607 North Fourth Street Aberdeen, SD 57401-2733
• 605-229-0263 • Fax 605-225-3455 • www.aspiresd.org

Dear Applicant:

Attached you will find a number of forms. These forms are required to be completed in their entirety and returned to the Aspire, Inc. The forms include:

1. Application - to be completed by whomever knows the individual best. This form needs to be completed in its entirety.

2. Authorization to Exchange Information – please use this form to provide the Aspire, Inc. with pertinent information we might need from other entities.

3. Physical Examination - this form must be completed and signed by the applicant's primary physician. The Aspire, Inc. will usually accept a physical examination that has been completed within one year.

4. Immunization History - this form should be completed by the applicant's primary physician or whomever has the most complete and current records. A copy of current immunizations will work.

5. Psychological Evaluation - the document should be current. This should include the diagnosis and IQ full-scale score.

The Aspire, Inc. is not responsible for costs incurred in obtaining the above information. Once the above-named forms have been received by our agency, the Admissions Committee will review the information. The committee may request further information, an individual interview, or pre-placement visit. If a complete admissions packet is not completed within 6 months, the information received will be discarded. After the admissions committee makes a decision, the applicant or guardian will be notified.

Please feel free to call if we can assist you in any way.

South Dakota Division of Developmental Disabilities Application for Service

Reason for Referral: ___________________________

Applicant Name:____
(First) (Middle) (Maiden) (Last)

Date of Birth: __________________ Sex: ☐ Female ☐ Male

Current Address:____
(Street) (City) (State) (Zip)

Permanent Address:____
(Street) (City) (State) (Zip)

Home Phone:____________________ Work Phone: ____________________ Cell Phone:_______________

Email Address:____

Family Contact:____
(First) (Middle) (Last) (Type of Relationship)

Address:____
(Street) (City) (State) (Zip) (Email address)

Home Phone:____________________ Work Phone: ____________________ Cell Phone:_______________

Additional Contact:____
(First) (Middle) (Last) (Type of Relationship)

Address:____
(Street) (City) (State) (Zip) (Email address)

Home Phone:____________________ Work Phone: ____________________ Cell Phone:_______________

SCHOOL INFORMATION – Check all that apply

☐ Currently attending school — Date school services projected to end:____________________________

☐ Graduated with signed diploma — Date school services ended:____________________________

☐ Received certificate of completion — Date school services ended:____________________________

School:_________________________ Contact Person:__________________ Phone:_________________

LEGAL REPRESENTATIVE/CONSERVATORSHIP – Check all that apply to the applicant if over 18 years old.

☐ Court Ordered Legal Representative and type (medical, limited, etc.):______________________________________

☐ Court Ordered Conservator and Name if different from Legal Representative:____________________________

☐ Power of Attorney and type:____

☐ No Legal Representative in place. ☐ Copies of Legal Documents are attached.

Legal Representative's Name:____
(First) (Middle) (Last)

Address:____
(Street) (City) (State) (Zip) (Email address)

Home Phone:____________Work Phone: ________________Cell Phone:

SERVICES REQUESTED – Check all that apply

☐ **Educational Services** Requested Start Date:____________________

☐ Integrated Classroom ☐ Self-Contained Classroom

☐ **Employment Services** Requested Start Date:____________________

☐ Day Services ☐ Supported Employment ☐ Community Employment
☐ Own my Own Business

☐ **Residential Services** Requested Start Date:____________________
(i.e., independent living skills, community living skills, financial, personal living, etc.)

☐ Live with family ☐ Group Home ☐ 24 hr. support needed
☐ Live alone ☐ Supervised apartment ☐ Daily support needed
☐ Live with roommate ☐ Rent apartment or home ☐ Weekly support needed
☐ Buy house ☐ Other____________________

DEVELOPMENTAL DISABILITY DIAGNOSIS – Check all that apply
(If available attach Psychological Evaluation) Please refer to evaluations for formal diagnosis:

IQ: ☐ Mild (52-70) ☐ Down Syndrome ☐ Fetal Alcohol spectrum Disorder
☐ Moderate (36-51) ☐ Cerebral Palsy ☐ Traumatic Brain Injury (prior to age 22)
☐ Severe (20-35) ☐ Epilepsy/Seizure Disorder ☐ Cognitive Disability
☐ Profound (20 or below) ☐ Autism ☐ Other:____________________
☐ Borderline (71-85) ☐ Aspergers Disorder ☐ Other:____________________

FINANCIAL INFORMATION – Check all that apply
To assist in determining applicant's eligibility for services, please list sources and amounts of income:

