# Sioux Rivers Regional MHDS Application Form

***For individuals living in: Cherokee, Plymouth, Sioux and Woodbury Counties***

**Application Date:** _____ **Date Received by Office:** _____

**First Name:** _____ **Last Name:** _____ **MI:** _____

**Nickname:** _____ **Maiden Name:** _____ **Birth Date:** _____

**Ethnic Background:** ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other _____

**Sex:** ☐Male ☐Female **US Citizen:** ☐Yes ☐No **If you are not a citizen, are you in the country legally?** ☐Yes ☐No

**SSN#**_____ **Marital Status:** ☐Never married ☐Married ☐Divorced ☐Separated ☐Widowed

**Legal Status:** ☐Voluntary ☐Involuntary-Civil ☐Involuntary-Criminal ☐Probation ☐Parole ☐Jail/Prison

**Are you considered legally blind?** ☐Yes ☐No **If yes, when was this determined?** _____

**Primary Phone #:** _____ **May we leave a message?** ☐Yes ☐No

**Current Address**: _____
Street City State Zip County

**I live:** ☐ Alone ☐ With Relatives ☐With Unrelated persons

☐**Use as current Mailing Address:** ☐Yes ☐No **If not,** _____

**Previous Address**_____
Street City State Zip County
Begin Date_____ End Date_____

**Current Service Providers:**

**Name** **Location**

1. _____
2. _____

**Current Residential Arrangement: (Check applicable arrangement)**

☐**Private Residence** ☐**Foster Care/Family Life Home** ☐**Correctional Facility** ☐**Homeless/Shelter/Street**
☐**Other**_____

**Veteran Status:** ☐Yes ☐No **Branch & Type of Discharge:** _____**Dates of Service:** _____

**Current Employment: (Check applicable employment)**

| | | |
|---|---|---|
| ☐Unemployed, available for work | ☐Unemployed, unavailable for work | ☐Employed, Full time |
| ☐Employed, Part time | ☐Retired | ☐Student |
| ☐Work Activity | ☐Sheltered Work Employment | ☐Supported Employment |
| ☐Vocational Rehabilitation | ☐Seasonally Employed | ☐Armed Forces |
| ☐Homemaker | ☐ Volunteer | ☐Other _____ |

**Current Employer:** _____ **Position:** _____
**Dates of employment:** _____ **Hourly Wage:** _____ **Hours worked weekly:** _____

**Employment History: (list starting with most recent to previous.)**

| Employer | City, State | Job Title | Duties | To/From |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

**Education: What is the highest level of education you achieved?** _____ **# of years** _____ **Degree**

**Emergency Contact Person:**

**Name:** _____ **Relationship:** _____

**Address:**_____ **Phone:** _____

**Guardian/Conservator appointed by the Court?** ☐**Yes** ☐**No**
☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
**(Please check those that apply & write in name, address etc.)**

**Name:** _____

**Address:** _____

**Phone:** _____

**Protective Payee Appointed by Social Security?** ☐**Yes** ☐**No**
☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
**(Please check those that apply & write in name, address etc.)**

**Name:** _____

**Address:** _____

**Phone:** _____

**List All People In Household:**

| Name | Age | Relationship | Social Security Number |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |

**INCOME**: **Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.** *SEE ATTACHMENT A

**If you have reported no income above, how do you pay your bills? (Do not leave blank if no income is reported!)**

_____

_____

| **Gross Monthly Income (before taxes):** (Check Type & fill in amount) | **Applicant Amount:** | **Others in Household Amount:** |
|---|---|---|
| ☐ **Social Security** | | |
| ☐ **SSDI** | | |
| ☐ **SSI** | | |
| ☐ **Veteran's Benefits** | | |
| ☐ **Employment Wages** | | |
| ☐ **FIP** | | |
| ☐ **Child Support** | | |
| ☐ **Rental Income** | | |
| ☐ **Dividends, Interest, Etc** | | |
| ☐ **Pension** | | |
| ☐ **Other** | | |
| **Total Monthly Income:** | | |

