Henry County CPC 106 N Jackson St. Mt Pleasant, IA 52641 319-385-4050 Fax 319-385-1948

MENTAL HEALTH ASSISTANCE FUNDING APPLICATION

Henry County Iowa

Today's date _____/_____/_____

Applicant FIRST_____MIDDLE_____LAST_____

Current Address _____CITY_____IA ZIP_____

Date of Birth _____/_____/_____ ***Social Security*** #_____

Sex (Circle one) M F

Ethnicity (Circle one) 1) White 2) African American 3) American Indian or Alaskan Native 4) Asian or Pacific Islander 5) Hispanic 6) Other _____.

Marital Status (Circle one) 1) Single 2) Married 3) Separated 4) Divorced 5) Widowed

Referred by (Circle one) 1) Self 2) Family 3) Case Management 4) Corrections 5) DHS 6) Other _____

Are you a **Veteran** Y N ***if yes list your*** **Service Branch_____ Dates of Service_____**

Are you **Blind** Y N **Disabled** Y N **Student** Y N

Do you have a (Circle) Guardian Power of Attorney Conservator Payee

Education What is the highest grade you have completed?_____

Have you ended employment voluntarily in the last sixty (60) days? Y N

Are you under Civil Commitment **Y N**

If YES, where were you committed?_____

Person to contact in case of emergency

Name_____Address_____City_____ZIP___

Phone _____

What is your diagnosis (if known) _____

List ALL the members of your household

Name	Relationship	Social Security #	Date of Birth

Employment History List your most recent work experiences and dates of employment

Employer	Address	Started	Ended

List all current **GROSS** monthly income for ***ALL HOUSEHOLD MEMBERS***:

Type of Income	Amount	Amount	Amount	Amount	Amount
Name of Wage Earner					
Earnings from work					
FIP/ADC/TANF					
Social Security					
Social Security Disability					
SSI					
Veterans Benefits					
IPERS					
Railroad Pensions					
Child Support					
Interest/Dividends/ETC.					
Self Employment					
Other (Explain)					

Resources List **ALL** resources as of the first day of the month:

Type of Resource	Amount	Location
Cash		
Checking Accounts		
Savings Accounts		
CD's		
Stocks/Bonds		
IRA'S		
Life Insurance Cash Value		
Trust Accounts		
Burial Accounts		
Property		
Other (Explain)		

Have you transferred or given away anything of value in the last year?

Health Insurance Information; Are you covered by any of the following : (Circle all that apply)

(If YES, Please list Company name and Policy Number for each type of coverage you have)

Insurance paid for by yourself: Name of insurance company_____
Insurance paid for by your Employer: Name of insurance company_____
Medicare: Medicare identification number _____
Medicaid: Medicaid identification number _____
Insurance provided by someone else: Name of insurance company_____
Other: Explain _____
NO INSURANCE COVERAGE

Circle all of the following services which you are requesting funding assistance:

Evaluation and Testing Transportation Medication Management
Psychotropic Prescription Assistance Therapy and Counseling Supported Community Living
RCF ICF/MR Supported Employment Workshop Services
Respite Care Home or Vehicle Modifications Skill Development (cooking, laundry,, etc.)
Case Management Payee Services Legal Services Assistance **(involuntary commitments only)**
Hospitalization (Including MHI) Other _____

Describe any services or supports you are currently receiving_____

_____

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF IT IS DETERMINED THAT I WILLFULLY MISREPRESENTED THESE FACTS, THEN THIS APPLICATION CAN BE DENIED ON THOSE GROUNDS.

I AM AWARE THAT THE INFORMATION REPORTED ON THIS APPLICATION MAY BE VERIFIED AND INVESTIGATED. IF I DO NOT HAVE LEGAL SETTLEMENT IN HENRY COUNTY A COPY OF THIS APPLICATION MAY BE PROVIDED TO THE COUNTY OR DEPARTMENT OF HUMAN SERVICES(STATE CASES) WHERE MY LEGAL SETTLEMENT IS DETERMINED TO BE. I HEREBY AUTHORIZE THE HENRY COUNTY CPC ADMINISTRATOR OR DESIGNEE AUTHORITY TO OBTAIN OR RELEASE PERTINENT INFORMATION TO DETERMINE MY ELIGIBILITY FOR FUNDING ASSISTANCE ACCORDING TO REQUIREMENTS CONTAINED IN THE HENRY COUNTY MENTAL HEALTH SERVICES MANAGEMENT PLAN. THE RELEASE TO INVESTIGATE THE INFORMATION CONTAINED IN THIS APPLICATION IS GOOD FOR 60 DAYS FROM THE DATE OF MY SIGNATURE.

