



The following information helps to better understand your personal situation, identify essential people in your life, as well as other resources possibly available. We do take family income into account when purchasing services. Your help is appreciated.

**Are you currently receiving help from another program such as Voc. Rehab, Dept of Human Services, or other? If so, indicate which program and nature of help:**

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**Marital Status:** \_\_\_Married \_\_\_Divorced \_\_\_Never Married \_\_\_Separated \_\_\_Widowed

**Total Number in Family:** \_\_\_\_\_ **How Many Dependent Children?** \_\_\_\_\_ **Ages** \_\_\_\_\_

**Spouse's Name & Employment Status:** \_\_\_\_\_

**If a dependent, please identify parents:** \_\_\_\_\_

**List Two People Who Would Always Have Your Address or Phone Number:**

Name	Address	Phone Number
1. _____	_____	_____
2. _____	_____	_____

**Do you have a valid driver's license?** \_\_\_Yes \_\_\_No  
**Do you have a car you can drive?** \_\_\_Yes \_\_\_No  
**Are you a veteran?** \_\_\_Yes \_\_\_No

**Financial Resources:**

**If you are requesting financial assistance you must complete the following information. Please insert the monthly amount you receive after the type of income (if not monthly, please indicate if weekly, monthly, or annually, etc):**

_____ Your wages	_____ Worker's Comp	_____ Social Security
_____ Spouse's wages	_____ VA Benefits	_____ SSI
_____ Mother's wages	_____ AFDC/Public Assistance	_____ Pension
_____ Father's wages	_____ Social Security Disability	

**Finally, what can we do to assist you?**

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**Consumer Signature or Representative:** \_\_\_\_\_

# SELF REPORT HEALTH ASSESSMENT SURVEY

NOTE: The Independent Living Philosophy is based on the idea that the individual is the best source of information about their situation, rather than relying solely on doctor or other medical reports. You can help us by completing the following survey. This will help us understand your particular situation.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, ZIP: \_\_\_\_\_

BIRTH DAY: \_\_\_/\_\_\_/\_\_\_

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Please check or circle the disability (disabilities) and/or health issues you experience.

- Multiple Sclerosis  Lou Gehrig's Disease (ALS)
- Problems with eyes, ears, throat  Dizziness, fainting, blackout
- Persistent bronchitis, asthma, emphysema  Stroke, paralysis, seizures
- Tumors, leukemia, or cancer  Allergies, skin problems
- Diabetes, thyroid, pituitary, glands  Loss or paralysis of limb
- Mental illness or nervous disorder  Alcohol or drug abuse
- Problems with reading, writing, math, or speech  Muscular Dystrophy
- Arthritis, back pain, or problems with spine and joints
- High blood pressure, chest pain, heart attack, or other heart problems
- Ulcer, hernia, colitis, intestinal bleeding or other internal/stomach problems
- Problems with kidney, bladder, prostate, reproductive organs
- Please describe any other disability, diagnosis, or health issue you would like us to know about:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK OR CIRCLE THE ACTIVITIES OR FUNCTIONAL LIMITATIONS YOU EXPERIENCE THAT INTERFERE WITH LIVING MORE INDEPENDENTLY.

- Walking, standing, sitting  Lifting or carrying things
  - Climbing or balancing  Stooping, bending, or kneeling
  - Reaching, handling, or fingering objects  Talking or hearing
  - Problems working an 8 hour day  Working outside
  - Being in cold, heat, or temperature changes  Being in wet, humid places
  - Being around noise or vibration  Reading, writing, doing math
  - Catching on to things, learning new tasks  Doing tasks which change often
  - Getting along with others  Making decisions
  - Being around dust, fumes, odors, or gasses  Keeping self control under pressure
- PLEASE ADD ANY OTHER COMMENTS OR DESCRIBE OTHE BARRIERS YOU EXPERIENCE IN TRYING TO BE INDEPENDENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please return this Health Survey with IL Service Application form to:**  
Alice Kehr  
Iowa Vocational Rehabilitation Services  
217 W 5<sup>th</sup> Street  
Spencer, Iowa 51301

IOWA VOCATIONAL REHABILITATION SERVICES  
INDEPENDENT LIVING PROGRAM  
CONSUMERS RIGHTS AND RESPONSIBILITIES AND CONSUMER PLAN WAIVER

To be eligible to receive independent living services an individual must have a significant disability that restricts their ability to be independent in their home and community, with the expectation that any services provided will increase their independence and control over their environment.

Information is gathered under the authority of the Rehabilitation Act of 1973, as amended (Public law 93-112) only to the extent it is needed to determine eligibility and jointly develop goals with the consumer. In many instances existing records or self report data will be sufficient.

**I understand that I have a right to:**

1. Have all information about me kept confidential, unless I provide written authorization for release outside the agency. The exception would be where required by Federal or State law, regulation or lawful court order.
2. The assistance of my counselor in jointly discussing and developing independent living goals.
3. Know that financial participation may be required of you, depending on gross family income, and taking into account family size, and using a sliding scale. The more you make, the higher percentage you would share.
4. Know that you and the counselor will need to explore other appropriate sources of assistance or programs, if available, to avoid duplication of services.
5. Appeal any decision I do not agree with, which I cannot resolve with my counselor. I may choose to speak to the counselor's supervisor. I may bypass the supervisor and directly request a Fair Hearing before an Impartial Hearing Officer. If not satisfied after speaking to the supervisor I may still request a Fair Hearing. A written request for a Fair Hearing shall be made to the Administrator of the Iowa Vocational Rehabilitation Services, 510 East 12th Street, Des Moines, Iowa 50319.
6. Contact the Iowa Client Assistance Program (ICAP) for help with my relations with the agency. I can contact them by calling (1-800-652-4298) or in Des Moines at 281-3957 (voice) or 242-6172 (TTY), or by writing ICAP, Iowa Department of Persons with Disabilities, Lucas State Office Bldg., Des Moines, Iowa 50319.
7. Have independent living services provided in compliance with all applicable State and Federal civil rights laws. All are served without regard to age, race, creed, color, sex, national origin, religion or disability. Compliance concerns are to be directed to: Chief, Administrative Services Bureau, Iowa Vocational Rehabilitation Services, 510 East 12th St. Des Moines, IA 50319.

**I understand that I am responsible for:**

1. Informing my counselor of any change in my address and telephone number.
2. Applying for any financial assistance which might be available to me from other sources.

**I ALSO UNDERSTAND THAT A FORMAL WRITTEN CONSUMER SERVICE PLAN WILL BE JOINTLY DEVELOPED BY MYSELF AND MY COUNSELOR TO IDENTIFY GOALS AND MONITOR PROGRESS, UNLESS I DECLINE THE NEED FOR A WRITTEN PLAN. MY CHOICE IS INDICATED BELOW, AND MAY BE CHANGED AT ANYTIME. GOALS AND OBJECTIVES WILL STILL BE MONITORED INFORMALLY IF THE FORMAL PLAN IS WAIVED. (please initial your choice)**

I prefer a written consumer service plan\_\_\_\_\_

I waive the need for a written plan\_\_\_\_\_

**Other comments I would like to make.**

These rights and responsibilities have been explained to me, and I have been given a copy

\_\_\_\_\_  
Consumer signature  
or Parent /Guardian

\_\_\_\_\_  
date

\_\_\_\_\_  
Counselor signature

\_\_\_\_\_  
date