Iroquois Center

620-723-2272
irqcenter.com
610 E Grant Greensburg, KS 67054

Community Supported Living Program

• Client Information

Full Name:

Date of Birth: / / Age: SSN:

Gender: Preferred Pronouns:

Current Address:

County of Residence: County of Respnsibility:

Registered Violent Offender? ☐ Yes ☐ No Registered Sex Offender? ☐ Yes ☐ No

• Referral Information

Referral Source:

Person Making Referral:

Email: Phone:

Relationship to Applicant:

CMHC / CCBHC: Case Manager:

Email: Phone:

• Required Documents Checklist

Completed Application	☐ Yes	☐ No	Medication List	☐ Yes	☐ No
Insurance Cards	☐ Yes	☐ No	Recent Therapy Notes	☐ Yes	☐ No
Recent Screens	☐ Yes	☐ No	Recent Case Mgmt Notes	☐ Yes	☐ No
Release of Information	☐ Yes	☐ No	Recent Psychosocial Notes	☐ Yes	☐ No
Current Diagnosis	☐ Yes	☐ No	Hospital Information	☐ Yes	☐ No
SPMI Determination	☐ Yes	☐ No			

• Program Guidelines

- Psychosocial groups are M-F 9:30am - 1:00pm (Optional / Encouraged)
- Participate in peer relationship building activities in the home (Optional / Encouraged)
- Remain medication compliant
- Meal plan and cook for yourself, maintain shared housekeeping duties as assigned
- Maintain personal hygiene and living spaces
- Work with a Case Manager on goals
- Attend therapy and peer support sessions (Optional / Encouraged)
- Treat peers and staff with respect
- Follow Housing policy for drugs and alcohol

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• Financial Information

SSI: ____________________ SSDI: ____________________

VA Benefits: ____________________ Other: ____________________

Medicaid Spend Down: ____________________

• Insurance Information - Please attach copies of insurance cards.

Medicare ☐ Medicaid ☐ Medikan ☐ Private Insurance ☐

• Emergency Contact

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone: ____________________

Release Signed: ☐ Yes ☐ No Date: ____________________

• Non-Family Emergency Contact

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone: ____________________

Release Signed: ☐ Yes ☐ No Date: ____________________

• Medical Information - Primary Doctor

Name: ____________________

Address: ____________________

Phone: ____________________

Release Signed: ☐ Yes ☐ No Date: ____________________

• Medical Information - Psychiatrist

Name: ____________________

Address: ____________________

Phone: ____________________

Release Signed: ☐ Yes ☐ No Date: ____________________

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- Other Providers (Dentist, Eye Doctor, etc.)

Name:

Address:

Phone:

Release Signed: ☐ Yes ☐ No Date:

- Other Providers (Dentist, Eye Doctor, etc.)

Name:

Address:

Phone:

Release Signed: ☐ Yes ☐ No Date:

Please attach documents if multiple needs are indicated.

- Diagnoses & Medications - Use the table below, or attach a list.

Diagnosis:

Medication:

Dosage:

Frequency:

Diagnosis:

Medication:

Dosage:

Frequency:

Diagnosis:

Medication:

Dosage:

Frequency:

Diagnosis:

Medication:

Dosage:

Frequency:

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• Hospitalizations (Past Year)

Hospital:

Reason:

Length of stay:

Release Signed: ☐ Yes ☐ No Date:

Hospital:

Reason:

Length of stay:

Release Signed: ☐ Yes ☐ No Date:

Hospital

Reason:

Length of stay:

Release Signed: ☐ Yes ☐ No Date:

• Additional Information

Past independent living experience:

Vehicle: ☐ Yes ☐ No

Make / Model: Color:

Plate # State:

DL#: State:

• Goals & Planning - Skills to learn / goals while in the program.

- Plan B - if you left the program early, Who would you stay with?

Name: Phone:

What assistance would be helpful?

- Applicant Certification

I certify the information provided is accurate and understand the next steps in the application process.

Signature: Date:

Witness: Date: