

SOUTHEAST IOWA LINK

MENTAL HEALTH DISABILITY SERVICES

Application Form

Application Date: _____ Date Received by local MHDS Office: _____
 Agency/contact person completing this form, including contact information: _____

First Name: _____ Middle Name: _____ Last Name: _____ Maiden: _____

Prefix: Dr. Miss Mr. Mrs. Ms. Prof. Suffix: D.D. Esq. I II III Jr. MD PhD Sr.

SSN#: _____ US Citizen: Yes No Date of Birth: _____ Gender: Female Male

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

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

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

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 _____ # Roommates: _____

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

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"/> Other _____	

Employment History: (list starting with most recent to all previous. Use another sheet if more space is needed)

Employer	Position	Phone	City, State	Start/End Date	Hrs.	Hrly Wage
1.						
2.						
3.						
4.						

Education:

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

Interested Persons/Emergency Contact:

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)

- 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)

Applicant Amount:

Total Monthly Income: _____

Others in Household Amount:

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
<input type="checkbox"/> Savings	_____	_____
<input type="checkbox"/> Checking Account	_____	_____
<input type="checkbox"/> Cash on Hand	_____	_____
<input type="checkbox"/> Time Certificates	_____	_____
<input type="checkbox"/> Burial Fund/Plot/Life Ins(cash value)	_____	_____
<input type="checkbox"/> CDs (cash value)	_____	_____
<input type="checkbox"/> Stocks/Bonds(cash value)	_____	_____
<input type="checkbox"/> Dividend Interest(cash value)	_____	_____
<input type="checkbox"/> Trust Funds	_____	_____
<input type="checkbox"/> Retirement Funds(cash value)	_____	_____
<input type="checkbox"/> 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)

Secondary Carrier (pays 2nd)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Insurance
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Marketplace Choice
Company Name _____	
Address _____	
Policy Number: _____	
(or Medicaid/Title 19 or Medicare Claim Number)	

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<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Insurance
<input type="checkbox"/> No Insurance	<input type="checkbox"/> 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 42-Intellectual Disability 43-Developmental Disability 47-Brain Injury 35-Substance Abuse

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? _____

Allergies: _____

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
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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 regional and/or local 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 regional and/or local MHDS 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 _____

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 ID DD BI SA

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:

- | | |
|--|--|
| <input type="checkbox"/> Over income/resource guidelines | <input type="checkbox"/> Other county of residence _____ |
| <input type="checkbox"/> Does not meet diagnostic criteria | <input type="checkbox"/> Applicant desires to stop process |
| <input type="checkbox"/> Does not meet plan criteria | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Assessment does not meet criteria | |

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

MHDS staff making determination & date: _____

Comments: _____
