

EASTERN IOWA MH/DS APPLICATION

DEMOGRAPHICS			
Application Date:			County Office:
Social Security #:		Birth Date: ____/____/____	Gender: [] Male [] Female
Last & First Name:			
	Last <i>(Please Print)</i>	First	MI
Maiden Name: (If applicable)			
Current Address:			How long at this address:
	<i>Street/Avenue (Please Print)</i>		
City, State, Zip:			County:
Mailing Address:	Street, City, State ,Zip:		

CONTACT DETAILS			
Phone #'s:	Cell Phone:	Home Phone:	
Email:			
DETAILS			
Marital Status:	<input type="checkbox"/> Divorce	<input type="checkbox"/> Married or Common Law	<input type="checkbox"/> Separated
			<input type="checkbox"/> Single (Never Married)
	<input type="checkbox"/> Widowed		
Race:	<input type="checkbox"/> White	<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Other(biracial; Sudanese; etc)
	<input type="checkbox"/> Native American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Unknown
Ethnicity:	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non Hispanic or Latino	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Status:	<input type="checkbox"/> Voluntary	<input type="checkbox"/> Involuntary, civil commitment	<input type="checkbox"/> Voluntary, criminal commitment
Veteran Status:	Military Branch:	Type of Discharge:	Discharge Date:

RESIDENTIAL ARRANGEMENTS			
<input type="checkbox"/> Alone-Private Residence	<input type="checkbox"/> 24 Hr Habilitation	<input type="checkbox"/> RCF/ID	<input type="checkbox"/> Correctional Facility
<input type="checkbox"/> w/Relatives-Private Residence	<input type="checkbox"/> 24 Hr SCL	<input type="checkbox"/> RCF/PMI	<input type="checkbox"/> Foster Care Family Life Home
<input type="checkbox"/> w/unrelated Persons-Private Residence	<input type="checkbox"/> ICF/ID	<input type="checkbox"/> Residential Care Facility	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Homeless/Shelter/Street	<input type="checkbox"/> ICF/Nursing Home	<input type="checkbox"/> State MHI	Is this a treatment center? If yes, location:
	<input type="checkbox"/> ICF/PMI	<input type="checkbox"/> State Resource Center	

OTHERS IN HOUSEHOLD		
First and Last Name:	Relationship:	Date of Birth:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

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LEGAL REPRESENTATIVE, CONSERVATOR, POWER OF ATTORNEY OR PROTECTIVE PAYEE

Do you have a legal representative, conservator, power of attorney or protective payee? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Legal Representative	Name:	Address:	Phone:
<input type="checkbox"/> Protective Payee	Name:	Address:	Phone:
<input type="checkbox"/> Conservator	Name:	Address:	Phone:
<input type="checkbox"/> Power of Attorney	Name:	Address:	Phone:

EDUCATION	
<input type="checkbox"/> Associates	<input type="checkbox"/> GED
<input type="checkbox"/> Bachelor	<input type="checkbox"/> H.S. Diploma
<input type="checkbox"/> Certificate	<input type="checkbox"/> Masters
<input type="checkbox"/> Current Student Grade level _____	<input type="checkbox"/> None Level Finished _____
<input type="checkbox"/> Doctorate	<input type="checkbox"/> Special Education

REFERRAL SOURCE	
<input type="checkbox"/> Community Corrections	<input type="checkbox"/> Physician
<input type="checkbox"/> Family and/or Friends	<input type="checkbox"/> RCF/ICF
<input type="checkbox"/> Hospital	<input type="checkbox"/> Self
<input type="checkbox"/> Other	<input type="checkbox"/> Social Service other than case management
<input type="checkbox"/> Other Case Management	<input type="checkbox"/> Targeted Case Management

CURRENT EMPLOYMENT

<input type="checkbox"/> Employed, Full Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed, available for work
<input type="checkbox"/> Employed, Part Time	<input type="checkbox"/> Seasonally employed	<input type="checkbox"/> Unemployed, unavailable for work
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Sheltered work employment	<input type="checkbox"/> Vocational Rehabilitation
<input type="checkbox"/> In the Armed Forces	<input type="checkbox"/> Student	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Other, Not applicable	<input type="checkbox"/> Supported employment	<input type="checkbox"/> Work Activity Employment

HEALTH INSURANCE INFORMATION

Insurance Type: <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other (list type): _____		
<input type="checkbox"/> Private Third Party Health Insurance Coverage Start Date (Month/YR) _____	<input type="checkbox"/> Iowa Medicaid (Iowa DHS) 1. IA Health Link 2. Fee-for-Service (FFS) 3. <i>Hawk-I</i>	
Policy #:	Medicaid #:	
Health Insurance Plan:	MCOs (circle one):	
	1. <u>AmeriHealth Caritas</u> 2. <u>Amerigroup</u> 3. <u>UnitedHealthcare</u>	

APPLICATION FOR BENEFITS

If you are NOT already receiving any benefits, have you applied for any of the following?

