



Application for MH/DD Services

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

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: _____

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.				
3.				

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

Protective Payee Appointed by Social Security? Yes No

<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Protective Payee (Please check those that apply & write in name, address etc.) Name: _____ Address: _____ Phone: _____
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<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Protective Payee (Please check those that apply & write in name, address etc.) Name: _____ Address: _____ Phone: _____
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List All People In Household:

Name	Birth Date	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.

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:

<input type="checkbox"/> Social Security	_____	_____
<input type="checkbox"/> SSDI	_____	_____
<input type="checkbox"/> SSI	_____	_____
<input type="checkbox"/> Veteran's Benefits	_____	_____
<input type="checkbox"/> Employment Wages	_____	_____
<input type="checkbox"/> FIP	_____	_____
<input type="checkbox"/> Child Support	_____	_____
<input type="checkbox"/> Rental Income	_____	_____
<input type="checkbox"/> Dividends, Interest, Etc.	_____	_____
<input type="checkbox"/> Pension	_____	_____
<input type="checkbox"/> Other	_____	_____
Total Monthly Income:	_____	_____

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

Type	Amount	Bank, Trustee, or Company
<input type="checkbox"/> Cash	_____	_____
<input type="checkbox"/> Checking Account	_____	_____
<input type="checkbox"/> Savings Account	_____	_____
<input type="checkbox"/> Certificates of Deposit	_____	_____
<input type="checkbox"/> Trust Funds	_____	_____
<input type="checkbox"/> Stocks and Bonds (cash value?)	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins (cash value?)	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
Total Resources:	_____	

Motor Vehicles: <input type="checkbox"/> Yes <input type="checkbox"/> No	Make & Year: _____	Estimated value: _____
(include car, truck, motorcycle, boat,	Make & Year: _____	Estimated value: _____
recreational vehicle, etc.)	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other real estate or land?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other? _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ Other Case Management

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 _____ DHS 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 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 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's Signature (or Legal Guardian) _____

Date _____

Signature of other completing form if not Applicant or Legal Guardian _____

Date _____