REFERRAL PACKET

Skyline Center has provided community living and employment related services to individuals with disabilities since 1963. Over the years, Skyline has expanded services to offer a comprehensive array of supports to meet the needs of persons living in Clinton and Jackson counties. Our guiding belief is to assist persons to achieve independent living, to access community-based resources, to break down barriers to independence and to achieve integrated employment through the provision of specialized training and support services.

Referrals are accepted from the Iowa Department of Human Services, Department of Vocational Rehabilitation, Managed Care Company's (MCO's), Case Management agencies, Mental Health Centers, local school districts and private parties.

Individuals referred for services are assessed on an individual basis. Skyline admission policies are the same for everyone, without regard to race, sex, religion, national origin, political affiliation or disability.

Any person not immediately accepted may have their name placed on a waiting list. A statement of disability or a psychological evaluation, SIS and a social history, if available, must be submitted with this packet prior to admission.

Nondiscrimination Statement:

<u>Discrimination is Against the Law</u>

Skyline Center, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Skyline Center, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Skyline Center, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Skyline Center, Inc.'s Corporate Compliance Officer.

If you believe that Skyline Center, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by using one of the following methods:

- Mail: Compliance Officer, 2600 N 4th Street, Clinton, Iowa 52732
- Phone: 1-855-661-2667
- Fax: (563) 243-9901
- Email: Compliance@SkylineCenter.org

If you need help filing a grievance, the Skyline Center, Inc. Corporate Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201; Phone: (800) 368-1019, TDD: (800) 537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

ATTENTION: If you speak a language listed below, language assistance services, free of charge, are available to you. If you require language assistance, please call (563) 243-4065.

Languages:
Arabic
Chinese
French
German
Hindi
Karen
Korean
Laotian
Pennsylvanian Dutch
Russian
Serbo-Croatian
Spanish
Tagalog
Thai
Vietnamese

If you have any questions or need assistance to complete this application, please contact one of the below listed persons:

- Dani Corbin, QI Coordinator/Admissions Chair (563)243-4065, ext.137
- Bridget Ainley, Community Living Director (563)243-4065, ext. 158
- Teresa Dolph, SEP Supervisor (563)243-6846 ext. 219

Available Programs/Services

Community Services

* Home Health: Skilled Nursing, Home Health Aide, Homemaker
* Community Integration: Day Habilitation
* Supported Living: Supported Community Living (SCL), Respite, Consumer Directed Attendant Care (CDAC), Interim Medical Monitoring and Treatment (IMMT), Home and Vehicle Modification (HVM), Personal Emergency Response System (PERS)
* Community Housing

Employment Services

* Community Employment: Supported Employment, Long Term Job Coaching, Vocational Rehabilitation Work Evaluation, Job Development.

SKYLINE CENTER, INC.
APPLICATION

A social history, if available, and psychological evaluation or statement of disability, a SIS or INTER-RA, is required with this application.

Date____________

Funding Source: (Check One):
ID Waiver_____ BI Waiver_____ Elderly Waiver_____ PD Waiver_____
Home Based Habilitation_____ AIDS/ HIV Waiver_____ Regional Funding_____ Medicaid_____
Medicare_____ Private Pay_____ Vocational Rehabilitation_____ United Way:______

Services applying for: (Please Check)
Day Habilitation_____Supported Community Living Daily :_____ Intermittent_____
Respite:_____ CDAC:_____Home Health:_____ Supported Employment_____
Housing (pre-rental application required)_____

PERSONAL INFORMATION:
Applicants Full Name:____

Applicants Address:____

Date of Birth:_____________________________ State ID Number:______________________

Phone Number:_____________________________ Marital Status:________________________

Diagnosis:____

Primary Language:________________________ Legal Status:_________________________

Guardian Name:____

Guardian Address:____

Guardian home phone:____________________ Cell:_________________Work:___________

REFERRAL
Referral Source: ____

Case manager:____

Case Manager Address: ____ Zip _______

Phone: ____ Email:___________________

Medicaid MCO: _____ Amerigroup _____ Iowa Total Care

MEDICAL INFORMATION:

Doctor Name:____

Doctor Address and Phone:____

Dentist Name:____

Dentist Address and Phone:____

Other Physician name:____

Other Physicians Address and Phone:____

Pharmacy Name and Address:____

____

EMERGENCY CONTACT INFORMATION:

