MH/DS of the East Central Region Application Form

For individuals living in: Benton, Bremer, Buchanan, Delaware, Dubuque, Iowa, Johnson, Jones, and Linn

Application Date: ____________________________ **Date Received by Office:** ______________________________

First Name: ____________________________ **MI:** _________ **Last Name:** _______________________________

Preferred Name: ____________________________________ **Maiden/Previous Name:** ___________________________________

Date of Birth: _______________ **SSN#:** ________________________ **E-Mail Address**_____________________________________

Sex: ☐Male ☐Female ☐ Other **US Citizen:** ☐Yes ☐No **If not a citizen, are you in the country legally?** ☐Yes ☐No

Race: ☐ American Indian ☐Asian/Pacific Islander ☐Black/African American ☐White ☐Other __________ ☐ Unknown

Marital Status: ☐Single ☐ Married ☐Divorced ☐Separated ☐Widowed **Primary Language:** _____________________

Legal Status: ☐Voluntary ☐Involuntary-Civil (Mental Health Commitment) ☐Involuntary-Criminal

Primary Phone: __________________________ **Secondary:** ___________________________ **May we leave a message?** ☐Yes ☐No

Current Address: ____

Street City State Zip County

Begin Date at this address: ________________________________

Mailing Address (if different than above): ____

Living Arrangement: ☐ Alone ☐ With family members ☐ With unrelated individuals

Current Residential Arrangement: ☐Private Residence ☐Foster Care/Family Life Home ☐Correctional Facility
☐Homeless/Shelter/Street ☐ Residential Facility, type: ____________________ ☐ Other: ______________________

Previous Address____

Street City State Zip County

Begin Date____________________ **End Date**____________________

Veteran Status: ☐Yes ☐No **Student:** ☐Yes ☐No

Current Employment (for minor, employment of parent/guardian):
☐Unemployed ☐Employed, Full time ☐Employed, Part time ☐Retired ☐Student ☐Other _____________________

Current Employer (if minor, parent/guardian employer): ____

Dates of employment: ________________________________ **Hourly Wage:** ________________ **Hours worked weekly:** _________

Years of Education: _______________________ **Highest Degree:** ____________________________________

List All Individuals in Household (see definition on instruction page to determine who to list):

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		

***If applying for funding for more than one individual, please see addendum to application**

Gross Monthly Income (before taxes**):**	**Applicant (or parent) Amount:**	**Others in Household Amount:**
☐ Employment Wages	_______________________	_______________________
☐ Social Security/SSDI/SSI	_______________________	_______________________
☐ Veteran's Benefits	_______________________	_______________________
☐ Child Support/Alimony	_______________________	_______________________
☐ FIP	_______________________	_______________________
☐ Pension	_______________________	_______________________
☐ Workers Comp	_______________________	_______________________
☐ Other: ______________________	_______________________	_______________________
Total Monthly Income:	_______________________	_______________________

Do you pay any of the following (please indicate amount per month): ☐Child Support____________ ☐ Alimony____________

If you have reported no income, how do you pay your bills? (Do not leave blank if no income is reported!) ___________________

____

Household Resources (NOT required for children):

Type	Amount/Value	Location/Company
☐ Cash	________	________
☐ Checking	________	________
☐ Savings	________	________
☐ Social Security Debit Card	________	________
☐ Trust Account	________	________
☐ Stocks/Bonds/CDs	________	________
☐ Burial Fund/Life Ins. (cash value)	________	________
☐ Retirement Fund (non-accruing)	________	________
☐ Motor vehicle (if more than one per licensed driver)	________	________
☐ Real estate (other than the home in which you reside)	________	________
☐ Other ________	________	________
Total Resources:	________	

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?**

____

Emergency Contact Person:
Name: ____________________ **Relationship:** __________ **Phone:** ____________

Do you have a Legal Guardian (For minor, parent info)? ☐No ☐Yes **If yes, who is your guardian?**
Name: ____________________ **Phone #:** ____________________

Do you have a Representative Payee or Conservator? ☐No ☐Yes **If yes, who is your payee/conservator?**
Name: ____________________ **Phone #:** ____________________

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)	Secondary Carrier (pays 2nd)
☐**Medicaid/Health and Wellness**	☐**Medicaid /Health and Wellness**
☐**Medicare:** ☐**A** ☐**B** ☐**D**	☐**Medicare :** ☐**A** ☐**B** ☐**D**
☐ **Private Insurance:** ____________	☐ **Private Insurance:** ____________
☐**No Insurance**	☐**No Insurance**
Start Date: ________	**Start Date:** ________
Limits: ____________	**Limits:** ____________
Deductible: ____________	**Deductible:** ____________

