

Eastern Iowa MH/DS Application

Eligibility

- Individual is a resident of one of the Eastern Iowa Mental Health Regions: Cedar, Clinton, Jackson, Muscatine, or Scott County
- Individual must meet income and resource guidelines
- Adult Services:
 - 18 years old or older
 - Must have a qualifying diagnosis of mental illness or intellectual disability
 - There is a wait list for individuals with developmental disability or brain injury
- Children Services:
 - Under the age of 18
 - Have qualifying diagnosis of a Serious Emotional Disturbance (SED)

Please contact your county of residence for questions or for more information.

How to Apply

1. Fill out the printable application.
2. Mail application to your county of residence.
 - Cedar County Community Services:**
400 Cedar Street, Tipton, Iowa 52772
 - Clinton County Community Supports Department:**
PO Box 2957, Clinton, Iowa 52733
 - Jackson County Mental Health Department:**
311 W. Platt Street, Maquoketa, Iowa 52060
 - Muscatine County Community Services:**
315 Iowa Ave. Ste 1, Muscatine, Iowa 52761
 - Scott County Community Services:**
600 W. 4th Street, Davenport, Iowa 52801
3. A member from your county Mental Health Office will contact you regarding your application.

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>		(Years or months)
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"/> Divorced	<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	
Primary Language:	<input type="checkbox"/> English	<input type="checkbox"/> Other- please list:			
Legal Status:	<input type="checkbox"/> Voluntary	<input type="checkbox"/> Involuntary, Civil Commitment	<input type="checkbox"/> Involuntary, 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		
<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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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? **Yes** **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 LEVEL

<input type="checkbox"/> None	Years of Education: _____
<input type="checkbox"/> H.S. Diploma	
<input type="checkbox"/> GED	
<input type="checkbox"/> Associates	
<input type="checkbox"/> Bachelors or Higher	

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"/> Social Service	<input type="checkbox"/> Other

CURRENT EMPLOYMENT STATUS

<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 TYPE

<input type="checkbox"/> No Insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> MEPD-Medicaid for Employed Persons w/Disabilities	<input type="checkbox"/> Other
<input type="checkbox"/> Private Third Party Health Insurance		<input type="checkbox"/> Iowa Medicaid (Iowa DHS)	
Policy #:		Medicaid State ID #:	
Name of Health Insurance Plan:		MCOs (check one if applicable): 1. Amerigroup 2. Iowa Total Care	

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"/> Health Insurance Care Coverage	<input type="checkbox"/> RR-Railroad Retirement Benefits	
<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"/> 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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EASTERN IOWA MH/DS APPLICATION

FINANCIAL DISCLOSURE of INCOME and RESOURCES		
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"/> RR-Railroad Retirement Benefits		
<input type="checkbox"/> SS-Social Security Retirement		
<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 Make: Model:	<input type="checkbox"/> Property/Business Interest Type: Address:		
Value: Year:	Property Value:		

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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 #:	
City, Zip Code			

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)	
Disability Group: <input type="checkbox"/> (40) MI <input type="checkbox"/> (42) ID <input type="checkbox"/> (43) DD <input type="checkbox"/> (47) BI	
Diagnosis (if known):	

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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 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 funding.

I hereby attest that the information I have provided is true and correct to the best of my knowledge. I also give permission to release this information to verify and/or communicate eligibility for the assistance requested. I also understand that this is a government document and if I knowingly provide false information, the Region has the right to pursue collection of funds.

X

Signature of Applicant

Date

X

Signature of Legal Representative

Date

(Application must be signed or witnessed and dated to be considered for assistance.)

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 appeal process.

REGIONAL CONTACT INFORMATION

County Member:	Address:	Phone & Fax #:
Cedar County	Cedar County Courthouse 400 Cedar St • Tipton IA, 52772	563-886-1726 fax: 563-886-1437
Clinton County	Clinton County Administrative Building 1900 N 3 rd St • Clinton IA, 52732	563-244-0563 fax: 563-243-9027
Jackson County	Jackson County Mental Health Department 311 W Platt St • Maquoketa, IA 52060	563-652-1743 fax: 563-652-0337
Muscatine County	Muscatine County Community Services 315 Iowa Ave Suite 1 • Muscatine, IA 52761	563-263-7512 fax: 563-262-9378
Scott County	Scott County Administrative Center • 4 th Floor 600 W 4 th St • Davenport, IA 52801	563-326-8723 fax: 563-326-8730