

WARREN COUNTY CENTRAL POINT OF COORDINATION APPLICATION FORM

Application Date: _____

SS #: _____

Name: _____
Last First MI

Sex: Male Female

Birth Date: _____

Current Address: _____
Street City State Zip County

Phone #: () _____

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: Yes No

Are you blind ? 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: _____

Veteran: Yes; No

Marital Status: (Check applicable status) 1. Single 2. Married 3. Divorced 4. Separated 5. Widowed

Legal Status: (Check applicable status) 1. Voluntary 2. Involuntary, Civil 3. Involuntary, Criminal

Living Arrangement: (Check applicable arrangement) 1. Alone 2. With Relatives 3. With Unrelated Individuals

Residential Arrangement: (Check applicable arrangement)

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

Disability Group/Primary Diagnosis: (Check applicable diagnosis)

40. Mental Illness 41. Chronic Mental Illness 42. Mental Retardation 43. Developmental Disability 44. Other

Diagnosis: Axis I _____
 Axis II _____
 Axis III _____
 Axis IV _____
 Axis V _____

Referral Source: (Circle applicable)

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

Education:

Years of Education: _____

GED Yes No

H.S. Diploma Yes No

Degree: _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays first)

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

Company Name _____

Address _____

Policy Number: _____

(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays second)

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

Company Name _____

Address _____

Policy Number _____

(or Medicaid/Title 19 or Medicare Claim Number)

Current Employment: (Check applicable employment)

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

Employer: _____

Position: _____

Others in Household:

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

Monthly Income:

(Check Type, Fill in amount)

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

Applicant Amount:

Others in Household Amount:

Total Monthly Income

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"/> Stocks and Bonds	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins.	_____	_____
<input type="checkbox"/> Other Resources	_____	_____

Total Resources _____

County Funded Services Being Requested: (Based on Assessment/ICP/Treatment Plan)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> ARO | <input type="checkbox"/> HCBS/HVM | <input type="checkbox"/> MHI | <input type="checkbox"/> RCF/MR |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> HCBS/Other | <input type="checkbox"/> Prescriptions | <input type="checkbox"/> RCF/PMI |
| <input type="checkbox"/> CSALA | <input type="checkbox"/> HCBS/Respite | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> CSP | <input type="checkbox"/> HCBS/SCL | <input type="checkbox"/> Psychological Eval. | <input type="checkbox"/> Voc./ADC |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> HCBS/Vocational | <input type="checkbox"/> Psychological Counseling | <input type="checkbox"/> Voc/SE |
| <input type="checkbox"/> General Assistance | <input type="checkbox"/> ICF/MR | <input type="checkbox"/> RCF | <input type="checkbox"/> Voc/WA |
| <input type="checkbox"/> Other; Describe: _____ | | | |

Services/Provider:

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

Contact Person (Case Manager, Social Worker, IMW, Coordinator, Etc.):

Name: _____ Relationship: _____
 Address: _____ Phone #: _____

Person Completing the Form (if other than applicant)

Name: _____ Relationship: _____
 Address: _____ Phone #: _____

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 _____

**Warren County Central Point of Coordination
Legal Settlement Form**

Instructional Page

Legal Settlement: is obtained once a person continuously resides in an Iowa county for a period of one year (six months if blind) without receiving any mental health, mental retardation, developmental disability, and/or substance abuse services/treatments/hospitalizations. Legal settlement is determined for the purposes of funding of these services upon request for county assistance.

Please complete this form in its entirety to assist Warren County in determining legal settlement and eligibility for funding. If the form is not completed properly the funding for services could be delayed while the county office investigates legal settlement information.

Name: Complete the persons full name (Last, First, Middle or Middle initial)

Date Completed: Today's date

Birth date: Month, day, and year are necessary for processing information

Social Security Number: All correct and current numbers are necessary for proper identification

Address: Full mailing address is preferred however a minimum of information will need to contain city, state, and county.

Dates of Residency: Complete this information to the day if available however an idea of month and year is essential.

Services: List any vocational, residential, hospitalization, and/or outpatient services that have been received for MH/MR/DD/BI/SA while living at the address listed at that time.

Agency/Location of Service: Is of assistance to obtain records and/or dates of services

Dates of Service: List dates as possible, again an idea of month and year is essential

Legal Settlement Determined: If a full year of residency was determined without any MH/MR/DD/BI/SA services list the county of legal settlement. If unable to determine legal settlement at the address listed continue back to the previous address and complete the same information. Continue as far back as needed to find one year in an Iowa county or another state without any MH/MR/DD/BI/SA services being rendered. If the applicant has received services since the age of majority the legal settlement will fall upon the person's parents/guardians legal settlement. The same process is used to determine the parent's legal settlement.

Releases of Information: Please complete a Warren County Release of Information for all **current and past providers** (i.e. hospitals, Community Mental Health Centers, Vocational agencies, Residential agencies, etc.) involved in providing services to the applicant and for the agency where this application is being completed.

Previous Address _____ City _____ State _____ County _____

Dates of Residency: _____ to _____
M/D/Y M/D/Y

Services (MH/MR/DD/SA) while at this address:

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____
M/D/Y M/D/Y

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____
M/D/Y M/D/Y

Legal Settlement Determined? yes County of Legal Settlement: _____
 no Please Continue.

Previous Address _____ City _____ State _____ County _____

Dates of Residency: _____ to _____
M/D/Y M/D/Y

Services (MH/MR/DD/SA) while at this address:

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____
M/D/Y M/D/Y

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____
M/D/Y M/D/Y

Legal Settlement Determined? yes County of Legal Settlement: _____
 no Please Continue.

Previous Address _____ City _____ State _____ County _____

Dates of Residency: _____ to _____
M/D/Y M/D/Y

Services (MH/MR/DD/SA) while at this address:

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____
M/D/Y M/D/Y

Type of Service: _____

Agency/Location of Service: _____

Dates of Service: _____ to _____
M/D/Y M/D/Y

Legal Settlement Determined? yes County of Legal Settlement: _____
 no Please Continue.

**Attach additional sheets as necessary to document county of legal settlement.*