

LOUISA COUNTY COMMUNITY SERVICES

Application Form

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

Last Name: _____ **First Name:** _____ **MI:** _____

Phone #: _____ **Birth Date:** _____ **SSN#** _____ **State ID#** _____

Current Address: _____
Street City State Zip County

Sex: Male Female **Ethnic Background:** White African American Native American Asian Hispanic Other _____

Guardian/Conservator appointed by the Court? Yes No

Protective Payee Appointed by Social Security? Yes No

<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Protective Payee (Please check those that apply & write in name, address etc.) Name: _____ Address: _____ Phone: _____
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<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Protective Payee <input type="checkbox"/> Conservator (Please check that apply & write in name, address etc.) Name: _____ Address: _____ Phone: _____
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Veteran Status: Yes No **Branch & Type of Discharge:** _____ **Dates of Service:** _____

Marital Status: Never married Married Divorced Separated Widowed

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

Are you here in the U.S. legally? Yes No **Living Arrangement:** Alone With relatives With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

<input type="checkbox"/> Private Residence	<input type="checkbox"/> State Resource Center	<input type="checkbox"/> Supported Comm. Living	<input type="checkbox"/> State MHI
<input type="checkbox"/> Foster Care/Family Life Home	<input type="checkbox"/> RCF/MR	<input type="checkbox"/> RCF/PMI	<input type="checkbox"/> RCF
<input type="checkbox"/> ICF	<input type="checkbox"/> ICF/PMI	<input type="checkbox"/> Correctional Facility	
<input type="checkbox"/> Homeless/Shelter/Street	<input type="checkbox"/> ICF/ MR	<input type="checkbox"/> Other _____	

Disability Group/Primary Diagnosis:

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:** _____

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

Referral Source:

<input type="checkbox"/> Self	<input type="checkbox"/> Community Corrections
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Social Service Agency
<input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other Case Management	

Education:

Years of Education: _____
GED: <input type="checkbox"/> Yes <input type="checkbox"/> No
H.S. Diploma: <input type="checkbox"/> Yes <input type="checkbox"/> No
College Degree: _____

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

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"/> Volunteer	<input type="checkbox"/> 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.				

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:?

<input type="checkbox"/> Social Security _____	<input type="checkbox"/> SSDI _____	<input type="checkbox"/> Medicare _____
<input type="checkbox"/> SSI _____	<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> DHS Food Assistance: _____
<input type="checkbox"/> Veterans _____	<input type="checkbox"/> Unemployment _____	
<input type="checkbox"/> FIP _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

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"/> Family Planning only
<input type="checkbox"/> Medicare A,B D	<input type="checkbox"/> Medically Needy	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number: _____		
(or Medicaid/Title 19 or Medicare Claim Number)		

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid-	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A,B, D	<input type="checkbox"/> Medically Needy	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number _____		
(or Medicaid/Title 19 or Medicare Claim Number)		

What is the name and location of your current general physician: _____

What is the name and location of your current Pharmacy? _____

Others in Household:

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

*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 _____

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Agency/Location of Service: _____

Dates of Service: _____ to _____

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____

Louisa County Community Services

DOB:

Member #:

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: _____

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 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 an Iowa 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 _____

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): _____

Comments: _____

CPC staff making determination & Date: _____

Louisa County Community Services

DOB:

Member #: