

WASHINGTON COUNTY CENTRAL POINT OF COORDINATION

Application Update Form

Date: _____ Date Received by CPC Office: _____

If completed by agency, name of agency/contact person and contact information: _____

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Birth Date: _____ Sex: Male Female

Current Address: _____
Street City State Zip County

Phone #: _____ Legal Settlement County: _____

Has any Guardian/Payee/Conservator information changed since initial application or last update form: Yes No

If yes, please provide new information including names, addresses, and phone contact information: _____

Veteran Status: Yes No Branch & Type of Discharge: _____ Dates: _____

Marital Status: Single Married Divorced Separated Widowed

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

Living Arrangement: Alone With relatives With unrelated persons **Note:** Please explain if living arrangement has changed since last application or update form: _____

Others in Household:

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

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): _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

<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"/> Medically Needy
Company Name _____	
Address _____	
Policy Number: _____	
<small>(or Medicaid/Title 19 or Medicare Claim Number)</small>	

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"/> Medically Needy
Company Name _____	
Address _____	
Policy Number _____	
<small>(or Medicaid/Title 19 or Medicare Claim Number)</small>	

Current Employer: _____ Position: _____

Dates of employment: _____ Hourly Wage: _____ Hours worked weekly: _____

Gross Monthly Income (before taxes):
(Check Type & fill in amount)

**Applicant
Amount:**

**Others in Household
Amount:**

<input type="checkbox"/> Food stamps	_____	_____
<input type="checkbox"/> FIP	_____	_____
<input type="checkbox"/> Social Security	_____	_____
<input type="checkbox"/> SSI	_____	_____
<input type="checkbox"/> Veterans Benefits	_____	_____
<input type="checkbox"/> Employment Wages	_____	_____
<input type="checkbox"/> Child Support	_____	_____
<input type="checkbox"/> SSDI	_____	_____
<input type="checkbox"/> Dividends, Interest, Etc	_____	_____
<input type="checkbox"/> Railroad Pension	_____	_____
<input type="checkbox"/> Other	_____	_____
Total Monthly Income:	_____	_____

NOTICE: Proof of income may be required with this update 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"/> Cash	_____	_____
<input type="checkbox"/> Checking Account	_____	_____
<input type="checkbox"/> Savings Account	_____	_____
<input type="checkbox"/> Certificates of Deposit	_____	_____
<input type="checkbox"/> Trust Funds	_____	_____
<input type="checkbox"/> Stocks and Bonds (cash value?)	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins (cash value?).	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
Total Resources:	_____	_____

Motor Vehicles: Yes No Make & Year: _____ Monthly Payment: _____
(include car, truck, motorcycle, etc.) Make & Year: _____ Monthly Payment: _____

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: _____

If known, what specific services including provider of those services are requested: (if applicable)

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

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 CPC staff to check for verification of the information provided including 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 legal settlement. 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