Northwest Iowa Care Connections

Application Form

For individuals living in: Clay, Dickinson, Lyon, O'Brien, Osceola, and Palo Alto Counties

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# _____ **State ID:** _____

Marital Status: ☒Never married ☒Married ☒Divorced ☒Separated ☒Widowed

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

Are you considered legally blind? ☒Yes ☒No If yes, when was this determined?

Primary Phone#: _____ May we leave a message? ☒Yes ☒No

Current Residence:

_____

Street City State Zip County

Date you moved here: _____ Reside: **:** ☒ Alone ☒ With Relatives ☒ Unrelated Persons

County of Residence: _____

Current Service Providers:

	Name:	**Location:**
1.		
2.		
3.		

Use as current Mailing Address: ☒Yes ☒No **If not,** _____

Street Address City State County

Current Residential Arrangement: (Check applicable arrangement)

☒Private Residence ☒Supported Comm. Living ☒State MHI ☒Homeless/Shelter/Street
☒Foster Care/Family Life Home ☒RCF ☒Correctional Facility

☒Other_____

Veteran Status: ☒**Yes** ☒**No** **Branch & Type of Discharge:** _____**Dates of Service:** _____

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	☒ Volunteer	☒Other

Current Employer: _____ **Position:** _____

Dates of Employment: _____ **Hourly Wage:** _____ **Hours worked weekly:** _____

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				

Educations: What is the highest level of education you achieved? _____ **# of years** _____ **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 ☒Protective Payee ☒Conservator
(Please check that apply & write in name, address etc.)

Name: _____

Address: _____

Phone: _____

List all People In Household:

Name	Date of Birth	Relationship
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 below, 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:**
☒ Social Security		
☒ SSDI		
☒ SSI		
☒ Veteran's Benefits		
☒ Employment Wages		
☒ FIP		
☒ Child Support		
☒ Rental Income		
☒ Dividends, Interest, Etc		
☒ Pension		
☒ Other		
Total Monthly Income:		

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

Type	Amount	Bank, Trustee, or Company
☒Cash		
☒Checking Account		
☒Savings Account		
☒Certificates of Deposit		
☒Trust Funds		
☒Stocks and Bonds (cash value?)		
☒Burial Fund/Life Ins (cash value?).		
☒Retirement Funds (cash value?)		
☒Other _____		
☒Other_____		
Total Resources:		

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:

☒Yes ☒No House including the one you live in? ☒Yes ☒No Any other real-estate or land? Other_____

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 1st)

☒Applicant Pays ☒Medicaid ☒Family Planning only
☒Medicare A,B D ☒Medically Needy ☒ MEPD
☒No Insurance ☒ Private Insurance ☒ HAWK-I

Company Name _____

Address _____

_____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)

Start Date: _____ Any limits? ☒Yes ☒No
Spend Down: _____ Deductible: _____

Secondary Carrier (pays 2nd)

☒Applicant Pays ☒Medicaid- ☒ Family Planning only
☒Medicare A,B, D ☒ Medically Needy ☒ MEPD
☒No Insurance ☒Private Insurance ☒ HAWK-I

Company Name _____

Address _____

_____

Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)

Start Date: _____ Any limits? ☒Yes ☒No
Spend Down: _____ Deductible: _____

Referral Source:

☒Self ☒Community Corrections ☒Family/Friend ☒Social Service Agency
☒Targeted Case Management ☒Other _____ ☒ Other Case Management

Have you applied for any of the public programs listed below?

(Please check those you have applied for and the status of your referral) Please advise if your application has been Approved or Denied. If you appealed the denial, please advise of the date of appeal _____ Please advise if you have applied for reconsideration. Please advise if you have had a hearing with an Administrative Law Judge and the date of the scheduled hearing:_____

☒**Social Security**_____ ☒**SSDI**_____ ☒**Medicare**_____

☒**SSI** _____ ☒**Medicaid**_____ ☒**DHS Food Assistance:**_____

☒**Veterans** _____ ☒**Unemployment**_____

☒**FIP** _____ ☒**Other**_____ ☒**Other**_____

Disability Group/Primary Diagnosis:

☒Mental Illness ☒Mental Retardation ☒Developmental Disability ☒Substance Abuse ☒Brain Injury

Specific Diagnosis determined by:_____ **Date:**_____
Axis I: _____**Dx Code:** _____
Axis II:_____ **Dx Code:** _____

What is the name and location of your current general physician: _____

What is the name and location of your current Pharmacy? _____

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 Northwest Iowa Care Connections staff to check for verification of the information provided including verification with Iowa county government and the state Iowa Dept. of Human Services (DHS) staff.

I understand that the information gathered in this document is for the use of Northwest Iowa Care Connections in establishing my ability to pay for services requested, and in assuring 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**

All County Access Point Contact Information: (Please contact Dickinson County for all enrollment questions)

Clay County
Kim Wilson
215 West 4th St. Suite #6
Spencer, IA 51301
Phone: 712-262-9438
Fax: 712-262-9016
Email: kwilson@co.clay.ia.us

Dickinson County
Beth Will/Sue Duhn
1802 Hill Ave. Suite 2502
Spirit Lake, IA 51360
Phone: 712-336-0775
Fax: 712-336-4961
Email: bwill@co.dickinson.ia.us
sduhn@co.dickinson.ia.us

Lyon County
Lisa Rockhill
315 1st Ave. Suite 200
Rock Rapids, IA 51246
Phone: 712-472-8420
Fax: 712-472-2261
Email: lrockhill@co.lyon.ia.us

O'Brien County
Janelle Schuknecht
155 S. Hayes Ave., Box 525
Primghar, IA 51245
Phone: 712-957-5985
Fax: 712-957-3206
Email: obgrdcpc@tcaexpress.net

Osceola County
Lisa Rockhill
300 7th St.
Sibley, IA 51249
Phone: 712-754-4209
Fax: 712-754-2549
Email: lrockhill@osceola.org

Palo Alto County
Maureen Sandberg
1010 Broadway, Box 403
Emmetsburg, IA 50536
Phone: 712-852-2832
Fax: 712-852-2404
Email: msandberg@co.palo-alto.ia.us

FOR REGIONAL OFFICE USE ONLY:

☒ Verification of All Household Income
☒ Copies of Guardianship Papers
☒ Releases of Information
☒ HIPAA Signature Form
☒ Psychological Evaluations/Reports
☒ Copies of All Health Insurance Cards