



**Counties Served:**  
 Boone Poweshiek  
 Franklin Story  
 Hamilton Warren  
 Hardin  
 Jasper  
 Madison  
 Marshall

Hamilton County Office  
 500 Fairmeadow Drive  
 Webster City, Iowa 50595  
 Phone: 515-832-9550  
 Fax: 515-832-9554

# Application for MH/DD Services

Application Date: \_\_\_\_\_ Date Received by Office: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Nickname: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ 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: \_\_\_\_\_

**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
1.					
2.					
3.					

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

Protective Payee Appointed by Social Security?  Yes  No

Legal Guardian  Conservator  Protective Payee  
 (Please check those that apply & write in name, address etc.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Legal Guardian  Conservator  Protective Payee  
 (Please check those that apply & write in name, address etc.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**List All People In Household:**

	Name	Birth Date	Relationship	Social Security Number
1.				
2.				
3.				
4.				
5.				

**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!)

\_\_\_\_\_

\_\_\_\_\_

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	_____	_____
<b>Total Monthly Income:</b>	_____	_____

**Household Resources:** (Check and fill in amount and location):

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 (cash value?)	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins (cash value?)	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<b>Total Resources:</b>	_____	

**Motor Vehicles:**  Yes  No  
 (include car, truck, motorcycle, boat, recreational vehicle, etc.)

Make & Year: _____	Estimated value: _____
Make & Year: _____	Estimated value: _____
Make & Year: _____	Estimated value: _____

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

House including the one you live in?  Yes  No Any other real estate or land?  Yes  No Other? \_\_\_\_\_  Yes  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 1<sup>st</sup>)**

**Secondary Carrier (pays 2<sup>nd</sup>)**

<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"/> MEPS
<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: _____		

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

**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"/> SSDI _____	<input type="checkbox"/> Medicare _____
<input type="checkbox"/> SSI _____	<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> DHS 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 Dept. of Human Services (DHS) 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's Signature (or Legal Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Signature of other completing form if not Applicant or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_