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

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: ________________________________
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: ___________________________________________________________________________