WASHINGTON COUNTY CENTRAL POINT OF COORDINATION
Application Form

Application Date: ________________ **Date Received by CPC Office:** ________________

If agency referral, 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:** ________________

Ethnic Background: ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other ________

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: ________________

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

Current Residential Arrangement: (Check applicable arrangement)

☐Private Residence
☐Foster Care/FLH
☐ICF
☐Homeless/Shelter/Street
☐State Hospital School
☐RCF/MR
☐ICF/PMI
☐ICF/ MR
☐Supported Comm. Living
☐RCF/PMI
☐Correctional Facility
☐Other________________
☐State MHI
☐RCF

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): ________________

Referral Source:

☐Self
☐Family/Friend
☐Targeted Case Management
☐Other Case Management
☐Community Corrections
☐Social Service Agency
☐Other ________

Education:

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

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐ Applicant Pays ☐ Medicaid
☐ Medicare ☐ Private Insurance
☐ No Insurance ☐ Medically Needy

Company Name ______________________________

Address ______________________________
____

Policy Number: ______________________________
(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays 2nd)

☐ Applicant Pays ☐ Medicaid
☐ Medicare ☐ Private Insurance
☐ No Insurance ☐ Medically Needy

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** ________________ ☐ **Foodstamps** ________________
☐ **FIP** ________________ ☐ **Other** ________________ ☐ **Other** ________________

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 ☐ Other ______________________________

Current Employer: ______________________________ **Position:** ______________________________

Dates of employment: ________________ **Hourly Wage:** ________________ **Hours worked weekly:** ______

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

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				
4.				
5.				

Others in Household:

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

Gross Monthly Income (before taxes): (Check Type & fill in amount)	**Applicant Amount:**	**Others in Household Amount:**
☐ Food stamps	________________	________________
☐ FIP	________________	________________
☐ Social Security	________________	________________
☐ SSI	________________	________________
☐ Veterans Benefits	________________	________________
☐ Employment Wages	________________	________________
☐ Child Support	________________	________________
☐ SSDI	________________	________________
☐ Dividends, Interest, Etc	________________	________________
☐ Railroad Pension	________________	________________
☐ Other	________________	________________
Total Monthly Income:	________________	________________

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
☐ 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 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: ____________

____

Why are you here today? What services do you <u>NEED</u>? (this section <u>must</u> be completed as part of this application!)

____

____

____

____

____

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? ____________

____

What is the name and location of you current general physician: ____________
What is the name and location of your current Pharmacy? ____________

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**

Legal Settlement: Legal Settlement is the term used to determine what county will provide funding for requested services. This is determined by a person residing twelve consecutive months (six months for persons considered legally blind) within a county without receiving treatment and/or other support type services for MR/DD/MH/BI/SA and/or Jail or imprisonment. If you do not find one full year at the above address without the above mentioned services please continue until legal settlement can be determined. If someone has received services since the age of majority they will be granted the legal settlement determination of their parents/guardians. Please complete this form to its entirety as much as possible. If you need more space, you may copy this sheet and/or use another sheet of paper.

***Are you considered legally blind?** ☐Yes ☐No **If yes, when was this determined?** ______________________________

*____
Current Address **City** **State** **County**
Dates of Residency at this address: _____________to ___________
Services (MH/MR/DD/SA) while at this address:
Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Legal Settlement Determined?
☐**Yes, County of Legal Settlement:** ____________
☐**No, Please Continue below**

*____
Previous Address **City** **State** **County**
Dates of Residency at this address: _____________to ___________
Services (MH/MR/DD/SA) while at this address:
Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Legal Settlement Determined? ☐**Yes, County of Legal Settlement:** _____________
☐**No, Please Continue.**

*____
Previous Address **City** **State** **County**
Dates of Residency at this address: _____________to ___________
Services (MH/MR/DD/SA) while at this address:
Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________

Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Legal Settlement Determined? ☐**Yes, County of Legal Settlement:** ____________
☐**No, Please Continue below**

*____
Previous Address **City** **State** **County**
Dates of Residency at this address: _____________to ___________
Services (MH/MR/DD/SA) while at this address:
Type of Service: ____
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Type of Service: ___________________________________
Agency/Location of Service: ____
Dates of Service: ____________________to __________________
Legal Settlement Determined? ☐**Yes, County of Legal Settlement:** _____________
☐**No, Please Continue on additional sheets of paper as needed**

I hereby attest that the legal settlement information I have provided is true and accurate 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 regarding legal settlement is for the use of the County in establishing my ability to pay for services requested. I also 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**

Contact Person: (including Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc.)**:**

Name: ______________________________ Relationship: ______________________

Address: ____________________________ Phone: ___________________________

Other Interested person(s):

Name: ______________________________ Relationship: ______________________

Address: ____________________________ Phone: ___________________________

NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR CPC USE ONLY

Unique ID#:__________________________ Date Contacted: ______________________

Disability Group-DX Type: ☐MI ☐CMI ☐MR ☐DD ☐SA ☐OTHER

Legal Settlement: ______________________________ (Attach Legal Settlement 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:

☐Over income guidelines

☐Does not meet diagnostic criteria

☐Does Not meet service plan criteria

☐Does not meet plan criteria

☐Other county of legal settlement _______________

☐Applicant desires to stop process

☐Other_____________________________________

Other referrals given (DHS, TCM, etc.): ____

County Co-payment amount/terms (if applicable): ____________________________________

CPC staff making determination & Date: ____

Comments: ____