## Household Resources: (Check and fill in amount and location):

| **Type** | **Amount** | **Bank, Trustee, or Company** |
|---|---|---|
| ☐Cash | | |
| ☐Checking Account | | |
| ☐Savings Account | | |
| ☐Certificates of Deposit | | |
| ☐Trust Funds | | |
| ☐Stocks and Bonds (cash value?) | | |
| ☐Burial Fund/Life Ins (cash value?) | | |
| ☐Retirement Funds (cash value?) | | |
| ☐Other _____ | | |
| **Total Resources:** | | |

**Motor Vehicles**: ☐Yes ☐No (include car, truck, motorcycle, boat, recreational vehicle, etc.)

Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____

**Do you, your spouse or dependent children own or have interest in the following:**

House including the one you live in? ☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?_____ ☐Yes ☐No

If yes to any of the above, please explain: _____

**Have you sold or given away any property in the last five (5) years?** ☐Yes ☐No **If yes, what did you sell or give away?**

**Health Insurance Information: (Check all that apply)**

**Primary Carrier (pays 1st)**

☐Applicant Pays ☐Medicaid ☐Family Planning only
☐Medicare A, B, D ☐Medically Needy ☐ MEPD
☐No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name _____

Address _____
_____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No

Spend down: _____ Deductible: _____

**Secondary Carrier (pays 2nd)**

☐Applicant Pays ☐Medicaid ☐ Family Planning only
☐Medicare A, B, D ☐ Medically Needy ☐ MEPD
☐No Insurance ☐Private Insurance ☐ HAWK-I

Company Name _____

Address _____
_____

Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No

Spend down: _____ Deductible: _____

**Referral Source:**

☐Self ☐Community Corrections ☐Family/Friend ☐Social Service Agency
☐Targeted Case Management ☐Other _____ ☐Other Case Management

## Have you applied for any of the public programs listed below?

**(Please check those you have applied for and the status of your referral) Has your application been Approved or Denied? If denied and you appealed, what is the date of appeal _____ ? Have you applied for reconsideration_____. Have you had a hearing with an Administrative Law Judge and what was the date of the scheduled hearing**: _____

☐Social Security_____ ☐SSDI_____ ☐Medicare_____

☐SSI _____ ☐Medicaid_____ ☐Food Assistance: _____

☐Veterans _____ ☐Unemployment_____ ☐FIP _____

☐Other_____ ☐Other_____

**Disability Group/Primary Diagnosis: (If known)**

☐Mental Illness ☐Chronic Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

**Specific Diagnosis determined by:_____ Date:_____**
**Axis I: _____Dx Code: _____**
**Axis II:_____ Dx Code: _____**

**Why are you here today? What services do you NEED? (this section must be completed as part of this application!)**

_____
_____
_____

**I certify that the above information is true and complete to the best of my knowledge, and I authorize Sioux Rivers Regional MHDS staff to check for verification of the information provided including verification with Iowa county government and the state of Iowa Dept. of Human Services (DHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the Sioux Rivers Region to establish my ability to pay for the services requested, and to assure the appropriateness of services requested. I understand that information in this document will remain confidential.**

_____
**Applicant's Signature (or Legal Guardian) Date**

_____
**Signature of other completing form if not Applicant or Legal Guardian Date**

# AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Client Name:_____ Date of Birth: _____/_____/_____ SS#:_____/_____/_____

I authorize Woodbury County, the Sioux Rivers Region, the Iowa Department of Human Services and the following individuals or agencies to share written and oral information about my needs and the services I receive:

Name or Agency to release and /or receive information:

*Siouxland Mental Health; Cherokee MHI; Clarinda MHI; Independence MHI; Mt. Pleasant MHI; Mercy Medical Center; St. Luke's Regional Health; Jackson Recovery Centers; Synergy Center; Mercy Behavioral Care; Associates for Psychiatric Services; Dean & Associates; Office of the Woodbury County Clerk of District Court; Siouxland Community Health Center; The Pride Group, Mosaic Council Bluffs Integrated Health Home; Magellan, IME, Mallard View.*

