County Social Services

Application Form

For individuals living in: Allamakee, Black Hawk, Butler, Cerro Gordo, Chickasaw, Clayton, Fayette, Floyd, Grundy, Hancock, Howard, Humboldt, Kossuth, Mitchell, Pocahontas, Tama, Webster, Winnebago, Winneshiek, Worth, & Wright Counties

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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

Email: _____

Current Residence:

_____ _____

Address **City** **State** **County**

Date you moved here: _____

Reside:
Alone ☐
With Relatives ☐
Unrelated persons ☐

Current Service Providers:

	Name	Location
1.		
2.		
3.		

Use as current Mailing Address: ☐Yes ☐No **If not,** _____

Address **City** **State** **County**

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)

☐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	☐ Volunteer	☐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: What is the highest level of education you achieved? _____ **# of years** _____ **Degree**

Emergency Contact Person:

Name: _____ **Relationship:** _____

Address:_____ **Phone:** _____

Guardian/Conservator appointed by the Court? ☐**Yes** ☐**No** **Protective Payee Appointed by Social Security?** ☐**Yes** ☐**No**

☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
(Please check those that apply & write in name, address etc.)
Name: _____
Address: _____
Phone: _____

☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
(Please check those that apply & write in name, address etc.)
Name: _____
Address: _____
Phone: _____

List All People In Household:

Name	Age	Relationship
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:**
☐ **Social Security**		
☐ **SSDI**		
☐ **SSI**		
☐ **Veteran's Benefits**		
☐ **Employment Wages**		
☐ **FIP**		
☐ **Child Support**		
☐ **Rental Income**		
☐ **Dividends, Interest, Etc**		
☐ **Pension**		
☐ **Other**		
Total Monthly Income:		

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

Type	Amount	Bank, Trustee, or Company
☐Cash		
☐Checking Account		
☐Savings Account		
☐Certificates of Deposit		
☐Trust Funds		
☐Stocks and Bonds (cash value?)		
☐Burial Fund/Life Ins (cash value?)		
☐Retirement Funds (cash value?)		
☐Other _____		
☐Other_____		

Total Resources: _____

Motor Vehicles: ☐Yes ☐No (include car, truck, motorcycle, boat, recreational vehicle, etc.)

Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____

Do you, your spouse or dependent children own or have interest in the following:

☐Yes ☐No - House including the one you live in? ☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?_____

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** ☐**Family Planning only**
☐**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: _____ **Deductable:** _____

Secondary Carrier (pays 2nd)

☐**Applicant Pays** ☐**Medicaid** ☐ **Family Planning only**
☐**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: _____ **Deductable:** _____

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?

(Please check those you have applied for and the status of your referral) Please advise if your application has been Approved or Denied. If you appealed the denial, please advise of the date of appeal _____ Please advise if you have applied for reconsideration. Please advise if you have had a hearing with an Administrative Law Judge and the date of the scheduled hearing: _____

☐**Social Security**_____ ☐**SSDI**_____ ☐**Medicare**_____
_____ _____ _____
☐**SSI** _____ ☐**Medicaid**_____ ☐**DHS Food Assistance:**_____
_____ _____ _____
☐**Veterans** _____ ☐**Unemployment**_____ _____
_____ _____
☐**FIP** _____ ☐**Other**_____ ☐**Other**_____

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 Social Services staff to check for verification of the information provided including verification with Iowa county government and the state Iowa Dept. of Human Services (DHS) staff.

I understand that the information gathered in this document is for the use of County Social Services in establishing my ability to pay for services requested, and in assuring 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**

****

To Be Completed by Service Provider

Mental Health Service Request Form

Disability Group/Primary Diagnosis (can check more than one):

☐Mental Illness ☐Chronic Mental Illness ☐Mental Retardation ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Specific Diagnosis determined by: _____ Date: _____
Axis I: _____Dx Code: _____
Axis II: _____ Dx Code: _____

Service Requested	CPT Code	Number Monthly Units	Unit Cost	Expected Start Date	Expected End Date
(1)					
(2)					
(3)					
(4)					
(5)					

_____

Counselor Name **Agency** **Phone**

_____

Person completing Service Request Form