☐ Medicare Number ____________________ ☐ Medicaid Number ____________________
☐ Social Security Number ____________________ Amount ________ Payee:____________________
☐ Supplemental Security Income Amount ________ Payee:____________________
☐ Social Security Disability Insurance Amount ________ Payee:____________________
☐ Veteran's Administration Amount ________ Payee:____________________

Other sources of Income and Amount: (e.g.: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, CDs, wages, interest, property owned, etc.) ____________________

COMMUNICATION – Check primary means of applicant's expression

☐ Speaks ☐ Sign Language ☐ Gestures ☐ Communication Device
☐ Other (please specify): ____________________

ADAPTIVE EQUIPMENT – Check all of the adaptive devices or equipment the applicant uses:

- ☐ Needs Assistance Walking
- ☐ Needs Assistance on Stairs
- ☐ Hearing Aid
- ☐ Corrective Lenses
- ☐ Orthopedic Splints
- ☐ Manual Wheelchair
- ☐ Catheter
- ☐ Colostomy Bag
- ☐ Orthopedic Shoes/Braces
- ☐ Electric Wheelchair
- ☐ G-Tube
- ☐ Wears Helmet
- ☐ Walker
- ☐ Mechanical Lift
- ☐ J-Tube
- ☐ White Cane
- ☐ Gait Belt
- ☐ Other: ____________

MEDICAL INFORMATION and RELATED SERVICES – Check all that apply. If applicable, attach extra page(s)

- ☐ Speech/Language
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Counseling
- ☐ Psychiatric
- ☐ Medical Diagnosis: ____________
- ☐ Medications: 1. Name: ____________ Reason: ____________

  2. Name: ____________ Reason: ____________

  3. Name: ____________ Reason: ____________

Previous/Current Placements and dates-

____

____

____

____

____

____

____

____

Required documents to enclose with this application – Check and attach all that apply

- ☐ IEP (if applicable)
  (Multidisciplinary Team Assessment)
- ☐ Support Plan
- ☐ Diagnosis Documentation
  (Psychological Evaluation and Medical Information)

SUPPORTS I NEED TO KEEP MYSELF & OTHERS SAFE – Check all that apply. (if applicable, attach extra page(s).

☐ Intentionally hurts self

Please describe: ____________

What appears to cause this? ____________

What is frequency? ____________

☐ Physically aggressive towards others

Please describe: ____________

What appears to cause this? ____________

What is frequency? ____________

Is this potentially dangerous to others? ____________

If yes, explain: ____________

☐ Disruptive (such as frequent tantrums, screaming, other emotional outbursts)
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______________________

☐ Sexual concerns
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______________________

☐ Takes others possessions
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______________________

☐ Any other concerns such as verbal or physical threats, difficulty relating to peers/authority, safety supports, etc.
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______

Legal convictions/history ☐ No ☐ Yes

If yes, please describe: ______________________

I acknowledge this is a request for agency planning purposes. Completion of this form is not a guarantee of services nor is it a commitment on my part to accept offered services.

APPLICANT SIGNATURE: ______________________

PARENT/LEGAL REPRESENTATIVE SIGNATURE: ______________________

DATE: ______________________

What do others like and admire about me:

Things I like to do and things I am good at:

Things that are important to me and make me happy:

Supports I need-what I am looking for to be successful:

Home & Community Based Service Providers (CSPs, FS 360) Checklist

Name: ____

INFORMATION REQUIRED FROM PARENTS:
Date Submitted:

_______________ Completed Request for Services
_______________ Completed Agency Application
_______________ Authorization for Release of Information (current with in 12 months)
_______________ Copy of Guardianship Order (if applicable)
_______________ Copy of Certified Birth Certificate
_______________ Copy of Social Security Card
_______________ Copy of State-Issued Photo ID Card
_______________ Copy of Medicaid/Medicare Card(s)
_______________ Copy of Medicare D Card (if applicable)

INFORMATION REQUIRED FROM SCHOOL DISTRICT:
Date Submitted:

_______________ Psychological Evaluation (**Wechsler Adult Intelligence** Test preferred)
_______________ Current ICAP and Summary Printout (with in 12 months of enrollment)
_______________ Most Recent 3-year Multidisciplinary Evaluation (if testing is included)
_______________ Updated Medical/Social Assessment
_______________ Current IEP

