GREENE-GUTHRIE-AUDUBON COUNTY COMMUNITY SERVICES
Application Form

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

If agency referral, name of agency/contact person and contact information: _____

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

SSN#:_____ **Birth Date**: _____ **Sex:** ☐Male ☐Female

Current Address: _____
Street City State Zip County

Phone #:_____ **Legal Settlement County:** _____

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

Guardian/Payee/Conservator: ☐Yes ☐No

☐Legal Guardian ☐Protective Payee ☐Conservator
(Check any that are appointed and write in name etc.)
Name: _____
Address: _____
Phone: _____

☐Legal Guardian ☐Protective Payee ☐Conservator
(Check any that are appointed and write in name etc.)
Name: _____
Address: _____
Phone: _____

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

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

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

Living Arrangement: ☐Alone ☐With relatives ☐With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

☐Private Residence	☐State Hospital School	☐Supported Comm. Living	☐State MHI
☐Foster Care/FLH	☐RCF/MR	☐RCF/PMI	☐RCF
☐ICF	☐ICF/PMI	☐Correctional Facility	
☐Homeless/Shelter/Street	☐ICF/ MR	☐Other_____	

Disability Group/Primary Diagnosis:
☐40-Mental Illness ☐41-Chronic Mental Illness ☐42-Mental Retardation ☐43-Developmental Disability ☐44-Other

Specific Diagnosis determined by:_____ **Date:**_____
Axis I: _____**Dx Code:** _____
Axis II:_____ **Dx Code:** _____
Axis III: _____ **Dx Code:** _____
Axis IV: _____ **Dx Code:** _____
Axis V: (GAF Score & date given): _____

Referral Source:

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

Education:

Years of Education: _____
GED: ☐Yes ☐No
H.S. Diploma: ☐Yes ☐No
College Degree: _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐ Applicant Pays ☐ Medicaid
☐ Medicare ☐ Private Insurance
☐ No Insurance ☐ Medically Needy

Company Name _____

Address _____

_____

Policy Number: _____

(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays 2nd)

☐ Applicant Pays ☐ Medicaid
☐ Medicare ☐ Private Insurance
☐ No Insurance ☐ Medically Needy

Company Name _____

Address _____

_____

Policy Number_____

(or Medicaid/Title 19 or Medicare Claim Number)

Have you applied for all other public programs? (Please indicate dates applied and decision if applicable):

☐ **Social Security**_____ ☐ **SSI**_____ ☐ **Medicaid** _____
☐ **Veterans** _____ ☐ **Unemployment**_____ ☐ **Foodstamps**_____
☐ **FIP** _____ ☐ **Other**_____ ☐ **Other**_____

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 ☐ Other _____

Current Employer: _____ **Position:** _____

Dates of employment: _____ **Hourly Wage:** _____ **Hours worked weekly:** _____

Employment History: (list starting with most recent to all previous. Use another sheet if more space is needed)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				
4.				
5.				

Others in Household:

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		

Gross Monthly Income (before taxes): (Check Type & fill in amount)	**Applicant Amount:**	**Others in Household Amount:**
☐ Food stamps		
☐ FIP		
☐ Social Security.		
☐ SSI		
☐ Veterans Benefits		
☐ Employment Wages		
☐ Child Support		
☐ SSDI		
☐ Dividends, Interest, Etc		
☐ Railroad Pension		
☐ Other		
Total Monthly Income:		

NOTICE: Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.
If you have reported no income above, how do you pay your bills? (Do not leave blank if no income is reported!)

_____

Household Resources: (Check and fill in amount and agency):

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 _____		
☐Other_____		
Total Resources:		

Motor Vehicles: ☐Yes ☐No Make & Year: _____ Monthly Payment: _____
(include car, truck, motorcycle, etc.) Make & Year: _____ Monthly Payment: _____

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

☐House including the one you live in ☐Any other real-estate or land ☐Other_____

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

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

Do you receive any current mental health or substance abuse services (include provider name, location, & dates):

Do you take any psychotropic medications? Who prescribed them and what was the date? _____

What is the name and location of you current general physician: _____
What is the name and location of your current Pharmacy? _____

If known, what specific services including provider of those services are requested: (if applicable)

Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
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The above listed services have been discussed with me and are requested with my knowledge and consent. As a signatory of this document, I certify that the above information is true and complete to the best of my knowledge, and I authorize the County CPC staff to check for verification of the information provided including verification with local and/or state Iowa Dept. of Human Services (DHS) staff. I understand that 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 settlement. 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**

Legal Settlement: Legal Settlement is the term used to determine what county will provide funding for requested services. This is determined by a person residing twelve consecutive months (six months for persons considered legally blind) within a county without receiving treatment and/or other support type services for MR/DD/MH/BI/SA and/or Jail or imprisonment. If you do not find one full year at

the above address without the above mentioned services please continue until legal settlement can be determined. If someone has received services since the age of majority they will be granted the legal settlement determination of their parents/guardians. Please complete this form to its entirety as much as possible. If you need more space, you may copy this sheet and/or use another sheet of paper.

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

*
Current Address City State County
Dates of Residency at this address: _____to _____
Services (MH/MR/DD/SA) while at this address:
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Legal Settlement Determined?
☐Yes, County of Legal Settlement: _____
☐No, Please Continue below

*
Previous Address City State County
Dates of Residency at this address: _____to _____
Services (MH/MR/DD/SA) while at this address:
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Legal Settlement Determined? ☐Yes, County of Legal Settlement: _____
☐No, Please Continue.

*
Previous Address City State County
Dates of Residency at this address: _____to _____
Services (MH/MR/DD/SA) while at this address:
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____

Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Legal Settlement Determined? ☐Yes, County of Legal Settlement: _____
☐No, Please Continue below

*
Previous Address City State County
Dates of Residency at this address: _____to _____
Services (MH/MR/DD/SA) while at this address:
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Type of Service: _____
Agency/Location of Service: _____
Dates of Service: _____to _____
Legal Settlement Determined? ☐Yes, County of Legal Settlement: _____
☐No, Please Continue on additional sheets of paper as needed

I hereby attest that the legal settlement information I have provided is true and accurate to the best of my knowledge and I authorize the County CPC staff to check for verification of the information provided including verification with local and/or state Iowa Dept. of Human Services (DHS) staff. I understand that the information gathered regarding legal settlement is for the use of the County in establishing my ability to pay for services requested. I also 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**

Contact Person: (including Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc.)**:**
Name: _____ Relationship: _____
Address:_____ Phone: _____

Other Interested person(s):
Name: _____ Relationship: _____
Address: _____ Phone: _____

NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR CPC USE ONLY

Unique ID#:_____ Date Contacted: _____

Disability Group-DX Type: ☐MI ☐CMI ☐MR ☐DD ☐SA ☐OTHER

Legal Settlement: _____ (Attach Legal Settlement Checklist if needed)

Determination: ☐Accepted ☐Denied (see comments below) ☐Pending (see comments below)

Funding Secured: ☐YES ☐NO Arranged: _____

Date of Decision: _____ Date NOD sent: _____

If denied, check applicable reason:
☐Over income guidelines
☐Does not meet diagnostic criteria
☐Does Not meet service plan criteria
☐Does not meet plan criteria
☐Other county of legal settlement _____
☐Applicant desires to stop process
☐Other_____

Other referrals given (DHS, TCM, etc.): _____

County Co-payment amount/terms (if applicable): _____

CPC staff making determination & Date: _____

Comments: _____