

**Tama County MH/DD Services Funds**  
**Application & Recertification Form**

Recert \_\_\_\_\_

New \_\_\_\_\_

**Application Date:** \_\_\_\_\_

**SS#:** \_\_\_\_\_ **State ID#:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Last First MI

**Sex:**  Male  Female **Birth Date:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_ **How Long at this Address:** \_\_\_\_\_

Street/P.O. Box #

City

State

Zip

County

**County of legal settlement:** \_\_\_\_\_

**Ethnic Background** (circle one): 0. Unknown; 1. White; 2. African American; 3. Native American; 4. Asian;  
5. Hispanic; 6. Other;

**Guardian/Payee/Conservator:**

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:**  Yes  No

**Marital Status:** (circle one) 1. Single, never married; 2. Married; 3. Divorced; 4. Separated; 5. Widowed

**Legal Status:** (circle one) 1. Voluntary; 2. Involuntary, civil; 3. Involuntary, criminal

**Living Arrangement:** (circle one) 1. Alone; 2. With relatives; 3. With unrelated individuals

**Residential Arrangement:** (circle applicable)

- |                          |                             |
|--------------------------|-----------------------------|
| 1. Private Residence     | 8. RCF/PMI                  |
| 2. State MHI             | 9. ICF                      |
| 3. State Hospital School | 10. ICF/MR                  |
| 4. Supported Comm Living | 11. ICF/PMI                 |
| 5. Foster Care/FLH       | 12. Correctional Fac.       |
| 6. RCF                   | 13. Homeless/Shelter/Street |
| 7. RCF/MR                | 14. Other                   |

**Applicant's Primary Diagnosis**(specify type)

40 Mental Illness \_\_\_\_\_

41 Chronic Mental Illness \_\_\_\_\_

42 Mental Retardation \_\_\_\_\_

43 Developmental Disability \_\_\_\_\_

Other: Describe: \_\_\_\_\_

**Referral Source:** (circle applicable)

- |                             |                          |
|-----------------------------|--------------------------|
| 1. Self                     | 5. Community Corrections |
| 2. Family/Friend            | 6. Social Service Agency |
| 3. Targeted Case Management | 7. Other _____           |
| 4. Other Case Management    |                          |

**Education:**

Years of education \_\_\_\_\_

GED:  Yes  No

H.S. Diploma:  Yes  No

Degree \_\_\_\_\_

**Current Employment:** (circle applicable)

- |                                     |                               |
|-------------------------------------|-------------------------------|
| 1. Unemployed, available for work   | 8. Sheltered Work Employment  |
| 2. Unemployed, unavailable for work | 9. Supported Employment       |
| 3. Employed, Full time              | 10. Vocational Rehabilitation |
| 4. Employed, Part time              | 11. Seasonally Employed       |
| 5. Retired                          | 12. Armed Forces              |
| 6. Student                          | 13. Homemaker                 |
| 7. Work Activity                    | 14. Other _____               |

**Primary Income Source:** \_\_\_\_\_

**Health Insurance Information:** (Check all that apply)

**Primary Carrier(pays first)**

**Secondary Carrier(pays second)**

Applicant Pays  Title-19  Medicaid  Medicare  
 Private Insurance  No Insurance  Medically Needy

Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Policy Number: \_\_\_\_\_  
(or Medicaid/Title 19 or Medicare Claim Number)

Applicant Pays  Title-19  Medicaid  Medicare  
 Private Insurance  No Insurance  Medically Needy

Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Policy Number: \_\_\_\_\_  
(or Medicaid/Title 19 or Medicare Claim Number)

**Others in Household:**

Name	Relationship	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MONTHLY INCOME:**

(Check type, fill in amount)

- 1. Employment Wages
- 2. Public Assistance
- 3. Social Security
- 4. SSDI
- 5. SSI
- 6. Veterans Benefits
- 7. Railroad Pension
- 8. Child Support
- 9. Dividends, Interest, Etc.
- 10. Other

**Applicant Amount:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other's in Household Amount:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If not currently receiving, has applicant applied for any of the following benefits?**

- 1. Unemployment Compensation
- 2. Social Security Disability
- 3. SSI
- 4. FIP (ADC)

