EASTERN IOWA MH/DS APPLICATION

DEMOGRAPHICS						
Application Date:				County Office:		
Social Security #:		**Birth Date:**		**Gender:**		
Last & First Name:						
	Last *(Please Print)*	First	MI			
Maiden Name: (If applicable)						
Current Address:				**How long at this address:**		
	Street/Avenue *(Please Print)*			(Years and 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.		

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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**			
☐ 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 HHS)**	
Policy #:		**Medicaid State ID #:**	
Name of Health Insurance Plan:		**MCOs** (*enter one if applicable*): 1. Iowa Total Care 2. Molina Healthcare 3. Wellpoint (formerly Amerigroup) 4. IME 5. Out of State Medicaid	

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 below)**		
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:

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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:**
☐ **Picture ID**	☐ **Mental Health Services**
☐ **Proof of Social Security #**	☐ **Residential Services**
☐ **Proof of Address**	☐ **Vocational Services**
☐ **Proof of Income**	☐ **Other Services — Please list below:**
☐ **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