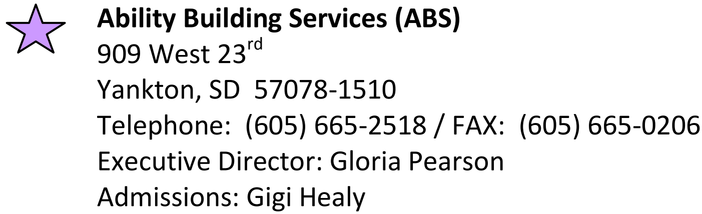
INFORMATION REQUIRED FROM PRIMARY PHYSICIAN:
Date Submitted:

_______________ “Home Community-Based Services (Medicaid)
_______________ Physical Examination (dated within 12 months of application)
_______________ List of prescription medications signed by primary physician
_______________ Current Vaccination Record
_______________ TB Risk Assessment (dated within 12 months of application)

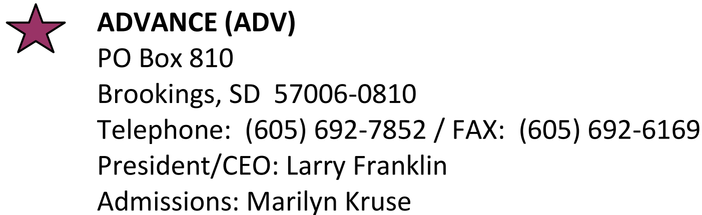
ADDITIONAL RECOMMENDATIONS:

_______________ Tour of agency
_______________ Tour of available residential services (when applicable)
_______________ Meet with provider
_______________ Complete one page profile

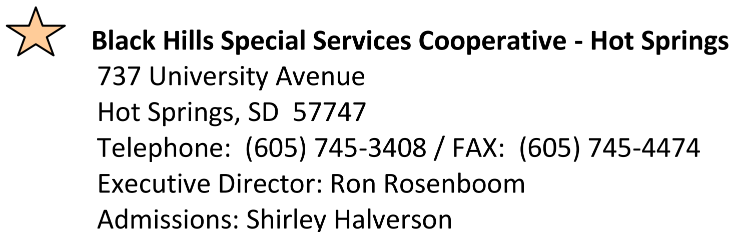
COMMUNITY SUPPORT PROVIDERS


Ability Building Services (ABS)
909 West 23rd
Yankton, SD 57078-1510
Telephone: (605) 665-2518 / FAX: (605) 665-0206
Executive Director: Gloria Pearson
Admissions: Gigi Healy

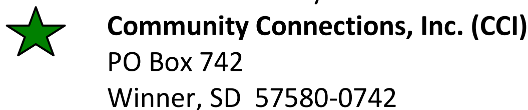
ASPIRE
607 North Fourth Street
Aberdeen, SD 57401-2733
Telephone: (605) 229-0263 / FAX: (605) 225-3455
Web Site: http://www.aspiresd.org
Executive Director: Jennifer Gray
Admissions: Arlette Keller


ADVANCE (ADV)
PO Box 810
Brookings, SD 57006-0810
Telephone: (605) 692-7852 / FAX: (605) 692-6169
President/CEO: Larry Franklin
Admissions: Marilyn Kruse

Black Hills Special Services Cooperative (BHSSC)
PO Box 218
Sturgis, SD 57785-0218
Telephone: (605) 347-4467 / FAX: (605) 347-5223
Web Site: http://www.bhssc.org
Executive Director: Ron Rosenboom
Admissions: Shirley Halverson


Black Hills Special Services Cooperative - Hot Springs
737 University Avenue
Hot Springs, SD 57747
Telephone: (605) 745-3408 / FAX: (605) 745-4474
Executive Director: Ron Rosenboom
Admissions: Shirley Halverson

Black Hills Workshop and Training Center (BHWTC)
PO Box 2104
Rapid City, SD 57709-2104
Telephone: (605) 343-4550 / FAX: 343-0879
Web Site: http://www.bhws.com
CEO: Brad Saathoff
Admissions: Kathy Staton


Community Connections, Inc. (CCI)
PO Box 742
Winner, SD 57580-0742

Telephone: (605) 842-1708 / FAX: (605) 842-0309
Web Site: http://www.winnercommunityconnections.com
Executive Director: Rebecca Carlson
Admissions: Melony Bertram

DakotAbilities (DA)
3600 South Duluth
Sioux Falls, SD 57105-6494
Telephone: (605) 334-4220 / FAX: (605) 334-7976
Web Site: http://www.dakotabilities.com
Executive Director: Robert Bohm
Admissions: Shelley Graham

