE FOR CHARGES: _____
PERSON TO RECEIVE SERVICES: _____
RELATIONSHIP TO POLICY HOLDER: _____ DATE: _____
I hereby agree to and accept responsibility of payment for any charges from services incurred that are not covered by my insurance carrier. I understand that all co-payments are due on the date of service and that I am the responsible party for payment of these charges.
DATE: _____

Signature of authorized person over 18

SS#: _____ DATE OF BIRTH: _____
ADDRESS: _____
Street city state zip
COUNTY OF SETTLEMENT/RESIDENCE: _____ LEGAL RESIDENT OF IOWA: YES NO
PHONE: _____ OTHER: _____
ARE YOU A CITIZEN/LEGAL RESIDENT OF THE U.S.: _____ YES _____ NO If not, are you interested in immigration assistance? YES NO
TARGETED CASE MANAGER: _____ PHONE: _____
AGENCY ADDRESS: _____
HAVE YOU APPLIED FOR DISABILITY BENEFITS? YES NO DO YOU NEED ASSISTANCE APPLYING FOR BENEFITS? YES NO
HOW MUCH DO YOU RECEIVE EACH MONTH IN BENEFITS: _____
DO YOU WORK? YES NO EMPLOYER: _____ AVG. INCOME: _____
ARE YOU CURRENTLY RECEIVING SERVICES? YES NO AGENCY: _____

"Helping families and individuals strengthen and enhance relationships through counseling, support, and advocacy."

Mailing:

Apollo Counseling & Resource Center, LLC
7532 Hickman Rd
Windsor Heights, IA, 50322
Ph: (515) 334-8891/Fax: (866) 633-8731

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EMERGENCY CONTACT INFORMATION:

(Please list at least two people who do not live with you that we may contact in case of an emergency)

Name/Relationship Phone

Name/Relationship Phone

MEDICAL INFORMATION: (If additional space is needed, please attach a separate sheet of paper with the information).

Please list below any current medical conditions:

CONDITION	DATE OF DIAGNOSIS	TREATMENT	DIAGNOSING PHYSICIAN

Please list below any medical conditions or surgeries in the last three years:

CONDITION	DATE OF DIAGNOSIS/SURGERY	TREATMENT/STILL TREATING	DIAGNOSING PHYSICIAN

Please list any current medications:

MEDICATION	STRENGTH/AMOUNT	FREQUENCY	PRESCRIBING PHYSICIAN

Please list any Mental Health diagnosis/hospitalizations within the last three years

CONDITION	HOSPITALIZATION(S)	TREATMENT	DIAGNOSED BY

ALLERGIES: _____

PHARMACY: _____ LOCATION: _____

PHONE: _____

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If the person applying to receive services is under the age of 18 or is receiving services under one of the children's service options and is under the age of 21, please complete the form below to authorize emergency/medical treatment in the event of an emergency while the minor is receiving services with Apollo CRC.

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR (Please print or type):

I, _____ parent or guardian of, _____ a minor,
Phone numbers: Home: _____ Work: _____ Cell: _____
do hereby authorize APOLLO COUNSELING & RESOURCE CENTER, LLC as my agent(s) to consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis or treatment and care which is deemed advisable by, and is to be rendered under, the general or special supervision of, a licensed physician. This authorization specifically includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given in advance of any specific evaluation, diagnosis, treatment and care required, but is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, treatment or care which a physician, in the exercise of his / her best judgment, may deem advisable. This authorization also grants to my agent(s) the power to sign for release of information to any third party payors who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from _____ to _____ unless sooner revoked in writing delivered to said agent(s).

Signature of Parent or Guardian

Date

Date of Birth:

Mailing Address:

Patient's Personal Physician:

Physicians Address:

Physician's Phone:

Hospital of Choice:

Patient Medications:

Patient Allergies:

Significant Medical History:

Parent/Guardian:

Employer:

Insurance:

Policy/Medicaid #:

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If the person applying for services is an adult, please fill out the following information to use in the event of an emergency for medical treatment while receiving services with Apollo CRC.

AUTHORIZATION TO CONSENT TO EMERGENCY TREATMENT OF AN ADULT (*Please print or type*):

I, _____ do hereby authorize APOLLO COUNSELING & RESOURCE CENTER, LLC as my agent(s) to consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis or treatment and care which is deemed advisable by, and is to be rendered under, the general or special supervision of, a licensed physician. This authorization specifically includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given in advance of any specific evaluation, diagnosis, treatment and care required, but is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, treatment or care which a physician, in the exercise of his / her best judgment, may deem advisable. This authorization also grants to my agent(s) the power to sign for release of information to any third party payors who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from _____ to _____ unless sooner revoked in writing delivered to said agent(s).

