SOUTHEAST IOWA LINK
MENTAL HEALTH DISABILITY SERVICES
Application Form

Application Date: _____ **Date Received by local MHDS Office:** _____

Name of agency/contact person completing this form, including contact information: _____

Prefix: ☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms. ☐Prof.

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **Maiden/Nickname:** _____

Suffix: ☐D.D. ☐Esq. ☐I ☐II ☐III ☐Jr. ☐MD ☐PhD ☐Sr. **Start Date:** _____ **End Date:** _____

Date of Birth: _____ **Sex:** ☐Female ☐Male

Race: ☐White ☐Black or African American ☐ American Indian or Alaska Native ☐Asian or Pacific Islander
☐Other (biracial; Sudanese; etc.) _____ ☐Unknown

US Citizen: ☐ Yes ☐No **SSN#:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Marital Status: ☐Single ☐ Married(includes common law) ☐Divorced ☐Separated ☐Widowed

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino

Primary Language: ☐English ☐Spanish ☐French ☐German ☐Vietnamese ☐Other: _____

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

State ID #: _____ **Legal Issues:** ☐Yes ☐No If yes, please specify: _____

Blind Determination: ☐Yes ☐No **Determination Date:** _____

Home Phone:_____ **Work/Other Phone:** _____ **Cell Phone:** _____ **Email:** _____

Current Address: _____
Street City State Zip County
Dates of Residency at this address: _____**to** _____

Current Residential Arrangement: (Check applicable arrangement)

☐ **Private Residence/Household – Alone** ☐ **Private Residence/Household – With Relatives**
☐ **Private Residence/Household – With Unrelated Persons** ☐ **Foster Care/Family Life Home**
☐**Correctional Facility** ☐ **Substance-Related Treatment Facility** ☐ **24-Hour Habilitation Home**
☐ **24-Hour Supported Community Living Home** ☐ **Residential Care Facility(RCF)** ☐ **RCF/ID** ☐ **RCF/PMI**
☐ **Intermediate Care Facility(ICF)/Nursing Home** ☐ **ICF/ID** ☐ **State MHI** ☐ **State Resource Center**
☐ **Homeless/Shelter/Street** ☐ **Other: Explain**_____

Mailing Address: ☐ Same ☐ Other: _____
Street City State Zip County

Veteran Status: ☐Yes ☐No **Military Branch and Type of Discharge:** _____ **Dates:** _____

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	☐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.				

Education:

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

Interested Persons:

Name:_____
Relationship: _____ Phone: _____

Name:_____
Relationship: _____ Phone: _____

Guardian/Payee/Conservator: ☐Yes ☐No

☐Legal Guardian ☐Protective Payee ☐Conservator
(Check any that are appointed and write in name etc.)

Name: _____

Address: _____

Phone: _____

☐Legal Guardian ☐Protective Payee ☐Conservator
(Check any that are appointed and write in name etc.)

Name: _____

Address: _____

Phone: _____

Others in Household:

First Name and Last Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		

Gross Monthly Income (before taxes): (Check type & fill in amount)	**Applicant Amount:**	**Others in Household Amount:**
☐Veterans Benefits	_____	_____
☐Social Security/SSDI	_____	_____
☐SSI	_____	_____
☐Employment Wages	_____	_____
☐Workers Comp	_____	_____
☐Public or General Assistance	_____	_____
☐Private Relief Agency	_____	_____
☐Food Assistance	_____	_____
☐Family and Friends	_____	_____
☐Child Support	_____	_____
☐FIP	_____	_____
☐R/R Pension	_____	_____
☐Other (Unemployment, etc)	_____	_____
Total Monthly Income:	_____	_____

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!)

_____
_____
_____

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

Type	Amount	Bank, Trustee, or Company
☐Cash on Hand		
☐Checking Account		
☐Savings		
☐Time Certificates		
☐Burial Fund/Plot/Life Ins(cash value)		
☐CDs (cash value)		
☐Stocks/Bonds(cash value)		
☐Dividend Interest(cash value)		
☐Trust Funds		
☐Retirement Funds(cash value)		
☐Other_____		
Total Resources:		

Motor Vehicles: ☐Yes ☐No Make, Model & Year: _____ Value: _____
(include car, truck, motorcycle, etc.) Make, Model & Year: _____ 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: _____
_____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐Applicant Pays ☐Medicaid
☐Medicare ☐Private Insurance
☐No Insurance ☐Marketplace Choice

Company Name _____
Address _____
Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays 2nd)

☐Applicant Pays ☐Medicaid
☐Medicare ☐Private Insurance
☐No Insurance ☐Marketplace Choice

Company Name _____
Address _____
Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)

Have you applied for all other public programs? (Please indicate dates applied and decision if applicable):

☐**Social Security**_____ ☐**SSI**_____ ☐**Medicaid** _____
☐**Veterans** _____ ☐**Unemployment**_____ ☐**Food Assistance**_____
☐**FIP** _____ ☐**Other**_____ ☐**Other**_____

Disability Group/Primary Diagnosis:
☐40-Mental Illness ☐41-Chronic Mental Illness ☐42-Mental Retardation ☐43-Developmental Disability ☐44-Other

Specific Diagnosis determined by:_____ **Date:**_____
Axis I: _____ **Dx Code:** _____
Axis II:_____ **Dx Code:** _____
Axis III: _____ **Dx Code:** _____
Axis IV: _____ **Dx Code:** _____
Axis V: (GAF Score & date given): _____

Do you receive any current mental health or substance abuse services (include provider name, location, & dates):
_____
_____
_____

Do you take any psychotropic medications? Who prescribed them and what was the date? _____
_____

Why are you here today? What services do you need? (this section must be completed as part of this application):

Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date

Referral Source:

☐Self ☐Community Corrections ☐Family/Friend(s) ☐Social Service Agency ☐Targeted Case Management
☐ IHH Care Coordinator ☐Hospital ☐Physician ☐RCF/ICF ☐Other _____

The above listed services have been discussed with me and are requested with my knowledge and consent. 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 MHDS staff to check for verification of the information provided including, but not limited to, verification with local and/or state Iowa Dept. of Human Services (DHS) staff. I understand that the information gathered in this document is for the use of the County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming residency. 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**

HIPAA Notice of Privacy Practice Provided: ☐Yes ☐No **Signature:** _____

NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR MHDS USE ONLY

Unique ID#:_____ Date Contacted: _____

Disability Group-DX Type: ☐MI ☐CMI ☐MR ☐DD ☐SA ☐OTHER

Residency: _____ (Attach Residency 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/resource guidelines
☐Does not meet diagnostic criteria
☐Does not meet plan criteria
☐Assessment does not meet criteria
☐Other county of residence _____
☐Applicant desires to stop process
☐Other_____

Other referrals given (DHS, TCM, IHH, etc.): _____
County Co-payment amount/terms (if applicable): _____
MHDS staff making determination & date: _____
Comments: _____