Dakota Milestones (DM)
PO Box 248
Chamberlain, SD 57325-0248
Telephone: (605) 734-5542 / FAX: (605) 734-4260
Web Site: http://www.dakotamilestones.org
Executive Director: Ronda Schelske
Admissions: Rhonda Schelske

Every Citizen Counts Organization, Inc. (ECCO)
PO Box 450
Madison, SD 57042-0450
Telephone: (605) 256-6628 / FAX: (605) 256-2060
Executive Director: Norman Jerke
Admissions: Karla Kessler

Huron Area Center for Independence (HACFI)
258 3rd Street SW
Huron, SD 57350
Telephone: (605) 352-5698 / FAX: (605) 352-1013
Web Site: http://www.cfindependence.com
Executive Director: Randy Meendering
Admissions: Lisa Tschetter

LifeQuest (LQ)
804 North Mentzer
Mitchell, SD 57301-2198
Telephone: (605) 996-2032 / FAX: (605) 996-0972
Web Site: http://www.lifequestsd.com
Executive Director: Daryl Kilstrom
Admissions: Paul Engen

LIVE Center, Inc. (LIVE)
PO Box 59
Lemmon, SD 57638-0059
Telephone: (605) 374-3742 / FAX: (605) 374-3238
Executive Director: Randy Schwab
Admissions: Kevin Alton

New Horizons
c/o Human Services Agency
PO Box 1030
Watertown, SD 57201-6030
Telephone: (605) 886-0123 / FAX: (605) 886-5447
Web Site: http://www.humanserviceagency.org
HSA President/CEO: Dr. Charles L. Sherman; ATCO Executive Director: Larry Merxbauer
Admissions: Cyndi Speiker

Northern Hills Training Center (NHTC)
625 Harvard Street
Spearfish, SD 57783-9730
Telephone: (605) 642-2785 / FAX: (605) 642-5069
Web Site: http://www.nhtc.org
Executive Director: Fred Romkema
Admissions: Carl Edwards

OAHE, Inc. (OAHE)
PO Box 503
Pierre, SD 57501-0503
Telephone: (605) 224-4501 / FAX: (605) 224-9619
Web Site: http://www.oaheinc.com
Executive Director: Ann Hoye
Admissions: Jennifer Regennitter

South Dakota Achieve (SDA)
4100 South Western
Sioux Falls, SD 57105-6699
Telephone: (605) 336-7100 / FAX: (605) 338-0259
Web Site: http://www.achievesd.org
President/CEO: Anne Rieck McFarland
Admissions: Melanie DeBates

Southeastern Directions for Life (SE)
2000 South Summit
Sioux Falls, SD 57105
Telephone: (605) 335-8956 / FAX: (605) 338-9385
Web Site: http://www.southeasternbh.org
Executive Director: Mark Bratt
Admissions: Debbra Anderson

SESDAC, Inc (SESDAC)
1314 East Cherry
Vermillion, SD 57069-1606
Telephone: (605) 624-4419 / FAX: (605) 624-7375
Web Site: http://www.sesdac.org
Executive Director: Gerry Tracy

Admissions: Jenna Gobel

Volunteers of America/West Oak (VOA)
908 N West Avenue
Sioux Falls, SD 57105
Telephone (VOA): (605) 334-1414 / FAX: (605) 335-3121
Telephone (WO): (605) 367-4293 / FAX: (605) 367-5714
CEO/Director Director: Pam Bollinger; West Oak Director: Kris Killeas
Admissions: Kurt Schiferl

South Dakota Department of Human Services

Division of Developmental Disabilities
Hillsview Properties Plaza
East Highway 34, c/o 500 East Capitol
Pierre, SD 57501
Telephone: (605) 773-3438

South Dakota Developmental Center
17267 W 3rd Street
Redfield, SD 57469
Telephone: (605) 472-2400

607 North Fourth Street Aberdeen, SD 57401-2733
• 605-229-0263 • Fax 605-225-3455 • www.aspiresd.org

Authorization to Exchange Information

I, ____________________________ authorize the exchange of protected and/or
(Name of person authorizing information exchanges)

confidential information between Aspire, Inc. and :______________________________
(Person/organization with whom exchange authorized)

____
(Address of above person/organization)

The purpose/need for such exchange is:

_______ Coordinate Services
_______ Eligibility for Services
_______ Diagnosis & Treatment
_______ Other (Specify) ______________
________ Legal Purposes
________ Referral for Service
________ Education Purposes

Specific information to be exchanged:

