

Application for MH/DD Services



CICS
Supporting Individuals. Strengthening Communities.

Application Date: _____ Date Received by Office: _____ CSN ID: _____

First Name: _____ Last Name: _____ MI: _____

Other Names Used: _____ Email: _____ 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

Current Address: _____
Street City State Zip County

When did you move here: _____

I live: ☐ Alone ☐ With Relatives ☐ With Unrelated Persons

Use as current mailing address: ☐ Yes ☐ No If not, _____

Previous Address: _____
Street City State Zip County

When did you move here: _____ End Date: _____

Current Service Providers:

Name

Location

1. _____
2. _____
3. _____

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: _____ to _____

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 previous):

Employer	City, State	Job Title	Duties	To/From

Education: How many years of education have you achieved? _____

What is your education level: ☐ Current Student ☐ Special Education ☐ GED ☐ High School Diploma
☐ Degree _____

Emergency Contact Person:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Guardian/Conservator appointed by the Court: ☐ 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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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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List All People In Household:

Name	Birth Date	Relationship	Social Security Number

Gross Monthly Income (before taxes): (Check type & fill in amount)	Applicant Amount:	Others in Household Amount:
<input type="checkbox"/> Social Security	_____	_____
<input type="checkbox"/> SSDI	_____	_____
<input type="checkbox"/> SSI	_____	_____
<input type="checkbox"/> Veteran's Benefits	_____	_____
<input type="checkbox"/> Employment Wages	_____	_____
<input type="checkbox"/> FIP	_____	_____
<input type="checkbox"/> Child Support	_____	_____
<input type="checkbox"/> Rental Income	_____	_____
<input type="checkbox"/> Dividends, Interest, etc.	_____	_____
<input type="checkbox"/> Pension	_____	_____
<input type="checkbox"/> Other _____	_____	_____
Total Monthly Income:	_____	_____

Household Resources: (Check type and fill in amount and location)	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 Insurance (cash value?)	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
Total Resources:	_____	

Motor Vehicles: <input type="checkbox"/> Yes <input type="checkbox"/> No	Make & Year: _____	Estimated value: _____
(include car, truck, motorcycle, boat, recreational vehicle, etc.)	Make & Year: _____	Estimated value: _____
	Make & Year: _____	Estimated value: _____

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!

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

House, including the one you live in:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other real estate or land:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Iowa Health and Wellness
<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)		
Start Date _____		Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spend down _____		Deductible _____

Secondary Carrier (pays 2nd)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Iowa Health and Wellness
<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)		
Start Date _____		Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spend down _____		Deductible _____

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 Case Management	<input type="checkbox"/> Other _____	

Have you applied for any of the public programs listed below? Has your application been Approved or Denied? (Please indicate those you have applied for and the status of your referral)

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

Disability Group/Primary Diagnosis (if known):

☐ Mental Illness ☐ Intellectual Disability ☐ Developmental Disability ☐ Substance Abuse ☐ Brain Injury

Specific Diagnosis determined by: _____ Date: _____

Axis I: _____ Dx Code: _____

Axis II: _____ Dx Code: _____

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

I certify that the above information is true and complete to the best of my knowledge, and I authorize regional or county staff to check for verification of the information provided including verification with Iowa regions and county government and the state of Iowa Department of Health and Human Services (HHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the region or county in establishing my ability to pay for services requested, and in ensuring the appropriateness of services requested. I understand that information in this document will remain confidential.

Applicant or Legal Guardian Signature (required) _____ Date _____

Other individual assisting to complete application _____ Date _____