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
- 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.

Cedar County
563-886-1726
jtischuk@cedarcounty.gov

Clinton County
563-244-0563
BEskildsen@clintoncounty-ia.gov

Jackson County
563-652-1743
lbopes@jacksoncounty.iowa.gov

Muscatine County
563-263-7512
Felicia.toppert@co.muscatine.ia.us

Scott County
563-326-8723
Lori.Elam@scottcountyiowa.gov

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

EASTERN IOWA MH/DS APPLICATION

DEMOGRAPHICS						
Application Date:			County Office:			
Social Security #:		**Birth Date:**	____/________/_______	**Gender:**	[ ] Male [ ] Female	
Last & First Name:						
	Last *(Please Print)*	First	MI			
Maiden Name: (If applicable)						
Current Address:		**How long at this address:**				
	Street/Avenue *(Please Print)*	(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:	☐ Divorced	☐ Married or Common Law	☐ Separated	☐ Single (Never Married)	☐ Widowed
Race:	☐ White	☐ Asian or Pacific Islander	☐ Other(biracial; Sudanese; etc)		
	☐ Native American	☐ Black or African American	☐ Unknown		
Ethnicity:	☐ Hispanic or Latino	☐ Non Hispanic or Latino	**US Citizen?**	☐ Yes ☐ No	
Primary Language:	☐ English	☐ Other- please list:			
Legal Status:	☐ Voluntary	☐ Involuntary, Civil Commitment	☐ Involuntary, Criminal Commitment		
Veteran Status:	Military Branch:	Type of Discharge:	Discharge Date:		

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

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

EASTERN IOWA MH/DS APPLICATION

LEGAL REPRESENTATIVE, CONSERVATOR, POWER OF ATTORNEY OR PROTECTIVE PAYEE			
Do you have a legal representative, conservator, power of attorney or protective payee? ☐ **Yes** ☐ **No**			
☐ Legal Representative	Name:	Address:	Phone:
☐ Protective Payee	Name:	Address:	Phone:
☐ Conservator	Name:	Address:	Phone:
☐ Power of Attorney	Name:	Address:	Phone:

EDUCATION LEVEL	
☐ None Years of Education: __________	
☐ H.S. Diploma	
☐ GED	
☐ Associates	
☐ Bachelors or Higher	

REFERRAL SOURCE	
☐ Community Corrections	☐ Physician
☐ Family and/or Friends	☐ RCF/ICF
☐ Hospital	☐ Self
☐ Social Service	☐ Other

CURRENT EMPLOYMENT STATUS		
☐ Employed, Full Time	☐ Retired	☐ Unemployed, available for work
☐ Employed, Part Time	☐ Seasonally employed	☐ Unemployed, unavailable for work
☐ Homemaker	☐ Sheltered work employment	☐ Vocational Rehabilitation
☐ In the Armed Forces	☐ Student	☐ Volunteer
☐ Other, Not applicable	☐ Supported employment	☐ Work Activity Employment

HEALTH INSURANCE TYPE			
☐ **No Insurance**	☐ **Medicare**	☐ **MEPD**-Medicaid for Employed Persons w/Disabilities	☐ **Other**
☐ **Private Third Party Health Insurance**		☐ **Iowa Medicaid (Iowa DHS)**	
Policy #:		**Medicaid State ID #:**	
Name of Health Insurance Plan:		**MCOs** (*circle 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?		
☐ FIP	☐ Health Insurance Care Coverage	☐ RR-Railroad Retirement Benefits
☐ SSDI (Social Security Disability)	☐ SSI (Supplemental Security Income)	☐ SS (Social Security Retirement)
☐ Unemployment Compensation	☐ Veteran's Benefits	☐ Workers compensation
What is the status of your benefit application(s)		
☐ Approved, but not started ☐ Denied	☐ Pending	☐ Other

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**
☐ Employment Wages		
☐ Child Support Received		
☐ Dividend interest		
☐ Family & Friends		
☐ FIP		
☐ RR-Railroad Retirement Benefits		
☐ SS-Social Security Retirement		
☐ SSI (Supplemental Security Income)		
☐ SSDI (Social Security Disability)		
☐ Unemployment Compensation		
☐ Veterans Benefit		
☐ Workers Compensation		
☐ Other (please specify)		
TOTAL INCOME:		

HOUSEHOLD RESOURCES			
Resource Type: (Check all that apply)	**Applicant Monthly $ Amount**	**Others in Household Monthly $ Amount**	**Location**
☐ Cash on hand			
☐ Checking Account			
☐ Saving Account			
☐ Annuity			
☐ Certificate of Deposit (CD's)			
☐ Individual Retirement Account (IRA)			
☐ Trust Funds			
☐ Stocks & Bond			
☐ Whole Life Insurance (cash value)			
☐ Other Resources (List type):			
TOTAL RESOURCES:			

☐ Vehicle Make: Model:	☐ Property/Business Interest Type: Address:
Value: Year:	Property Value:

EASTERN IOWA MH/DS APPLICATION

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:**
☐ **Picture ID**	☐ **Mental Health Services**
☐ **Proof of Social Security #**	☐ **Residential Services**
☐ **Proof of Address**	☐ **Vocational Services**
☐ **Proof of Income**	☐ **Other Services-Please list:**
☐ **Letter of Court Appointment (If applicable)**	
Disability Group: ☐ (40) MI ☐ (42) ID ☐ (43) DD ☐ (47) BI	
Diagnosis (if known):	

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 3rd St • Clinton IA, 52732	563-244-0563 fax: 563-243-9027
Jackson County	Jackson County 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 • 4th Floor 600 W 4th St • Davenport, IA 52801	563-326-8723 fax: 563-326-8730