Our Mission:
To inspire our clients to achieve their personal goals.

Our Vision:
A community empowered by the contributions of all.

Application for Services

Our Values:

Self-Worth, Dignity & Respect
Inherent Potential
Rights & Responsibilities
Life-Long Learning
Independence
Self-Determination

Candeo affirms the Universal Declaration of Human Rights found at:
or by requesting a copy from the Candeo admissions staff.

Candeo • 9550 White Oak Lane Suite 200, Johnston, Iowa 50131
Phone: (515) 259-8110 • Fax: (515) 259-8109 • E-mail: admissions@candeoiowa.org
APPLICATION PROCEDURE

Our agency/site does not and shall not discriminate against clients on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

1. Complete Request for Services Form

2. Submit all additional documents as required on Request for Services Form

3. The Admission Representative will conduct an initial interview with the Applicant, Guardian /Advocate and Case Manager.

4. Interview information and application materials will be shared with the Admissions Committee who will review the information within 5 business days. The Admissions Committee will take into account the information presented and decide on one of the following:
   a. Accepted for waitlist/coordination of services
   b. A call for review or clarification of problematic issues
   c. Not accepted for services

5. The Admissions Administrator will communicate (in writing) the decision to the applicant, referral source, and P/G/A (when applicable) within 10 days of the decision.

   Referral List: All applicants interviewed and reviewed for acceptance will be placed on an internal referral list until appropriate funding, staff base, and if applicable, housemate and living situation is established. Applicants will be moved from the referral list to coordination of services based on need and confirmation of appropriate funding, staff base, and if applicable, housemate and living situation. Timeframe an applicant will be on referral list will be determined by emergent need, number of qualified applicants, funding, staff base and living situation and NOT by date of application/interview.

6. Upon moving from the referral list to coordination of services, the new client will be assigned a Service Manager who will begin the process for client services and determine the date to begin services.

7. An applicant not accepted may re-apply as conditions warrant. Reapplication must include documented evidence that the issues cited for non-acceptance have been resolved.

8. The referral source, applicant or P/G/A (when applicable) may appeal in accordance with Policy #622 – Appeals.
Admissions Criteria

1. For All Applicants
   a. The applicant must be requesting community-based services
   b. The applicant and their guardians (if applicable) must accept the risks associated with community-based services.
   c. Applicant, family and/or guardian must be willing to cooperate with Candeo for purpose of programming and care.
   d. The applicant must be willing and able to follow all Doctor's orders (dietary, medication administration etc.) with supervision or prompting (as needed).
   e. The applicant must have the following in place before starting services:
      i. Be his/her own payee, or have an assigned payee in service area, external to any Candeo affiliate
      ii. Have Primary Care Physician and Psychologist appointments set up within 30 days of starting services with Candeo
      iii. Have assigned case manager in the service area region
   f. The applicant must not be involved in illegal alcohol use, alcohol abuse or illegal drug use or must be actively involved and attending a Substance Abuse program or support. Services may be suspended or rescheduled if the client/applicant is under the influence of alcohol or illegal drugs, and the incident will be reported. Failure to remain in active treatment and free of use/abuse may be cause for discharge.
   g. The applicant’s location of services must be free of weapons that could endanger a client or staff, or if licensed legal weapons are on the premises, they must be secured in a way that is acceptable to the team. If a weapon is discovered or is unsecured on the premises, services may be suspended until the weapon is determined to be removed or secured properly. Refusal to comply may be cause for discharge.
   h. The applicant must have adequate financial sponsorship by a contract accepted by Candeo
   i. The services being requested must fall within Candeo’s scope of practice be in alignment of Candeo’s mission, vision, values and philosophy of services. Candeo’s staff must represent the basic core competencies required to meet the individual’s needs.
   j. The applicant using a wheelchair must be able to assist in transfers to and from their wheelchair. The applicant understands that if their need for physical transfers increase Candeo will re-evaluate its ability to support the client regarding the scope of practice and core competencies for lifting and transferring which may result in discharge from services.

2. HCBS – ID/BI Waiver Supported Community Living (SCL) Services
   a. The applicant must have a primary diagnosis of Intellectual Disability; primary need for services should stem from Intellectual Disability diagnosis, and be age 18 years or older.
   b. The applicant must have a primary diagnosis of Brain Injury; primary need for services should stem from Brain Injury diagnosis, and be age 18 years or older.

3. Other contracted Supported Community Living (SCL) services
   a. The applicant must have a primary diagnosis of Developmental Disability, Mental Illness or Autism (or any diagnosis along the Autism Spectrum), and be age 18 years or older.

4. Supported Employment (SE) Services
   a. Job Development and Job Coaching: The applicant must have a primary diagnosis of Intellectual Disability, Developmental Disability, Mental Illness or Autism, (or any diagnosis along the Autism Spectrum), and be 18 years or older.

