EASTERN IOWA MH/DS SERVICES APPLICATION

County _____

DEMOGRAPHICS						
Application Date:			**Date Received by the County:**			
Social Security #:		**Birth Date:**	_____/_____/_____	**Gender:**	☐ Male ☐ Female	
Name:						
Maiden Name:						
(If applicable)	Last		First		MI	

Current Address:		**How long at this address:**	
	Street/Avenue		
City, State, Zip:		**County:**	
Mailing Address:			

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		
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		
Name:	**Relationship:**	**Date of Birth:**
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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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	
☐ Associates	☐ GED
☐ Bachelor	☐ H.S. Diploma
☐ Certificate	☐ Masters
☐ Current Student Grade level _____	☐ None
☐ Doctorate	☐ Special Education

REFERRAL SOURCE	
☐ Community Corrections	☐ Physician
☐ Family and/or Friends	☐ RCF/ICF
☐ Hospital	☐ Self
☐ Other	☐ Social Service other than case management
☐ Other Case Management	☐ Targeted Case Management

CURRENT EMPLOYMENT		
☐ 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 INFORMATION					
Insurance Type:	☐ Medicaid	☐ Medicare	☐ No Insurance	☐ Private Third Party	☐ MEPD
	☐ IA Health & Wellness Plan	Begin Date for type of insurance, if known:			
Please Provide the following information:					
Policy #:					
Group ID:					
Company Name:					

APPLICATION FOR BENEFITS			
If you are NOT already receiving any benefits, have you applied for any of the following?			
☐ FIP	☐ Retirement Pension	☐ SSDI (Social Security Disability)	☐ SSI (Supplemental Security Income)
☐ SS (Social Security Retirement)	☐ Unemployment Compensation	☐ Veteran's Benefits	
☐ Health Care Coverage	☐ Workers compensation		
What is the status of your benefit application(s)			
☐ Approved, but not started	☐ Denied	☐ Pending	☐ Other

FINANCIAL DISCLOSURE of RESOURCES and INCOME		
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**		
☐ **Social Security Retirement**		
☐ **Retirement Pension**		
☐ **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	Value:	Year:	
☐ Property/Business Interest	Type:	Address:	

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CURRENT CASE MANAGER, SOCIAL WORKER, CARE COORDINATOR			
Name:			
Agency Name:			
Address:		**Phone #:**	

EMERGENCY CONTACT			
Name		**Relationship:**	
Address:		**Phone #:**	

PERSON COMPLETING THE FORM (IF OTHER THAN APPLICANT)			
Name:		**Relationship:**	
Address:		**Phone #:**	

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 understand 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 residency. I understand that information in this document will remain confidential.
- 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 County funding.
- I affirm the information in this application is true and correct. I further authorize and permit the Eastern Iowa MH/DS Region to investigate and verify this information as needed. I further understand that I may be required to REPAY the Region if this information is false.

_____ _____

Signature of Applicant or Legal Representative Date

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 process.

DIAGNOSIS DETERMINATION

DIAGNOSIS: ☐ (40) MI ☐ (42) ID ☐ (43) DD ☐ (47) BI

EASTERN IA MH/DS REGIONAL CONTACT INFORMATION		
County Member:	**Address:**	**Phone #:**
☐ Cedar County	Cedar County Courthouse 400 Cedar St •Tipton IA, 52772	563-886-1726
☐ Clinton County	Administrative Building 1900 N 3rd St • Clinton IA, 52732	563-244-0563
☐ Jackson County	Jackson County Courthouse 201 W Platt St • Maquoketa, IA 52060	563- 652-4246
☐ Muscatine County	Community Services 315 Iowa Ave Suite A • Muscatine, IA 52761	563-263-7512
☐ Scott County	Administrative Center • 4th Floor 600 W 4th St • Davenport, IA 52801	563-326-8723

ADMINISTRATIVE-Office use only	
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)**	

GUIDING PRINCIPLES

- The Region must operate in the spirit of cooperation with trust amongst all, with open communication and respect for differences of opinion.
- Each county's property tax dollars should be spent on services for their residents.
- One (1) county, one (1) vote.
- Each county needs to maintain a local presence (local access office) for their residents.

- Each county must provide uniform services while including utilization of an open provider panel.
- The region should not create another layer of government and should maintain current administrative costs, not increase them.
- Case management providers are chosen by the county, not by the region.