SOUTHWEST IOWA MHDS REGION APPLICATION

Name (First, MI, Last): _____ U.S. Citizen ☐ Yes ☐ No

Previous surnames/maiden name: _____ Date of Birth: _____ Male / Female

Social Security #:_____ County of Residence:_____

Current Address: _____
Street Address City State Zip

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

How long have you lived at current address?:_____

If you are currently living in a residential care facility, halfway house or jail, please complete last page.

Have you received any previous Mental Health, Developmental disability or Substance abuse treatment?: No Yes
Date of First treatment: _____ Have you received continuous treatment since that time?: No Yes

Referral Source: (circle applicable)
1 Self 2 Family/Friend 3 Targeted Case Management 4 Other Case Management/IHH
5 Community Corrections 6 Social Service Agency 7 Other _____

Who gave you this application? _____

Ethnicity: 0 Unknown 1 White, not Hispanic 2 African-American, not Hispanic
3 American Indian or Alaskan Native 4 Asian or Pacific Islander 5 Hispanic
6 Other (i.e. Multiracial, Indochinese, etc.)

Guardian/Payee/Conservator: (check any that are appointed and write in name, etc.)
[ ] None appointed [ ] Legal Guardian [ ] Protective Payee [ ] Conservator

Name: _____ Phone Number: _____
Address: _____

Marital Status: 1 Single, never married 2 Married (includes common-law) 3 Divorced
4 Separated 5 Widowed

Legal Status: (circle one) 1 Voluntary 2 Involuntary, civil commitment 3 Involuntary, criminal

Veteran: No Yes
Branch Dates

Living Situation: (circle one)
1 Alone 2 With relatives 3 With unrelated individuals

Applicant's Primary Diagnosis: (specify type)
[ ] 40 Mental Illness _____
[ ] 42 Mental Retardation _____
[ ] 43 Developmental Disability _____
[ ] Other: Describe _____
_____

Residential Arrangement: (circle applicable)
1. Private Residence
2. State MHI
3. State Hospital School
4. Supported Comm. Living
5. Foster Care/ FLH
6. Residential Care Facility
7. RCF/MR
8. RCF/PMI
9. Intermediate Care Facility
10. ICF/MR
11. ICF/PMI
12. Correctional Facility
13. Homeless/Shelter/Street
14. Other _____

Education:
Years of Education _____ H.S. Diploma: [ ] Yes [ ] No GED: [ ] Yes [ ] No Degree: _____

Health Insurance Information: (check all that apply)

[ ] Applicant Pays

[ ] Medicaid -Please indicate type (Iowa Health and Wellness, Medically Exempt, MEPD, Medically Needy, Marketplace Choice-Coventry, Co-Opportunity): _____ Policy Number: _____ Co-pay Amount: _____

[ ] Medicare- A, B, D Policy Number: _____

[ ] Private Insurance

[ ] No Insurance

Carrier #1 _____ Carrier # 2 _____

Address _____ Address _____

Primary Income Source: _____

Number of People in Household: _____

Monthly Income: (Check type, fill in *gross* amount – before any deductions)

	Applicant Amount	**Others in Household Amount**
[ ] 1. Employment wage - reported as	[ ] hourly Wage _____ # hours per week _____ [ ] monthly Amount _____ [ ] annually Amount _____	[ ] hourly Wage _____ # hours per week _____ [ ] monthly Amount _____ [ ] annually Amount _____
[ ] 2. Public Assistance	_____	_____
[ ] 3. Social Security	_____	_____
[ ] 4. SSDI	_____	_____
[ ] 5. SSI	_____	_____
[ ] 6. Veterans Benefits	_____	_____
[ ] 7. Railroad Pension	_____	_____
[ ] 8. Child Support	_____	_____
[ ] 9. Dividends, Interest, Etc.	_____	_____
[ ] 10. Other _____	_____	_____

Current Employment: (Circle applicable)

1 Unemployed, available for work
2 Unemployed, unavailable for work
3 Employed, full-time
4 Employed, part-time
5 Retired
6 Student
7 Work Activity
8 Sheltered Work Employment
9 Supported Employment
10 Vocational Rehabilitation
11 Seasonally Employed
12 Armed Forces
13 Homemaker
14 Other _____

Employer name and address: _____

Resources: (Check and fill in amount and agency)

Type		Amount		Bank, Trustee, or Company
[ ] Cash		_____		_____
[ ] Checking Account		_____		_____
[ ] Savings Account		_____		_____
[ ] Certificate of Deposit		_____		_____
[ ] Trust Funds		_____		_____
[ ] Life Insurance (cash value)		_____		_____
[ ] Stocks and Bonds		_____		_____
[ ] Vehicle	Value:	_____	Year:	_____
[ ] Real Estate	Value:	_____	Location:	_____
[ ] Burial Fund/Trust		_____		_____
[ ] Other Resources		_____		_____

Emergency Contact: (or someone who knows how to reach you)
Name: _____ Relationship: _____
Address: _____ Phone Number: _____

Person Completing the Form: (if other than applicant)
Name: _____ Relationship: _____
Address: _____ Phone Number: _____

Reason for Application:
[ ] Civil Commitment:
[ ] Substance Abuse (ch 125) [ ] Mental Impairment (ch 229) [ ] Dual filing
[ ] Outpatient Mental Health Treatment from _____
[ ] Seeking Funding for:
[ ] Residential Services [ ] Vocational Services [ ] Other _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE FOR HEALTH CARE PROVIDERS

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practice, Policy and Procedure.

_____ _____
Signature of Individual Date

IN THE EVENT THIS NOTICE IS RECEIVED BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

_____ _____
Signature of personal representative Date

_____
Legal authority of personal representative

Please remember that all information must be complete before the application will be considered.

PLEASE READ BEFORE SIGNING

Your signature below signifies the information included in this application is true and correct.

I do solemnly swear or affirm that the above information is true and correct. I do further authorize the Southwest Iowa MHDS Region and/or designee to investigate and verify this information, if needed, including mental health/substance abuse treatment.
Initial_____

Signature: _____ date: _____

Stop here if living in a private residence. If you are in a group living arrangement please complete back page.

In order to determine which MHDS Region in Iowa has funding responsibility for you, please complete the following information with as much detail as possible. This does not affect your eligibility for funding, it only determines who is responsible. Begin with your current address. Continue completing each address section in full until the address is one that is community-based (i.e. apartment, family home, house, HCBS waiver home,etc).

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________

Address: ____ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address: Where and when

- ☐ Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist ___________________________
- ☐ Substance Abuse counseling/treatment by a licensed professional ___________________________
- ☐ Community Services – General Assistance, Case Management, Social Worker ___________________________
- ☐ Probation, parole, prison, jail ___________________________