5. Habilitation Services – SCL
   a. The applicant must be eligible for Habilitation Services as defined by the Iowa Administrative Code (IAC 78.27(2)) and be age 18 years or older.
Once the following documentation has been received along with the completed application, the Admissions Coordinator or a Leadership Representative will contact all parties to schedule an initial interview:

**All Applicants:**

- _____ Case Management  _____ Service Coordination *(please identify current program)*
- _____ Signed Release of Information included in application
- _____ Case Management plan / Service Management plan *(including TCM Assessment)*
- _____ General medical / physical examination completed within the last 12 months
- _____ Guardianship documents *(if applicable)*
- _____ Social History
- _____ Current up to date list of all medical practitioners
- _____ Behavior support plans and/or Behavior modification plans *(if applicable)*
- _____ WRAP and/or Crisis Plan *(if applicable)*
- _____ Psychological Evaluation *(if applicable)*
- _____ Level of Care Assessment *(ICAP, Locus, InterRai, SIS-if applicable, CASH)*
- _____ Copy of Social Security Card and insurance card

**Note:** Incomplete applications will not be reviewed.

*Candeo believes in self-determination and as an organization we support this belief through:
- Empowering people to honor their own self-worth
- Empowering people to recognize their own roles in society
- Empowering people to value life-long learning
- Empowering people to make informed decisions and experience natural consequences
- Empowering people to accomplish their own dreams and goals
- Empowering people to exercise their rights and responsibilities*
REQUEST FOR SERVICES

Date of Application: ____________________________________________________________

Applicant Full Name: __________________________________________________________

Preferred Name/Pronouns: ______________________________________________________

Gender: __________________________ Race: ________________________________

Address: ___________________________________________________________ Zip

Phone: __________________________ Date of Birth: __________________________

Social Security Number: ____________ Medicaid Number: ______________________

Is applicant their own guardian? _______ If not, who is? _______________________

Parent / Guardian Name: ______________________________________________________

Address: ___________________________________________________________ Zip

Phone: (home) __________ (work) __________ (cell) __________________________

Please check the services desired from Candeo:

Intellectual Disability _______SCL/Daily _______SCL/Hrly _______Employment _______Host Home

Habilitation _______SCL/Daily _______SCL/Hrly _______Employment _______Host Home

Brain Injury _______SCL/Daily _______SCL/Hrly _______Employment _______Host Home

Employment Service (please specify)

______Discovery _______Job Development _______Job Coaching

Identify Goals/Need for Services: ______________________________________________

__________________________________________________________________________

__________________________________________________________________________

MEDICAL

Primary Disability: __________________________________________ Date of onset: __________

Secondary Disability: __________________________________________ Date of Onset: __________

Medications: ____________________________________________________________________

__________________________________________________________________________
FINANCIAL

Current benefits (list amount received each month)
SSI _____ SSDI _____ Food Stamps _____ TANF ________
Housing Assistance (section 8) _____ Veteran Benefits _____ Worker’s Comp _____
Other __________________________________________________________

Have you received past benefits that are now terminated? __________________________

Would you like benefits planning education? __________________________

EDUCATION

School/Location ___________________________________________________________

Highest Grade Completed: __________________________ Date: ________________

Did you participate in Special Education? __________________________

VOCATIONAL (please complete-application will not be reviewed if states see Social History)

Please list previous employers / work experiences, job duties, dates and reasons for leaving.

Employer: _____________________________________________________________

Address: __________________________________________________________________

Phone: __________________________ Manager/Supervisor: _______________________

Dates of Employment: (start date) __________________________ (end date) ________________

Duties / Responsibilities: __________________________________________________

______________________________________________________________

Reason for Leaving: __________________________________________________

______________________________________________________________ Hourly wage: ________________

Employer: _____________________________________________________________

Address: __________________________________________________________________

Phone: __________________________ Manager/Supervisor: _______________________

Dates of Employment: (start date) __________________________ (end date) ________________

Duties / Responsibilities: __________________________________________________

______________________________________________________________
Reason for Leaving: ____________________________________________  Hourly wage: ______________

Please attach your resume or any additional information if necessary.

Please identify the days and hours that you are available to work: __________________________

Please identify vocational interests, as well as your specific strengths, and any other information
that would be helpful for us to know: ________________________________________________

RELATED SKILLS (please complete-application will not be reviewed if states see plan)

Self-help skills you are able to perform: ______________________________________________

Strengths: _________________________________________________________

Areas of Need: _______________________________________________________

Leisure time preferences: _____________________________________________

REFERRAL

Referral Source: _______________________________________________________

Case manager: _______________________________________________________

Case Manager Address: ________________________________________________ Zip

Phone: __________________________ Email: _____________________________

Medicaid MCO: ___Amerigroup  ___Iowa Total Care  ___Molina

Funding Source for SCL: _____________________________________________

Funding Source for HBH: _____________________________________________

Funding Source for Employment: _______________________________________

Tier: __________________________
Does the client have an open Voc. Rehab (IVRS) case? Yes_____ No____

Assigned IVRS Counselor and Contact information: _________________________________

____________________________________________________________________________

County of Legal Settlement: ________________________________________________

Agencies / Individuals to receive reports: _______________________________________

Other interested people you want involved on your team: __________________________

____________________________________________________________________________

Person filling out form: _______________________________________________________

Candeo 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: ___________________________________________________________

Co-guardian: ________________________ Co-guardian: __________________________
AUTHORIZATION TO RELEASE / RECEIVE CONFIDENTIAL INFORMATION

I, ______________________, hereby give permission to Candeo to release information to:

  Candeo's Admissions Committee

The reason for the information being released is:

  to determine eligibility and provide recommendations for services

The specific information to be released is:

  application for services packet

How the information is to be used:

  during the Admissions Committee meeting to review application

This release is valid for one year, unless Candeo is contacted and the release is revoked.

Signature of Applicant: ___________________________

Signature of Co-Guardian (if applicable): _______________________

Signature of Co-Guardian (if applicable): _______________________

Date: ___________________________________________