Name/Relationship:____

Address/Phone:____

Name/Relationship:____

Address/Phone:____

Name/Relationship:____

Address/Phone:____

MEDICAL INFORMATION

Allergies ____

____

Medication	Dosage	Frequency	Physician	Reason Prescribed

___

FINANCIAL RESOURCE INFORMATION

Is the applicant their own payee: _____ Yes ____No

Payee Name:____

Payee Address:____

Payee Phone: ____

Conservator: _____Yes _____No

Conservator Name:____

Conservator Address:____

Conservator Phone: ____

Sources of Income:
Current benefits (list amount received each month)
SSI:_______________ SSDI_______________ Veterans Benefits:_______________

Work Income:_______________ Veteran's Benefits:_______________

Housing Assistance (section 8)_______________ Worker's Comp:_______________

Other ____

Have you received past benefits that are now terminated?___________________________

Checking Account Location:_____________________________Amount:___________

Savings Account Location:_________________________Amount:________________

Do you have a burial contract: _____Yes _____No

Location of burial contract:____

SOCIAL HISTORY INFORMATION

Reason for Referral:____
____

Description of current/previous living environments:________________________________
____
____

Description of previous services received:____
____
____

Describe any legal involvement (if any):____
____

List any cultural/religious affiliations:____

____

List any hobbies, leisure time pursuits, activities, clubs, organizations:_________________

____
____

List any likes/dislikes:____

____

List any violent/aggressive sexually acting out behaviors:____________________________

____

List any Medical/Psychiatric/Behavioral Conditions (include substance abuse history, illnesses, hospitalizations, suicidal ideations/behaviors, current or previous therapies and treatments, special diets, etc.____

____

____

List any daily/weekly routine:____

____

____

Your Strengths:____

____

Does you have any physical conditions that might need special consideration in work/living settings? Yes or No

If Yes, Explain____

____

____

Any Additional Comments:____

____

____

Educational Background:

School/Location:____

Highest Grade Completed:____________________________ Date:____________________

Employment History:

List all jobs you have had, starting with the most recent first:

Employer:	Job/Responsibilities:	Dates:	Reason for leaving:

Medical Review:

Date of last Immunizations:

Small Pox _____________ Diphtheria______________

Measles_______________ Pertussis______________

Polio_________________ Rubella_______________

Mumps________________ Hep B Series____________

Flu vaccine:____________ Tetanus:_______________

List any surgeries and dates:____

____

List any Medical Diagnosis (ie diabetes, epilepsy etc):_______________________________

____

Supported Employment (only)

Do you have any physical conditions that need special consideration in a work setting? Y or N

If Yes please explain:____

____

____

Skyline requires that the individual has knowledge of and support for this referral before it will be considered by the Admissions Committee. If in agreement, please sign below:

Applicant Signature/Date: ____

Guardian Signature/Date:____

Name of person completing application:___________________________________

Home Health Intake/Referral Form

Patient's Name:______________________________________ Date:_____________________
Address:____ Phone:____________________
Age:_____________ DOB:_______________

Emergency Contact:____
____
Referral Source:____
SSN:___________________________________ Medicare:_____________________________
Medicaid:______________________________
Private Insurance Name/Number:____

Diet:____
Allergies:____
Primary Diagnosis:____ Date:______________
Secondary Diagnosis:____ Date:______________
Other Diagnosis and dates:____
____
____

Physicians Name:____ Phone:_____________
Notes:____
____
____
____
____
____

Special Equipment (specify have or need):____
____

Services to be provided:	Frequency of services to be provided:

Skyline Residential Services, Inc.
Rental Application

APPLICANT:

Name: ______________________________________ SSN#______________________________
PLEASE ATTACH COPY OF SOCIAL SECURITY CARD

Current Address, City, State, Zip: ____

How Long at This Address?____

Family Size (# in household): ____

Phone: ________________________________DOB: __________________________________
PLEASE ATTACH WRITTEN VERIFICATION OF DOB

Place of Employment:____

What are your sources of income?

Source #1	Amount of Annual Income
Source #2	Amount of Annual Income
Source #3	Amount of Annual Income

Do You Have a Service Plan? __________ If yes, please provide a copy.

Do You Have a Guardian? __________ If yes, please provide name________________________ and copy of Guardianship Papers.