Signature

Date

Date of Birth: _____

Mailing Address: _____

Patient's Personal Physician: _____

Physicians Address: _____

Physician's Phone: _____

Hospital of Choice: _____

Patient Medications:

Patient Allergies:

Significant Medical History:

Parent/Guardian (if applicable): _____

Employer: _____

Insurance: _____

Policy/Medicaid #: _____

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PERSONAL/FAMILY INFORMATION:

MOTHER: _____	LIVE WITH:	YES	NO
FATHER: _____	LIVE WITH:	YES	NO
SIBILINGS: _____	LIVE WITH:	YES	NO
_____	LIVE WITH:	YES	NO
_____	LIVE WITH:	YES	NO

IF YOU ARE AN ADULT, DO YOU HAVE A LEGAL GUARDIAN OR POWER OF ATTORNEY? PLEASE STATE:

CONSERVATOR? PLEASE STATE:

OTHER MEMBERS OF THE HOUSEHOLD:

LANGUAGES SPOKEN IN THE HOME:

RELIGIOUS/CULTURAL TRADITIONS:

FAMILY TRADITIONS:

EXTRACURRICULAR ACTIVITIES:

HOBBIES/INTERESTS:

HAVE YOU EVER FILED OR COMPLETED A LIVING WILL OR ADVANCED DIRECTIVES? *A copy of this will be needed for Apollo CRC's records.*

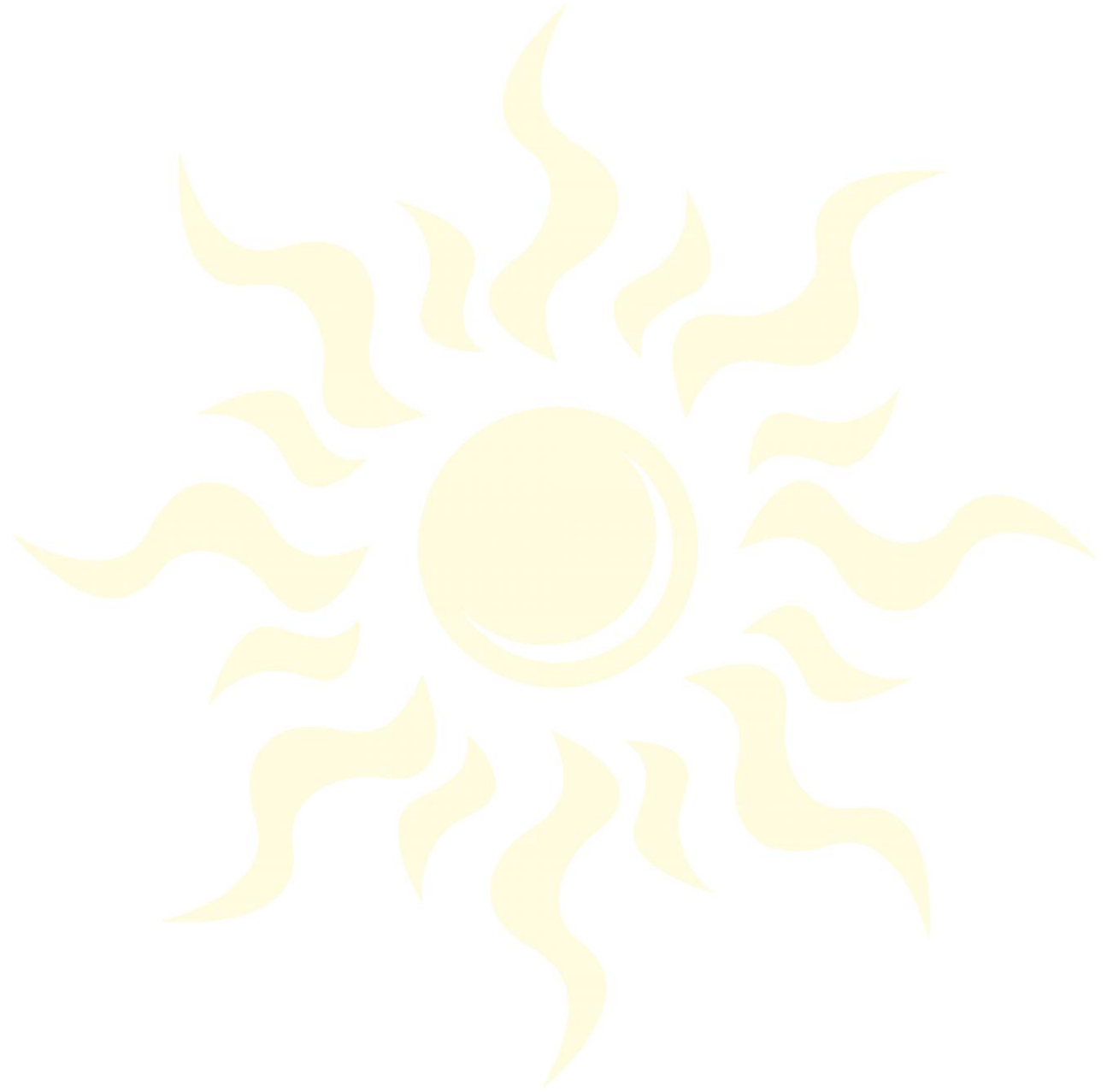
WHERE IS IT LOCATED?

