Application for MH/DD Services

CICS
Supporting Individuals. Strengthening Communities.

Application Date: _____ Date Received by Office: _____ CSN ID:_____

First Name: _____ Last Name: _____ MI: _____

Other Names Used: _____ Email: _____ 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

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

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

When did you move here: _____

I live: ☐ Alone ☐ With Relatives ☐ With Unrelated Persons

Use as current mailing address: ☐ Yes ☐ No If not, _____

Previous Address: _____ _____ _____ _____ _____
Street City State Zip County

When did you move here: _____ End Date: _____

Current Service Providers:

	Name	Location
1.	_____	_____
2.	_____	_____
3.	_____	_____

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: _____ to _____

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

Education: How many years of education have you achieved? _____

What is your education level: ☐ Current Student ☐ Special Education ☐ GED ☐ High School Diploma
☐ 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	Birth Date	Relationship	Social Security Number

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 type and fill in amount and location)	Amount	Bank, Trustee, or Company
☐ Cash		
☐ Checking Account		
☐ Savings Account		
☐ Certificates of Deposit		
☐ Trust Funds		
☐ Stocks and Bonds (cash value?)		
☐ Burial Fund/Life Insurance (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: _____

INCOME: 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!

_____

_____

_____

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 ☐ Iowa Health and Wellness
☐ 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 ☐ Iowa Health and Wellness
☐ 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 Case Management ☐ Other _____

Have you applied for any of the public programs listed below? Has your application been Approved or Denied? (Please indicate those you have applied for and the status of your referral)

☐ Social Security _____ ☐ SSD _____ ☐ Medicare _____
☐ SSI _____ ☐ Medicaid _____ ☐ HHS Food Assistance _____
☐ Veterans _____ ☐ Unemployment _____ ☐ FIP _____
☐ Other _____ ☐ Other _____

Disability Group/Primary Diagnosis (if known):

☐ 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 regional or county staff to check for verification of the information provided including verification with Iowa regions and county government and the state of Iowa Department of Health and Human Services (HHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the region or county in establishing my ability to pay for services requested, and in ensuring the appropriateness of services requested. I understand that information in this document will remain confidential.

_____ _____
Applicant or Legal Guardian Signature (required) Date

_____ _____
Other individual assisting to complete application Date