Signature of Applicant

_____Date___/____/___Phone _____

PROHIBITION AGAINST DISCRIMINATION

We shall consider this application without regards to race, color, sex, handicap, religion, national origin, or political belief. Every applicant, whether granted assistance or not, has the right to appeal to the Henry County Board of Supervisors and may represent him/her self or may be represented by legal counsel at his/her own expense. The written appeal or communication shall be made to the Henry County CPC Administrator at 106 North Jackson Mt Pleasant IA 52641 within ten (10) days of written notification regarding benefits.This communication shall include the applicants name, current address, and phone number if applicable, and shall state the reason for appeal. A face to face consultation with the CPC Administrator shall be scheduled. If you are granted Mental Health Assistance Funding by the terms of the Henry County Management Plan, you may be required to repay all or part of the monies paid on your behalf by Henry County. Henry County provides, as well as purchases, the following services: transportation, case management and residential care facility services. Thus the potential for a conflict of interest exists when Henry County decides whether or not to authorize payment for services. Henry County is committed to making payment decisions solely on the basis of applicant eligibility, service needs, and cost analyses without favoring County provided services. Applicants are encouraged to appeal any decision felt to be influenced by this potential conflict of interest.

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NAME _____DATE_____

HOUSEHOLD SIZE_____

LIST THE LAST TWO MONTHS BILLS FOR THE FOLLOWING:

Expense Item	Month 1 Amount	Month 2 Amount	For Office Use Do Not Complete
RENT			
MORTGAGE			
PROPERTY TAXES			
HOMEOWNERS INSURANCE			
ELECTRICITY			
HEATING			
SEWER/WATER			
PRESCRIPTIONS			
DOCTOR VISITS			
HEALTH INSURANCE PREMIUMS			
FOOD (DO NOT INCLUDE FOOD STAMPS SPENT)			
CLOTHING			
CHILDCARE			
WORK RELATED EXPENSES			
TRANSPORTATION			

DO YOU HOUSEHOLD HAVE ANY OUTSTANDING FINES/COURT COSTS FOR WHICH YOU ARE LIABLE ? Y N

IF YES, TOTAL AMOUNT DUE _____

I THE UNDERSIGNED CERTIFY THAT THE ABOVE NOTED COSTS ARE TRUE AND ACCURATE

Signature _____Date _____

FOR OFFICE USE ONLY, DO NOT COMPLETE THIS SECTION

Gross Income $_____- Total Monthly Expense $_____ = Net Countable Income$_____

Household Income Limit $_____ Repay YES
NO

CPC Sigature _____

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LEGAL SETTLEMENT DETERMINATION WORKSHEET **NAME _____**

Completion of this information is *most important* for Mental Health Assistance Funding approval. Please follow the instructions exactly. If you have questions about this form please call 319 385 4050. Thank you.

Are you blind? YES NO

If YES, have you resided for 6 months at your current address? YES NO

Have you lived for 12 consecutive months in any County in Iowa? YES NO

If YES, name the County where you have lived for 12 months _____

Did you receive services for mental health/substance abuse while living there? YES NO

If you are still a minor, who has legal custody of you now? _____

What County do they live in now? _____

Please list, starting with your current address all the places where you have lived, going back to the place you lived when you turned 18 years old. You may use the back of this sheet if necessary. Also, list the approximate dates you lived at these addresses. Finally, record whether or not you received any mental health or substance abuse treatment while at this address.

Address #1 (current address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #2 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #3 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #4 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #5 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #6 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #7 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #8 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #9 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____

Address #10 (address including city and state) Dates of residence(month/day/year) **Dates** of mental health services & **provider**

_____/_____/_____