Referral Source: ☐ **Self** ☐**Community Corrections** ☐**Family/Friend** ☐**Hospital** ☐**Case Management** ☐**Social Service Agency** ☐**Physician** ☐**RCF/ICF** ☐**Other** ________

Have you applied for Social Security/SSI/SSDI? Date ________ **Have you applied for Medicaid/Hawki? Date:** ________

Disability Group: (If known)
☐Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Current Mental Health Agency (if applicable): ____________________

Other Service Providers: ____________________

What service(s) are you applying for? **Provider name (if known)**

____________________ ____________________
____________________ ____________________

I hereby attest that the information I have provided is true and I give MHDS of the East Central Region permission to release this information to verify and/or communicate eligibility for the assistance requested. I understand that this is a government document and I may be subject to prosecution if I knowingly provide false information. I understand that information in this document will remain confidential.

I acknowledge that I have received a copy of the MHDS of the ECR Notice of Privacy practices. ________
(Please initial)

____
Applicant's (or Legal Guardian's) Signature **Date**

MH/DS of the East Central Region Application Form

Addendum if Applying for Funding for Additional Family Members

Additional Family Member 1:

First Name: ___________________________ **MI:** _________ **Last Name:** _____________________________

Preferred Name: __________________________________ **Maiden/Previous Name:** _________________________________

Date of Birth: _______________ **SSN#:** ________________________ **E-Mail Address**___________________________________

Sex: ☐Male ☐Female ☐ Other **US Citizen:** ☐Yes ☐No **If not a citizen, are you in the country legally?** ☐Yes ☐No

Race: ☐ American Indian ☐Asian/Pacific Islander ☐Black/African American ☐White ☐Other __________ ☐ Unknown

Marital Status: ☐Single ☐ Married ☐Divorced ☐Separated ☐Widowed **Primary Language:** ____________________

Legal Status: ☐Voluntary ☐Involuntary-Civil (Mental Health Commitment) ☐Involuntary-Criminal

Primary Phone: _________________________ **Secondary:** __________________________ **May we leave a message?** ☐Yes ☐No

Are income and resources the same as those of the primary applicant? ☐ Yes ☐ No **If no, please give details:** ____________

____

Do you have a Legal Guardian (For minor, parent info)? ☐No ☐Yes **If yes, who is your guardian?**
Name: ____ **Phone #:** ____

Is insurance the same as the primary applicant's? ☐ **Yes** ☐ No **If no, please provide insurance information:**

____

Have you applied for Social Security/SSI/SSDI? Date __________ **Have you applied for Medicaid/Hawki? Date:** __________

Disability Group: (If known)
☐Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Current Mental Health Agency (if applicable): ____

Other Service Providers: ____

What service(s) are you applying for? **Provider name (if known)**

____ ____
____ ____

Additional Family Member 2:

First Name: ___________________________ **MI:** _________ **Last Name:** _____________________________

Preferred Name: __________________________________ **Maiden/Previous Name:** _________________________________

Date of Birth: _______________ **SSN#:** ________________________ **E-Mail Address**___________________________________

Sex: ☐Male ☐Female ☐ Other **US Citizen:** ☐Yes ☐No **If not a citizen, are you in the country legally?** ☐Yes ☐No

Race: ☐ American Indian ☐Asian/Pacific Islander ☐Black/African American ☐White ☐Other __________ ☐ Unknown

Marital Status: ☐Single ☐ Married ☐Divorced ☐Separated ☐Widowed **Primary Language:** ____________________

Legal Status: ☐Voluntary ☐Involuntary-Civil (Mental Health Commitment) ☐Involuntary-Criminal

Primary Phone: _________________________ **Secondary:** __________________________ **May we leave a message?** ☐Yes ☐No

Are income and resources the same as those of the primary applicant? ☐ Yes ☐ No **If no, please give details:** ____________

____

Do you have a Legal Guardian (For minor, parent info)? ☐No ☐Yes **If yes, who is your guardian?**
Name: ____ **Phone #:** ____

Is insurance the same as the primary applicant's? ☐ **Yes** ☐ No **If no, please provide insurance information:**

____

Have you applied for Social Security/SSI/SSDI? Date __________ **Have you applied for Medicaid/Hawki? Date:** __________

Disability Group: (If known)
☐Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Current Mental Health Agency (if applicable): ____

Other Service Providers: ____

What service(s) are you applying for? **Provider name (if known)**

______________________________________ ______________________________________
______________________________________ ______________________________________

Additional Family Member 3:

First Name: ______________________ **MI:** ________ **Last Name:** ________________________

Preferred Name: ____________________________ **Maiden/Previous Name:** ___________________________

Date of Birth: ____________ **SSN#:** ____________________ **E-Mail Address**____________________________

Sex: ☐Male ☐Female ☐ Other **US Citizen:** ☐Yes ☐No **If not a citizen, are you in the country legally?** ☐Yes ☐No

Race: ☐ American Indian ☐Asian/Pacific Islander ☐Black/African American ☐White ☐Other ________ ☐ Unknown

Marital Status: ☐Single ☐ Married ☐Divorced ☐Separated ☐Widowed **Primary Language:** ________________

Legal Status: ☐Voluntary ☐Involuntary-Civil (Mental Health Commitment) ☐Involuntary-Criminal

Primary Phone: ____________________ **Secondary:** ____________________ **May we leave a message?** ☐Yes ☐No

Are income and resources the same as those of the primary applicant? ☐ Yes ☐ No **If no, please give details:** __________

____

Do you have a Legal Guardian (For minor, parent info)? ☐No ☐Yes **If yes, who is your guardian?**
Name: ________________________________ **Phone #:** ____________________________________

Is insurance the same as the primary applicant's? ☐ **Yes** ☐ No **If no, please provide insurance information:**

____

Have you applied for Social Security/SSI/SSDI? Date __________ **Have you applied for Medicaid/Hawki? Date:** __________

Disability Group: (If known)
☐Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Current Mental Health Agency (if applicable): ____

Other Service Providers: ____

What service(s) are you applying for? **Provider name (if known)**

______________________________________ ______________________________________
______________________________________ ______________________________________

Mental Health/Disability Services of the East Central Region Application Checklist

What do I include with my application?

- Completed and signed application. The third and fourth pages are only used if you are applying for funding for more than one individual in the household.
- The last two months of bank statements you and your spouse/significant other received (for adults only). If you receive SSI/SSDI on a Direct Express Card, you can obtain your recent account activity at www.usdirectexpress.com or by calling 1-888-741-1115.
- Copies of paystubs or proof of income for the last two months for you and all members of your household
  - For adults (18 and over): includes the individual, the individual's spouse or domestic partner, and any children, step-children, or wards under the age of 18 who reside with the individual.
  - For children (under 18): includes the individual, the individual's parents (or parent and domestic partner), stepparents or guardians, and any children, step children, or wards under the age of 18 of the individual's parents (or parent and domestic partner), stepparents, or guardians who reside with the individual.
- A copy of your visa or green card if you are not a citizen of the US.
- A signed Release of Information for each agency for which you would like funding and any other agency or person you would like us to be able to get information from or give information to.
  - Please fill in your name and demographic information as well as the provider/individual's name and address.
  - You must use a separate release for each individual/provider. If you need additional releases, please make copies of the release or request releases from one of the county offices listed below.
  - Make sure you sign the release above first dark line. If you would like substance abuse or information regarding AIDS released, please check the applicable box and sign this section also.
  - Please do not sign a blank Release of Information since it cannot be used.
- A signed Copy of the "Authorization for the Use or Disclosure of Confidential Information" (ISAC Multi-Party ROI) form so the region can obtain or release information with other regions and counties if needed to determine eligibility or approve services.

For Adults: An approved application is sufficient for outpatient mental health services. Other services require proof of a qualifying diagnosis and an assessment of needs (see MHDS of ECR Management Plan). You will be asked to provide this information or sign a release for the provider who can supply the information.

For Children: An approved application is sufficient for an evaluation. Additional outpatient mental health services require proof of a qualifying diagnosis of serious emotional disturbance.

What are some hints to make sure my application is complete?

- Please remember to write down the services you are requesting and the provider you wish to use. If you do not know who you want for an outpatient mental health provider, call the intake office at 319-892-5671 and they will provide options.
- Please do not leave questions blank. If they are not applicable (N/A) or $0, please indicate this.
- List all income, before taxes, that was received by you or your spouse/significant other. This would include child support, alimony, disability benefits, unemployment insurance or other benefits. Do not include employment income for minors.
- List child support that you or your significant other pay and provide documentation of the payment for the past two months.
- Be sure to list the name of any medical insurance company and policy number that you may have, including Medicare and Medicaid/Title 19/MCO.

Where do I send my application when it is complete?

- E-mail: intake@ecriowa.us (please send via secure e-mail)
- Fax: 319-892-5679
- Mail: MHDS of the ECR
  1240 26th Ave Court SW
  Cedar Rapids, IA 52404

Revised 7/20