________ Immunization Records
________ Psychological Evaluation
________ Psychiatric Evaluation
________ Counseling Reports
________ Physical Examination
________ Dental Examination
________ Social History
________ Neurological Reports
________ Behavior Mgmt Reports
________ Incident Reports
________ ICAP
________ Personal Info sheet
________ Lab Tests/Results
________ Seizure reports
________ Speech/Hearing/Language
________Occupational/Physical Therapy
________Current Service Plans (ISP)
________Independent Living Skills Evals
________Vocational Evaluation Reports
________Work Experience Records
________Current Educational Plan (IEP)
________Legal Guardianship Document
________Medication History
________Behavioral History
________Financial Statements
________Nutritional Screenings
________Vision Screenings
________ Other (specify)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire (insert date or event): ___________________. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ ____________________
(Signature Person with whom exchange authorized) (Date)

____ ____________________
(Signature of Parent(s)/Legal Guardian(s) - Relationship (Date)

Form #25.18

Aspire, Inc.
607 N Fourth Street
Aberdeen, SD 57401

Physical Examination Report

Name ______________________ Date __________ Day __________ Time __________

Medicaid # ______________________ Medicare # ______________________

Allergies ______________________________________ DOB __________

Current Diagnosis/Disability ______________________________________

____

Current Diet ______________________________________

Last Pap Smear ______________________

Last Mammogram ______________________

Last Colonoscopy ______________________

Last Tetanus Shot ______________________ Booster Administered at CPX Yes ☐ No ☐

Date given __________

Last Pneumonia Shot ______________________ Booster Administered at CPX Yes ☐ No ☐

Date given __________

Other vaccines: ______________________ Date: ______________

Height ______ Weight ______ Pulse ______ Resp ______ Temp ______ B/P ______

Aspire Staff Comments: ______________________________________

____

____

(4) cc: Service Coordinator
Nursing (2)

Form #24.3
Revised 10/20/2011

Name: ______________________ **DOB:** ____________ **Date:** ____________

Exam Completed

Yes	No	NA	Refused			COMMENTS
				1.	General appearance (nutrition, general hygiene)	
				2.	Nose, throat, neck, mouth (teeth)	
				3.	Chest, lung	
				4.	Heart, circulatory system	
				5.	Abdomen	
				6.	Genitals -Prostate Exam (40+) ☐Yes ☐No If no, why? ____________	
************************ *****						
				7.	Anorectal	
				8.	Musculoskeletal	
				9.	Neurological	
				10.	Skin	
				11.	Breast Exam	
				12.	Pelvic Exam	
				13.	**Pap Smear**	
				14.	Testicular Exam	

Assessment / Orders ______________________________

<u>All items below require a response</u>

1. Labs to be drawn at Aspire, Inc. ☐ No ☐ Yes, Specify labs/frequency ____________
2. Copies of labs drawn today at appointment faxed to Aspire ☐ Yes ☐ No
3. PSA drawn at appointment (required for males age 50+) ☐Yes ☐ No If no, why? ____________
4. Annual influenza/H1N1 vaccine ☐ Yes ☐No If no, why? ____________
5. Referrals: ☐none or ☐specify ____________
6. Diet: Continue same ☐Yes ☐No - Change to: ____________
7. Activities: ☐No restrictions or ☐ specify ____________
8. Any restriction to alcoholic beverages? ☐No ☐Yes - Specify ____________
9. Medications: ☐may refill for one year or specify ____________
10. Mammo: ☐annually ☐other & reason: ____________
11. Colonoscopy: ☐Schedule ☐ No & reason: ____________

13. Pap Smear: ☐ annually ☐other & reason: ____________

    ☐ recommend general anesthesia ☐ No longer needed & reason ____________

14. Immunizations up to date ☐ Yes ☐No, Vaccines given: ____________
15. Medical Records informed to fax dictation to Aspire ☐ Yes ☐ No

______________________	______________________	____________
Printed Physician's Name	**Physician's Signature**	**Date**

Aspire, Inc.

Name: ______________________ DOB: ______________________

Immunization History

Hepatitis Screening: __________ Hepatitis B Series: ________ ________ ________

DPT: ______________________ Mumps: ______________________

Polio: ______________________ Rubella: ______________________

______________________ MMR: ______________________

Rubeola - 7 day Measles:

Tuberculosis/Mantoux: ______________________

Childhood Measles: ______________________

Pneumovax: ______________________

Current Immunizations

Tetanus Diptheria (Td)	Influenza		Tuberculosis Testing		
			given	read	results
Tetanus Toxoid (TT)					

Registered Nurse: ______________________ Date: ______________________

______________________ ______________________

Form #24.40

Revised 10/6/08