

Lee County Central Point of Coordination Application

Return Application Requested By: _____ HIPPA Yes ___NO___

Date of Application: ____/____/____ **Phone:** #(____)-____-____

Name of Applicant: _____
Last First M.I.

Current Address: _____

City State Zip County

Social Security # ____-____-____ **Birth Date:** ____/____/____

Sex: Male _____ Female _____

Parent Name (If applicant is under 18)

Name Address

Ethnicity:

- 1) White, not Hispanic _____
- 2) African American _____
- 3) Native American _____
- 4) Asian or Pacific Islander _____
- 5) Hispanic _____
- 6) Other (Biracial, Indochinese etc.) _____

Guardian:(name) _____ **Conservator:(name)** _____

Payee:(name) _____

Veterans of US Armed Forces:

Yes _____ No _____

Marital Status:

- 1) Single, never married _____
- 2) Married _____
- 3) Divorced _____
- 4) Separated _____
- 5)Widowed _____

Legal Status:

Voluntary: _____ Involuntary, Civil Commit: _____
Involuntary, Criminal Commit: _____

Applicant's Living Arrangement:

- 1) Lives alone _____
- 2) Lives with relatives _____
- 3) Lives with persons unrelated to applicant _____

Disability Group (primary diagnosis): Mental Illness _____
Chronic Mental Illness _____ Mental Retardation _____
Developmental Disabilities _____ Other _____

Referred By:

- 1) Self _____ 2) Family Member _____ 3) Case Management _____
4) Community Corrections _____ 5) Social Services other than Case Management _____
6) Other _____

Years of Education: (High School or GED) _____ College Years Completed: _____

Health Insurance: (Indicate all that apply)

- 1) Insured by Employer _____ 2) Other Private Insurance _____
Name of Insurance Provider _____
3) Medicare _____
4) Medicaid _____ Medicaid (Title XIX)# _____
5) No Insurance _____ 6) Other (explain) _____

Current Employment Status: Employer: _____

Unemployed, available for work _____	Student _____
Unemployed, unavailable for work _____	Work Activity Employment _____
Employed, full time _____	Sheltered Work Employment _____
Employed, part time _____	Vocational Rehabilitation _____
Retired _____	Armed Forces _____
Homemaker _____	

Primary Income Source:

Family and Friends _____
Private Relief Agency _____
SSDI _____
SSI _____
SS _____
Pension _____
Food Stamps _____
Veterans Benefits _____
Workers Comp. _____
General Assistance _____
FIP _____

Do You Rent Your Home: Yes _____ No _____

Do You Own Your Home: Yes _____ No _____

Number of Persons Residing In Your Household:

Adults: _____ **Persons Under 18:** _____ **Household Total:** _____

Names of Persons Residing In Your Household, Including Yourself:

Name: _____ **Relationship:** _____

Monthly Gross Income for the Household:

Public Assistance \$ _____ Social Security \$ _____ V.A. Benefits \$ _____

S.S.I. \$ _____ Employment Wages Per Hour \$ _____

Number of Hours Worked Each Week _____

Total Monthly Wage \$ _____

Child Support \$ _____

S.S. D. I. \$ _____ Dividend Interest \$ _____

Other Income \$ _____ Income Description _____

Total Monthly Income \$ _____

Resources:

Cash on Hand \$ _____ Checking \$ _____ Savings \$ _____

Time Certificates \$ _____ Trust Funds \$ _____ Stocks/Bonds \$ _____

Other Resources \$ _____ Resource Description _____

Other Resources \$ _____ Resource Description _____

Total Resources \$ _____

Do you have a Case Manager: No _____ Yes _____ Name _____

Do you have an Income Maintenance Worker: No _____ Yes _____ Name _____

Who is your Beneficiary: _____

Address: _____ Phone: _____

Do you have life insurance or pre-burial arrangements paid: Yes _____ No _____

Have you applied for Social Security Disability: Yes _____ No _____

Employment History:

Employer	Employer's City	Job Duties	From Month	Year	To Month	Year

Legal Settlement:

Note: List all previous addresses up to the point where you lived at an address for three hundred and sixty five days consecutively without receiving any services for mental illness, mental retardation and/or developmental disabilities. Use addition paper if needed.

Please list where you have lived in the past, **begin with your current address.**

Current Address: _____ City _____ State _____

What dates have you lived at this address? From: _____ To: _____

Did you receive treatment or support services for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes ____ No ____

(If yes) What were the dates? From: _____ To: _____

Where were services provided: _____

Previous Address: _____ City _____ State _____

What dates did you live at this address? From: _____ To: _____

Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes ____ No ____

(If yes) What were the dates? From: _____ To: _____

Who provided your service(s): _____

Previous Address: _____ City _____ State _____

What dates did you live at this address? From: _____ To: _____

Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes ____ No ____

(If yes) What were the dates? From: _____ To: _____

Who provided your service(s): _____

Previous Address: _____ City _____ State _____

What dates did you live at this address? From: _____ To: _____

Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes _____ No _____

(If yes) What were the dates? From: _____ To: _____

Who provided your service(s): _____

Signature: I hereby state that the above information is accurate to the best of my knowledge. I understand that I may be liable for the full cost of services provided to me, which were paid based on inaccurate information, which I may have supplied.

Release: I hereby authorize the Lee County Central Point of Coordination Office designee to request any and all information to verify the application data. The applicant has a right to appeal the decision of the Central Point of Coordination Office by writing a letter requesting an appeal within 30 days of the issuance of the notice of decision concerning that action. The appeal form may be obtained from the Central Point of Coordination Office, P.O. Box 190 Fort Madison, Iowa. We will consider this application without regard to race, color, sex, age, handicap, religion, national origin or political belief.

Consumer/Guardian Signature: _____ **Date:** _____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Signature of Individual

Date

In the event this request is made by the individual's personal representative:

Signature of
Personal Representative

Legal Authority of
Personal Representative

Date

Approved: _____ Denied: _____ Pending: _____

Approved As: **Lee County Settlement** _____
 State Case Funding _____
 County of Residence _____

(Lee County settlement does not guarantee funding approval.)

Primary Diagnosis: MI _____ CMI _____ MR _____ DD _____

If denied, reason for this denial is:

No Legal Settlement	_____	Income Over Guidelines	_____
Other Insurance Coverage	_____	Resources Over Guideline	_____
Other	_____	Legal Settlement In Other County	_____

Explanation: _____

County C.P.C. Office Fiscally Responsible: _____

Authorization: _____ Date: _____

Lee County Central Point of Coordination Office

P.O. Box 190, Fort Madison, IA 52627

(319)-372-5681 or (319)-376-0042

Fax: (319)-372-8921