***The Information released or shared may include:***

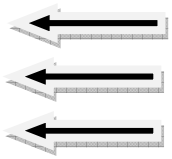
| | | |
|---|---|---|
| **( ) Psychiatric Evaluation / Assessment /Admit Report** | **( ) Individual Comprehensive Plan** | **( ) Social History** |
| **( ) Agency participation, plans, and progress reporting** | **( ) Financial Information** | **( ) Psychological Evaluation/Report** |
| **( ) Physical Status (including medical, dental )** | **( ) Psychiatric and Medical History** | **( ) Discharge Summary** |
| **( ) Face Sheet** | **( ) Motor Vehicle Information** | **( ) Other (please specify)** |

**Note exceptions or limits to this release:**_____

## SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I SPECIFICALLY AUTHORIZE the release of confidential information relating to:

| *Type of Information* | ***Authorizing Initials*** |
|---|---|
| Mental Health evaluation/treatment | |
| Substance Abuse | |
| AIDS/HIV-related | |



I understand that information obtained shall be used for the purpose of determining legal residence and eligibility for funding assistance from Woodbury County or the State of Iowa and for the planning and delivery of mental health services. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment; however my refusal to sign may affect the ability of Woodbury County to obtain the information needed for determining funding eligibility and care planning.

I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR Part 2) and Iowa Code (Chapters 125, 228, 229 and Section 141A.9) and cannot be disclosed without my written consent unless otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I have the right to inspect the disclosed information at any time.

Federal and/or Iowa law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization as indicated below. I further understand that the Iowa Department of Human Services and Woodbury County, WITHOUT FURTHER AUTHORIZATION, may redisclose said information to all individuals/agencies listed above. I SPECIFICALLY AUTHORIZE and consent to the disclosure and redisclosure as described above.

I understand that if the person or organization that receives the information is not a health plan or health care provider, Federal Privacy Regulations may no longer protect the released information. This Authorization is effective for 12 months after the date it is signed. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the healthcare provider and record keeper. A photocopy, or exact reproduction of this signed Authorization shall have the same force and effect as this original. I have read this form, or it has been explained to me, and I understand its content. I hereby authorize the release of information as indicated above.

| **Signature of Patient / Applicant or Legal Guardian:** | **Relationship, if NOT the patient:** | **Date:** |
|---|---|---|
| | | |

# ATTACHMENT A

## Income ● Resource ● Eligibility Verification

## Woodbury County Mental Health/Disability Services Program

### 1. PROOF OF LEGAL RESIDENCE REQUIREMENT

Iowa Code 331.294(1): *"County of residence" means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county in which the person last resided while the person is present in another county receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.*

- A copy of the applicant's driver's license or picture I.D. that shows current address, **OR**
- A copy of a recent bill or piece of mail with a legible postmark delivered by the U.S. Post Office to the client at their current address, **OR**
- If applicant is living in a homeless shelter or community living facility, a letter signed and dated by personnel stating the applicant is residing in that facility.

### 2. HOUSEHOLD INCOME VERIFICATION REQUIREMENTS

**For applicants 18 years of age and over:** Include income of applicant, applicant's spouse or domestic partner, and any children, stepchildren, or wards over the age of 14 that reside with applicant.

**For applicants under the age of 18**: Include income of applicant (if over 14), applicant's parents (or parent and domestic partner), stepparents, or guardians who reside with applicant.

- Copies of payroll stubs for past 60 days from all employers. If a payroll stub reflects year-to-date earnings, only the most recent payroll stubs will be required.
- If applicant or spouse/domestic partner is self employed, provide a copy of most recent Federal tax return completed.
- If applicable, a copy of Supplemental Security (SSI) or Social Security Disability (SSD) determination, pension payment, and child support amount, etc.
- If an applicant indicates that no one in the household has any income, written documentation is required from all applicable adult household members stating as such and evidence of outside assistance such as food stamps, financial help from relatives, etc., must be provided.

### 3. RESOURCE VERIFICATION REQUIREMENTS (Applicant and other applicable household members)

- A copy of all checking account statements for past 2 months
- A copy of all savings account statements for past 2 months
- A copy of a statement from all retirement accounts such as IRAs, 401(k), pension plans, annuities, certificates of deposit, stocks, bonds or trust fund accounts dated no earlier than the previous tax year.

***NOTE: If applicant or applicable household member has a legal payee, all income and resource verification documents must be obtained from the payee and attached to completed CPC application.***