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EXPECTATIONS/REASONS FOR SERVICES:

WHAT IS THE REASON FOR SERVICE (CIRCLE ALL THAT APPLY):

- HABILITATION BASIC SKILL DEVELOPMENT MENTAL HEALTH TREATMENT IN HOME COUNSELING (CHILDREN ONLY)
ADVOCACY 24 HOUR HCBS SUPPORTED COMMUNITY LIVING (SCL) RESPITE CRISIS INTERVENTION

WHAT GOALS DO YOU WANT TO SET DURING SERVICES:

HOW OFTEN DO YOU WANT/NEED SERVICES:

WHAT ARE THE BEST TIMES FOR SERVICES:

AUTHORIZATION OF APPLICATION

APPLICANT

DATE

PARENT/GUARDIAN

DATE

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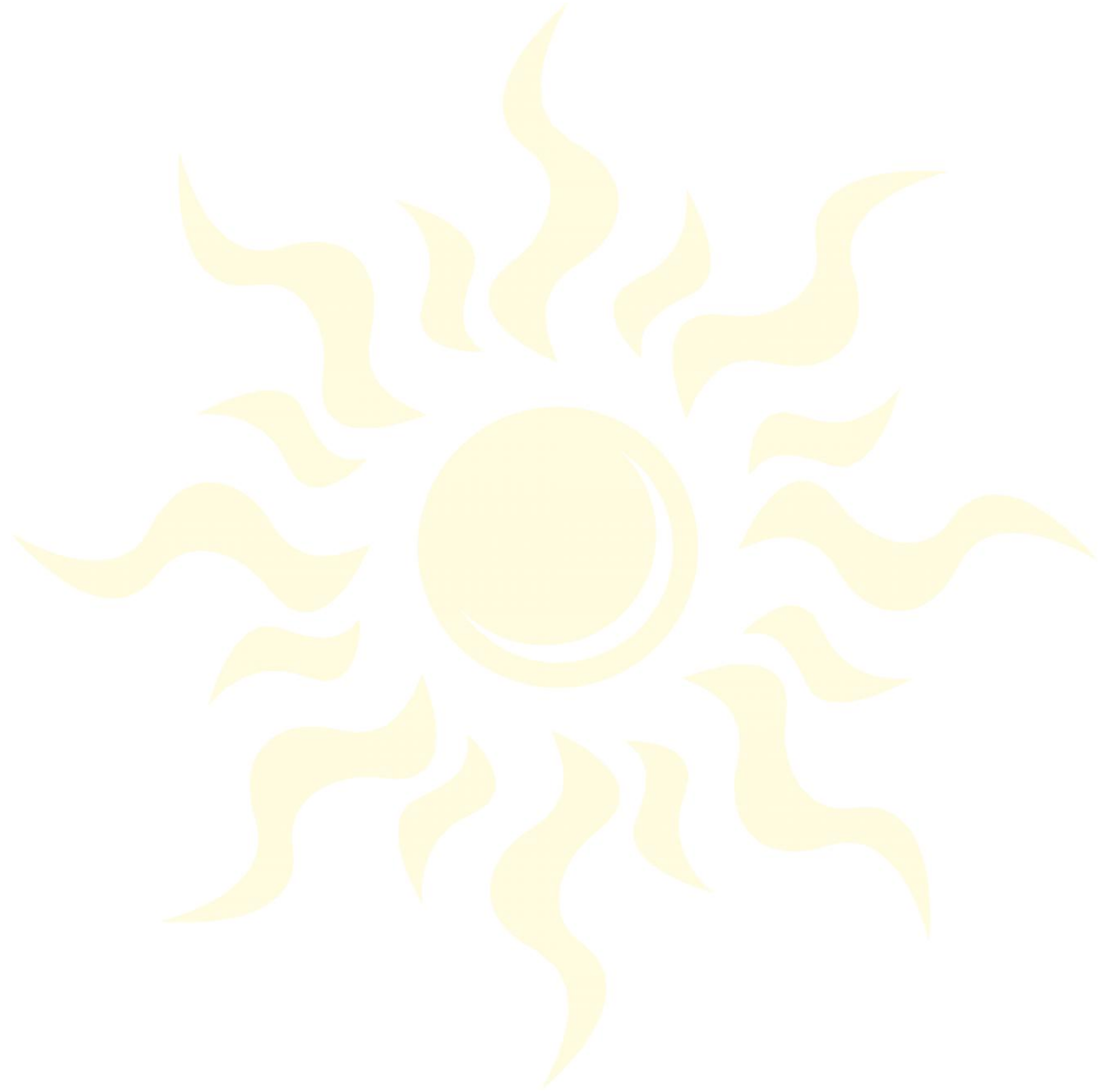
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Please complete and attach a release of information for any current services providers, medical professionals, family members, or government agencies that Apollo CRC may need to contact to coordinate services.



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