

Sioux Rivers Regional MHDS Application Form

For individuals living in: 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)

<input type="checkbox"/> Unemployed, available for work	<input type="checkbox"/> Unemployed, unavailable for work	<input type="checkbox"/> Employed, Full time
<input type="checkbox"/> Employed, Part time	<input type="checkbox"/> Retired	<input type="checkbox"/> Student
<input type="checkbox"/> Work Activity	<input type="checkbox"/> Sheltered Work Employment	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Seasonally Employed	<input type="checkbox"/> Armed Forces
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Volunteer	<input type="checkbox"/> 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)

- Social Security
- SSDI
- SSI
- Veteran's Benefits
- Employment Wages
- FIP
- Child Support
- Rental Income
- Dividends, Interest, Etc
- Pension
- Other

Applicant Amount:

Others in Household Amount:

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: _____
 Make & Year: _____
 Make & Year: _____

Estimated value: _____
 Estimated value: _____
 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)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A, B, D	<input type="checkbox"/> Medically Needy	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number: _____ (or Medicaid/Title 19 or Medicare Claim Number)		
Start Date: _____	Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spend down: _____	Deductible: _____	

Secondary Carrier (pays 2nd)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A, B, D	<input type="checkbox"/> Medically Needy	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number: _____ (or Medicaid/Title 19 or Medicare Claim Number)		
Start Date: _____	Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spend down: _____	Deductible: _____	

Referral Source:

<input type="checkbox"/> Self	<input type="checkbox"/> Community Corrections	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Social Service Agency
<input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Other _____	<input type="checkbox"/> 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: _____

<input type="checkbox"/> Social Security _____	<input type="checkbox"/> SSDI _____	<input type="checkbox"/> Medicare _____
<input type="checkbox"/> SSI _____	<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> Food Assistance: _____
<input type="checkbox"/> Veterans _____	<input type="checkbox"/> Unemployment _____	<input type="checkbox"/> FIP _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> 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 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; Independence MHI; Creative Living Center, Plain Area
 Mercy Medical Center; St. Luke's Unity Point; 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; Social Security Administration; Community Services Network

The Information released or shared may include:

- | | | |
|--|--|--|
| <input type="checkbox"/> Psychiatric Evaluation / Assessment /Admit Report | <input type="checkbox"/> Individual Comprehensive Plan | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Agency participation, plans, and progress reporting | <input type="checkbox"/> Financial Information | <input type="checkbox"/> Psychological Evaluation/Report |
| <input type="checkbox"/> Physical Status (including medical, dental) | <input type="checkbox"/> Psychiatric and Medical History | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Motor Vehicle Information | <input type="checkbox"/> 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:

<i>Type of Information</i>	<u><i>Authorizing Initials</i></u>
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 Sioux Rivers 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 Sioux Rivers 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 Sioux Rivers, **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:
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ATTACHMENT A
Income • Resource • Eligibility Verification
Sioux Rivers Regional Mental Health & Disabilities Services

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 MHDS application.