In order to assess the effectiveness of our Affirmative Fair Housing Market Plan we need to ask the following question—Race/Ethnicity:____

Are you interested in a One Bedroom_________________ Or Efficiency_________________?

How Did You Hear of Our Project?____

RESOURCES:

Do you have a checking acct(s)_______ Amount: _____________ Location: ________________

Do you have a savings acct(s)_______ Amount: _____________ Location: _________________

Do you have any CD's_____________ Amount: _____________ Location: ________________

Do you have any stocks, bonds, trust funds or life insurance? ____________________________

Any other resources or assets: ____

Continued on next page

What is the name, address and phone number of your financial institution?

Has any family member disposed of any assets for less than fair market value in the last 2 years? ______________________If so what was the amount received? __________________________
What was the market value at the time of disposition? _________________________________

The following information is provided to ensure that you are informed of your rights and responsibilities as a tenant of a HUD assisted project:

You are required to sign releases in order to verify your income i.e. social security, bank, employment etc. upon filling out this application. These will be sent out to verify your income and to calculate your rent, although a final decision will not be made until all of the verifications are complete.

A social security number is required at the time of application. If you have not been assigned a number you need to provide a written certification signed and dated. Individuals have 60 days from the date of the certification to obtain and supply documentation to verify the disclosed social security numbers.

HUD will compare the information that you provide with the information that Federal, State, or local agencies have regarding your family's income and household composition.

Federal law prohibits the owner from discriminating against individuals with handicaps. Skyline Residential Services will make reasonable accommodation to people who are deaf or blind, by providing printed materials in Braille when requested, and by obtaining telecommunications equipment. Residential Services will also ensure that all of its offices and rental locations are accessible. In summary, owners have responsibilities for making reasonable accommodations in policies, providing auxiliary aids, making units and facilities accessible and permitting handicap persons to use assistive animals when they may provide the tenant with equal housing opportunities.

Also, accepted are applications from people with chronic mental illness who are limited in their ability to live independently and could benefit from more suitable housing conditions. Chronic mental illness is defined as a persistent mental or emotional impairment that limits the individual's ability to live and
perform activities of daily living in an independent manner.

Students under the age of 24, and enrolled at an institution of higher learning, either full or part-time, may make application for housing and housing assistance. The student must meet the age and enrollment criteria, above, and must disclose veteran and marital status to the owner, as well as information about their dependents. If the student is not a veteran, married, or does not have dependents, then the owner will conduct a two-part test to determine if the student is eligible for Section 8 assistance, and if his or her parents, either singly or jointly, are eligible for Section 8 assistance. If the parents are ineligible then the student must prove his or her own eligibility and demonstrate his or her independence from them as explained in Vol. 71, No. 68, Part II, Department of Housing and Urban Development, Eligibility of Students for Assisted Housing

Under Section 8 of the U.S. Housing Act of 1937; Supplementary Guidance; II. Guidance, B. Student Eligibility Requirements.

Skyline Residential Services, Inc. as the landlord of this project does not restrict or discriminate against any applicant or tenant because of the ownership of pets. You are allowed to keep common household pets i.e. cat, dog, bird, fish, rodents, or turtles in the project as long as you as the tenant uphold the established list of pet rules in the pet policy addendum to the lease and you pay the pet deposit of $300.00(cats and dogs only.)

Meal service is not a condition of occupancy. The project will not provide you with meals. This is your responsibility and you are not charged for any such service.

I hereby certify that I have received a copy of this application and that the information I am providing is true and correct to the best of my knowledge and belief. I understand that if it is determined that I willfully misrepresented any facts then this application can be denied for that reason.

____

Applicant's Signature Date

____

Guardian's Signature, if applicable Date

____

Skyline Residential Services, Inc. representative Signature Date

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Revised: 2-25-13/6-19-07/5-21-02

Please provide a list of all states in which you or any household member have resided:

____ ______________________________________

____ ______________________________________

Have you or any member of your family been subject to State lifetime sex offender registration in any state.

Yes: ________________________

No: _________________________

If yes, please provide a list of the states in which you or a household member is registered as a lifetime sex offender: ____

Applicant signature: ____

Family member signature: ____

Date: ____

Skyline Residential Services, Inc. representative signature

Revised: 10.30.20/4.22.16