SOUTHEAST IOWA LINK
MENTAL HEALTH DISABILITY SERVICES
Application Form

Application Date: _____ **Date Received by local MHDS Office:**_____
Agency/contact person completing this form, including contact information: _____

First Name: _____ **Middle Name:**_____ **Last Name:**_____ **Maiden:**_____

Prefix: ☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms. ☐Prof. **Suffix:** ☐D.D. ☐Esq. ☐I ☐II ☐III ☐Jr. ☐MD ☐PhD ☐Sr.

SSN#: _____ **US Citizen:** ☐Yes ☐No **Date of Birth**: _____ **Gender:** ☐Female ☐Male

Veteran Status: ☐Yes ☐No **Military Branch and Type of Discharge:** _____ **Dates:** _____

Marital Status: ☐Single ☐Married(includes common law) ☐Divorced ☐Separated ☐Widowed

Race: ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Asian or Pacific Islander
☐Other (biracial; Sudanese; etc.) _____ ☐Unknown

Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino

Primary Language: ☐English ☐Spanish ☐French ☐German ☐Vietnamese ☐Other: _____

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

State ID #: _____ **Legal Issues:** ☐Yes ☐No If yes, please specify: _____

Blind Determination: ☐Yes ☐No **Determination Date:** _____

Home Phone:_____ **Work/Other Phone:** _____ **Cell Phone:** _____ **Email:** _____

Current Address: _____
Street City State Zip County

Dates of Residency at this address: _____**to** _____ **# Roommates:**_____

Current Residential Arrangement: (Check applicable arrangement)

☐ **Private Residence/Household – Alone** ☐ **Private Residence/Household – With Relatives**
☐ **Private Residence/Household – With Unrelated Persons** ☐ **Foster Care/Family Life Home**
☐ **Correctional Facility** ☐ **Substance-Related Treatment Facility** ☐ **24-Hour Habilitation Home**
☐ **24-Hour Supported Community Living Home** ☐ **Residential Care Facility(RCF)** ☐ **RCF/ID** ☐ **RCF/PMI**
☐ **Intermediate Care Facility(ICF)/Nursing Home** ☐ **ICF/ID** ☐ **State MHI** ☐ **State Resource Center**
☐ **Homeless/Shelter/Street** ☐ **Other: Explain**_____

Mailing Address: ☐ Same ☐ Other: _____
Street City State Zip County

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 _____	

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

Employer	Position	Phone	City, State	Start/End Date	Hrs.	Hrly Wage
1.						
2.						
3.						
4.						

Education:

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

Interested Persons/Emergency Contact:

Name:_____
Relationship: _____ Phone: _____

Name:_____
Relationship: _____ Phone: _____

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: _____

Others in Household:

First Name and Last Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		

Gross Monthly Income (before taxes): (Check type & fill in amount)	**Applicant Amount:**	**Others in Household Amount:**
☐Veterans Benefits	_____	_____
☐Social Security/SSDI	_____	_____
☐SSI	_____	_____
☐Employment Wages	_____	_____
☐Workers Comp	_____	_____
☐Public or General Assistance	_____	_____
☐Private Relief Agency	_____	_____
☐Food Assistance	_____	_____
☐Family and Friends	_____	_____
☐Child Support	_____	_____
☐FIP	_____	_____
☐R/R Pension	_____	_____
☐Other (Unemployment, etc)	_____	_____
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**
☐Savings	_____	_____
☐Checking Account	_____	_____
☐Cash on Hand	_____	_____
☐Time Certificates	_____	_____
☐Burial Fund/Plot/Life Ins(cash value)	_____	_____
☐CDs (cash value)	_____	_____
☐Stocks/Bonds(cash value)	_____	_____
☐Dividend Interest(cash value)	_____	_____
☐Trust Funds	_____	_____
☐Retirement Funds(cash value)	_____	_____
☐Other_____	_____	_____
Total Resources:	_____	

Motor Vehicles: ☐Yes ☐No Make, Model & Year: _____ Value: _____
(include car, truck, motorcycle, etc.) Make, Model & Year: _____ Value: _____

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: _____
_____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐Applicant Pays ☐Medicaid
☐Medicare ☐Private Insurance
☐No Insurance ☐Marketplace Choice

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 ☐Marketplace Choice

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**_____ ☐**Food Assistance**_____
☐**FIP** _____ ☐**Other**_____ ☐**Other**_____

Disability Group/Primary Diagnosis:
☐40-Mental Illness ☐42-Intellectual Disability ☐43-Developmental Disability ☐47-Brain Injury ☐35-Substance Abuse

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): _____

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? _____
_____

Allergies: _____

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

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
Service Requested	Provider (if known)	Rate/Unit	Effective Date

Referral Source:

☐Self ☐Community Corrections ☐Family/Friend(s) ☐Social Service Agency ☐Targeted Case Management
☐ IHH Care Coordinator ☐Hospital ☐Physician ☐RCF/ICF ☐Other _____

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 regional and/or local MHDS staff to check for verification of the information provided including, but not limited to, 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 regional and/or local MHDS in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming residency. I understand that information in this document will remain confidential.

Applicant's Signature (or Legal Guardian) **Date**

HIPAA Notice of Privacy Practice Provided: ☐Yes ☐No **Applicant's Signature:** _____

SEIL Individual Safety Card Provided: ☐Yes ☐No **Applicant's Signature:** _____

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

Unique ID#:_____ Date Contacted: _____

Disability Group-DX Type: ☐MI ☐ID ☐DD ☐BI ☐SA
Residency: _____ (Attach Residency 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/resource guidelines
☐Does not meet diagnostic criteria
☐Does not meet plan criteria
☐Assessment does not meet criteria
☐Other county of residence _____
☐Applicant desires to stop process
☐Other _____

Other referrals given (DHS, TCM, IHH, etc.): _____

MHDS staff making determination & date: _____

Comments: _____