



# AmeriServe International Inc.

300 W. Broadway, Suite 20  
Council Bluffs, IA 51503  
Phone: 712-322-0270  
Fax: 712-322-1411

## AmeriServe International Inc. Application for Services

### Applicant Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address Apt#  
City State Zip

Medicaid # \_\_\_\_\_ SSN: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip

### Current Placement Information

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip

Agency Contact Person: \_\_\_\_\_ Position/Title: \_\_\_\_\_

### Eligibility Information

County of legal settlement/Financial Responsibility: \_\_\_\_\_

Central Point of Coordination: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip

Case Manager: \_\_\_\_\_

Medicaid eligibility established?  Yes  No If no, date eligibility process was:  
Initiated \_\_\_/\_\_\_/\_\_\_ Completed \_\_\_/\_\_\_/\_\_\_

HCBS eligibility established?  Yes  No If no, date eligibility process was:  
Initiated \_\_\_/\_\_\_/\_\_\_ Completed \_\_\_/\_\_\_/\_\_\_

### Financial Information

Financial Resources:

SSI Amt./Mo. \$ \_\_\_\_\_  SSR Amt./Mo. \$ \_\_\_\_\_  
 SSDI Amt./Mo. \$ \_\_\_\_\_  RR/Pension Amt./Mo. \$ \_\_\_\_\_  
 VA Benefits Amt./Mo. \$ \_\_\_\_\_  Other Amt./Mo. \$ \_\_\_\_\_

### Type of Service Requested

Supported Community Living:  Hourly  24-hour  CDAC  
 HCBS / MR  HCBS / Elderly  
 Respite  Intermittent Medical Monitoring

Applicant Name: \_\_\_\_\_

**Reason for Referral to AmeriServe**

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**Desired Service Outcomes/Goals**

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**Presenting Issues and/or Concerns**


**Medical:** Seizures?  Yes  No  Controlled Type/Frequency: \_\_\_\_\_

**Other recurring medical issues:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavioral:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Self Care/Skill Development/Community Access:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referral Source Information**

Name: \_\_\_\_\_ 

Address: \_\_\_\_\_  
Street Address City State Zip

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Person Completing This Form**

\_\_\_\_\_  
**Date**