<input type="checkbox"/> FIP	<input type="checkbox"/> Retirement Pension	<input type="checkbox"/> SSDI (Social Security Disability)	<input type="checkbox"/> SSI (Supplemental Security Income)
<input type="checkbox"/> SS (Social Security Retirement)	<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Veteran's Benefits	
<input type="checkbox"/> Health Care Coverage	<input type="checkbox"/> Workers compensation		

What is the status of your benefit application(s)

<input type="checkbox"/> Approved, but not started	<input type="checkbox"/> Denied	<input type="checkbox"/> Pending	<input type="checkbox"/> Other
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FINANCIAL DISCLOSURE of RESOURCES and INCOME		
GROSS MONTHLY INCOME DETAILS		
Monthly Income Source: \$ GROSS (Check Type, Fill in amount)	Applicant Monthly \$ Amount	Others in Household Monthly \$ Amount
<input type="checkbox"/> Employment Wages		
<input type="checkbox"/> Child Support Received		
<input type="checkbox"/> Dividend interest		
<input type="checkbox"/> Family & Friends		
<input type="checkbox"/> FIP		
<input type="checkbox"/> SSI (Supplemental Security Income)		
<input type="checkbox"/> Retirement Pension		
<input type="checkbox"/> SSI (Supplemental Security Income)		
<input type="checkbox"/> SSDI (Social Security Disability)		
<input type="checkbox"/> Unemployment Compensation		
<input type="checkbox"/> Veterans Benefit		
<input type="checkbox"/> Workers Compensation		
<input type="checkbox"/> Other (please specify)		
TOTAL INCOME:		

HOUSEHOLD RESOURCES			
Resource Type: (Check all that apply)	Applicant Monthly \$ Amount	Others in Household Monthly \$ Amount	Location
<input type="checkbox"/> Cash on hand			
<input type="checkbox"/> Checking Account			
<input type="checkbox"/> Saving Account			
<input type="checkbox"/> Annuity			
<input type="checkbox"/> Certificate of Deposit (CD's)			
<input type="checkbox"/> Individual Retirement Account (IRA)			
<input type="checkbox"/> Trust Funds			
<input type="checkbox"/> Stocks & Bond			
<input type="checkbox"/> Whole Life Insurance (cash value)			
<input type="checkbox"/> Other Resources (List type):			
TOTAL RESOURCES:			
<input type="checkbox"/> Vehicle	Value:	Year:	
<input type="checkbox"/> Property/Business Interest	Type:	Address:	

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CURRENT CASE MANAGER, SOCIAL WORKER, CARE COORDINATOR

Name:			
Agency Name:			
Address:		Phone #:	
City, Zip Code			

EMERGENCY CONTACT

Name		Relationship:	
Address:		Phone #:	
City, Zip Code			

PERSON COMPLETING THE FORM (IF OTHER THAN APPLICANT)

Name:		Relationship:	
Address:		Phone #:	

PLEASE READ BEFORE SIGNING

- Your application must be complete or there may be a delay in the funding decision. If you need assistance to complete this application, please contact your local County office.
- I understand the information gathered in this document is for the use of the County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal residency. I understand that information in this document will remain confidential.
- I agree to inform the local County office of any changes provided in this application within 10 days of the change.
- I understand I may be expected to contribute toward the cost of my services after receiving a Notice of Decision. This includes client participation at a Residential Care Facility. Failure to comply with the Notice of Decision may result in the termination of County funding.
- I affirm the information in this application is true and correct. I further authorize and permit the Eastern Iowa MH/DS Region to investigate and verify this information as needed. I further understand that I may be required to REPAY the Region if this information is false.

Signature of Applicant or Legal Representative

Date

RIGHT OF APPEAL


If you do not agree with the action of the local County office or the Region you may request a reconsideration of the decision. You will receive a Notice of Decision that will explain the process.

DIAGNOSIS DETERMINATION

DIAGNOSIS: (40) MI (42) ID (43) DD (47) BI

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EASTERN IA MH/DS REGIONAL CONTACT INFORMATION		
County Member:	Address:	Phone #:
<input type="checkbox"/> Cedar County	Cedar County Courthouse 400 Cedar St • Tipton IA, 52772	563-886-1726
<input type="checkbox"/> Clinton County	Administrative Building 1900 N 3 rd St • Clinton IA, 52732	563-244-0563
<input type="checkbox"/> Jackson County	Jackson County Courthouse 311 W Platt St • Maquoketa, IA 52060	563- 652-4246
<input type="checkbox"/> Muscatine County	Community Services 315 Iowa Ave Suite A • Muscatine, IA 52761	563-263-7512
<input type="checkbox"/> Scott County	Administrative Center • 4 th Floor 600 W 4 th St • Davenport, IA 52801	563-326-8723
ADMINISTRATIVE-Office use only		
Required Documents to validate data listed in application:	Services Requested:	
<input type="checkbox"/> Picture ID	<input type="checkbox"/> Mental Health Services	
<input type="checkbox"/> Proof of Social Security #	<input type="checkbox"/> Residential Services	
<input type="checkbox"/> Proof of Address	<input type="checkbox"/> Vocational Services	
<input type="checkbox"/> Proof of Income	<input type="checkbox"/> Other Services-Please list:	
<input type="checkbox"/> Letter of Court Appointment (If applicable)		

<i>GUIDING PRINCIPLES</i>		
<ul style="list-style-type: none"> ◆ The Region must operate in the spirit of cooperation with trust amongst all, with open communication and respect for differences of opinion. ◆ Each county's property tax dollars should be spent on services for their residents. ◆ One (1) county, one (1) vote. ◆ Each county needs to maintain a local presence (local access office) for their residents. 	 <p style="text-align: center; color: blue; font-weight: bold;">Eastern Iowa MH/DS Region</p>	<ul style="list-style-type: none"> ◆ Each county must provide uniform services while including utilization of an open provider panel. ◆ The region should not create another layer of government and should maintain current administrative costs, not increase them. ◆ Case management providers will be designated by the regional Governing Board of Directors.