

Ringgold County Supportive Services
507 South Henderson Drive
Mount Ayr, Iowa 50854
641-464-2067
ccole@ringgoldcounty.us

Day Habilitation Program Application

Ringgold County Supportive Services operates a Day Habilitation program in Mount Ayr, Iowa, that is a non-profit organization established for adults with intellectual disabilities with an emphasis on helping individuals to become more independent and valued community member. To request services, please complete the application below. For questions regarding this application, please contact Chanelle Cole, Director, at 641-464-2067 or ccole@ringgoldcounty.us.

RCSS Intake Eligibility Checklist

Instructions: Please review each statement and indicate **Yes** or **No** to determine intake eligibility.

1. Referral Information

- Yes / No – The applicant has been referred by case management, an organization, or a private individual.

2. Age Eligibility

- Yes / No – The applicant is 18 years of age or older.
- Yes / No – *If no:* Approval by the Board has been granted and documented in the official meeting minutes to authorize an exception.

3. Clinical and Support Needs

- Yes / No – The applicant has a documented diagnosis of an intellectual disability.
- Yes / No – The applicant is able to function safely in an environment with a 6-to-1 individual-to-staff ratio.

4. Funding and Financial Responsibility

- Yes / No – The applicant has an identified funding source or an approved method of self-payment.
- Yes / No – *If services are not funded through the ID Waiver:* The applicant agrees to complete and pay for a level of care assessment to determine the appropriate tier.

1. Applicant General Information

- Full Name: _____
- Date of Birth (MM/DD/YYYY): _____
- Age: _____
- Gender: _____
- Home Address: _____
- Phone Number: _____
- Email Address: _____

2. Referral Source Information

- Referral Source: Case Management Organization Private Individual Other Entity
- Contact Person Name: _____
- Agency/Organization Name: _____
- Phone Number: _____
- Email Address: _____

3. Primary Contact and Legal Guardian Information

- Contact Name: _____
- Relationship to Applicant: _____
- Legal Guardianship Status: Full Guardian Partial/Limited Guardian Self/No Guardian
- Phone Number: _____
- Email Address: _____

4. Clinical & Support Information

- Is there a documented diagnosis of an intellectual disability? Yes / No
- Is the applicant able to function safely in a 6-to-1 individual-to-staff ratio? Yes / No
- Please identify any required physical, behavioral, or communication supports:

5. Funding & Financial Information

- Primary Funding Source: ID Waiver Self-Funded Other_____
 - If ID Waiver, enter Waiver ID/Number: _____
 - Non-ID Waiver Agreement (If Applicable):
Yes / No – I understand that a level of care assessment is required to determine the appropriate tier, and I agree to assume full financial responsibility for the cost of this assessment.
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6. Acknowledgement & Signatures

By signing below, I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge.

- Applicant/Guardian Signature: _____
 - Date: _____
 - RCSS Director/ Staff Signature: _____
 - Date: _____
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