**What is the status of any such application?**

- Approved but not started       Denied       Pending

**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"/> Life Insurance (cash value)	_____	_____
<input type="checkbox"/> Stocks and Bonds	_____	_____
<input type="checkbox"/> Vehicle	Value: _____	Year: _____
<input type="checkbox"/> Real Estate	Value: _____	Location: _____
<input type="checkbox"/> Burial Fund/Trust	_____	_____
<input type="checkbox"/> Other Resources	_____	_____

**Where did you live before you moved to your current address?**

1. Previous Address \_\_\_\_\_  
 Street Address City State Zip Code County  
**When did you live at this address?** \_\_\_/\_\_\_/\_\_\_ **To** \_\_\_/\_\_\_/\_\_\_  
 Month Year Month Year  
**Employer:** \_\_\_\_\_ **Job:** \_\_\_\_\_ **Dates:** \_\_\_\_\_  
**Did you receive mental health or substance abuse services while at this address?** [ ] Yes [ ] No  
 Agency Name Address  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Where did you live prior to the above listed address?**

Previous Address: \_\_\_\_\_ Dates (Month and Year) \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_

**List any previous services such as hospitalization, group homes, mental health center, social service, etc. Use separate sheet if necessary.**

\_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_

**Current Case Manager or Social Worker** \_\_\_\_\_

Agency	Address	Phone
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<b>SERVICES BEING REQUESTED:</b> (Based on ICP or Treatment Plan)					
[ ] HCBS-SCL	[ ] ICF/MR	[ ] RCF	[ ] RCF/MR	[ ] RCF/PMI	[ ] SCL
[ ] HCBS-Resp.	[ ] Voc. SW	[ ] Voc. WAC	[ ] Voc. ADC	[ ] Voc. SE	[ ] Voc. Other
[ ] HCBS-HVM	[ ] CSP	[ ] ADT	[ ] Evaluation	[ ] Therapy/Treatment	[ ] Psych Rehab
[ ] HCBS-Voc.	[ ] Med. Mgm.	[ ] MHI	[ ] Commitment	[ ] Case Management	
[ ] HCBS-Other	[ ] Rent Subsidy	[ ] Transp.	[ ] Respite	[ ] Protective Payee	
[ ] Pers. Allow.	[ ] Medical	[ ] Other: Describe: _____			

**Specify Services Requested:**

1. Type of Service \_\_\_\_\_ Agency \_\_\_\_\_  
Units requested \_\_\_\_\_ Unit = hour day month other (circle one)  
Expected Unit Cost \_\_\_\_\_ COA # \_\_\_\_\_  
Expected **Start** Date \_\_\_\_\_ Expected **End** Date \_\_\_\_\_

**EXPECTED OUTCOMES:** Describe what you expect to happen as a result of this service. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Type of Service \_\_\_\_\_ Agency \_\_\_\_\_  
Units requested \_\_\_\_\_ Unit = hour day month other (circle one)  
Expected Unit Cost \_\_\_\_\_ COA # \_\_\_\_\_  
Expected **Start** Date \_\_\_\_\_ Expected **End** Date \_\_\_\_\_

**EXPECTED OUTCOMES:** Describe what you expect to happen as a result of this service. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Type of Service \_\_\_\_\_ Agency \_\_\_\_\_  
Units requested \_\_\_\_\_ Unit = hour day month other (circle one)  
Expected Unit Cost \_\_\_\_\_ COA # \_\_\_\_\_  
Expected **Start** Date \_\_\_\_\_ Expected **End** Date \_\_\_\_\_

**EXPECTED OUTCOMES:** Describe what you expect to happen as a result of this service. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Person Completing the Form** (if not applicant)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

[ ] Yes [ ] No My social security number can be used by the CPC as my identification number.

**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. 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

**For CPC Use Only:**

Legal Settlement/Financial Decision: \_\_\_\_\_ Date: \_\_\_\_\_ Reason for Denial: \_\_\_\_\_  
Program Decision: \_\_\_\_\_ Date: \_\_\_\_\_ Reason for Denial: \_\_\_\_\_