LYON/OSCEOLA COUNTY COMMUNITY SERVICES
Application Form

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

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

Phone #:_____ **Birth Date:**_____ **SSN#**_____ **State ID#**_____

Current Address: _____
Street City State Zip County

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

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 ☐Protective Payee ☐Conservator
(Please check that apply & write in name, address etc.)
Name: _____
Address: _____
Phone: _____

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

Marital Status: ☐Never married ☐Married ☐Divorced ☐Separated ☐Widowed

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

Are you here in the U.S. legally? ☐Yes ☐No **Living Arrangement:** ☐Alone ☐With relatives ☐With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

☐Private Residence	☐State Resource Center	☐Supported Comm. Living	☐State MHI
☐Foster Care/Family Life Home	☐RCF/MR	☐RCF/PMI	☐RCF
☐ICF	☐ICF/PMI	☐Correctional Facility	
☐Homeless/Shelter/Street	☐ICF/ MR	☐Other_____	

Disability Group/Primary Diagnosis:
☐Mental Illness ☐Chronic Mental Illness ☐Mental Retardation ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

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

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

Referral Source:

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

Education:

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

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

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 all previous. Use another sheet if more space is needed)

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

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

(Please check those you have applied for and the status of your referral) Please advise if your application has been Approved or Denied. If you appealed the denial, please advise of the date of appeal _____ Please advise if you have applied for reconsideration. Please advise if you have had a hearing with an Administrative Law Judge and the date of the scheduled hearing:?_____

☐**Social Security**_____ ☐**SSDI**_____ ☐**Medicare**_____

☐**SSI** _____ ☐**Medicaid**_____ ☐**DHS Food Assistance:**_____

☐**Veterans** _____ ☐**Unemployment**_____

☐**FIP** _____ ☐**Other**_____ ☐**Other**_____

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)

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)

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

What is the name and location of your current Pharmacy? _____

Others in Household:

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

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!)

_____
_____
_____

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 _____	_____	_____
☐ 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:_____
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 ☐ Any other real-estate or land ☐ Other_____

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?**
_____
_____

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, including prescription medications, for Mental Health, Mental Retardation, Developmental Disabilities, Brain Injury, Substance Abuse and/or Jail or imprisonment. Please complete the following information in its entirety as much as possible to assist us in determining your county of legal settlement. If you need more space, you may copy the following sheet and/or use another sheet of paper to provide this information.

***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** _____

*
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** _____

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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** _____

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: _____

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 Iowa county government and the state Iowa Dept. of Human Services (DHS) staff.

I understand that the information gathered in this document is for the use of an Iowa 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**

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
☐Other county of legal settlement _____
☐Does not meet diagnostic criteria
☐Applicant desires to stop process
☐Does Not meet service plan criteria
☐Other_____
☐Does not meet plan criteria

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

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

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CPC staff making determination & Date: _____