Heart of Iowa Community Services

Funding Application

Application Date: _____

LAST Name: _____ **FIRST Name:** _____ **MI:** _____

Phone #: _____ **Birth Date:** _____ **SSN#:** _____

Current Address: _____
Street City State Zip County

Primary Language: ☐ English ☐ Spanish ☐ Bosnian ☐ Croatian **Sex:** ☐ Male ☐ Female

Ethnic Background: ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Hispanic ☐ Other_____

· **Guardian/Conservator appointed by the Court?** ☐ **Yes** ☐ **No**

· **Protective Payee Appointed by Social Security?** ☐ **Yes** ☐ **No**

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

Name: _____

Address: _____

Phone:

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

Name: _____

Address: _____

Phone:

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

Are you currently on commitment? ☐ Yes ☐ No **If Yes, please explain:** _____

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

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

Are you a US Citizen & residing in the U.S. legally? ☐ Yes ☐ No

Living Arrangement: ☐ Alone ☐ With relatives ☐ With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

☐ Private Residence	☐ State Resource Center	☐ ICF	☐ Supported Comm. Living
☐ Foster Care/Family Life Home	☐ RCF	☐ ICF/ MR	☐ Correctional Facility
☐ Homeless/Shelter/Street	☐ RCF/MR	☐ ICF/PMI	
☐ State MHI	☐ RCF/PMI	☐ Other_____	

Disability Group/Primary Diagnosis:

☐ Mental Illness ☐ Chronic Mental Illness ☐ Intellectual Disability ☐ Developmental Disability ☐ Substance Abuse ☐ Brain Injury

Specific Diagnosis determined by:_____ **Date**:_____

Axis I: _____ **Dx Code:** _____

Axis II:_____ **Dx Code:** _____

If agency referral, name of agency/contact person and contact information: _____

_____

Referral Source:

☐ Self	☐ Community Corrections
☐ Family/Friend	☐ Social Service Agency
☐ Targeted Case Management	☐ Hospital / Physician
☐ Other Case Management	☐ RCF/ICF
☐ Other: _____	

Education:

Years of Education: _____

GED: ☐ Yes ☐ No

H.S. Diploma: ☐ Yes ☐ No

College Degree: _____

Why are you here today? What services do you NEED? (This section **must** be completed as part of this application!)

_____

_____

_____

_____

_____

_____

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:** **Number of Hours worked weekly:**

HAVE YOU APPLIED FOR ANY PUBLIC PROGRAMS listed below?

(Please check those you have applied for and the status of your referral)

Has your application has been ☐ Approved or ☐ Denied. (If you appealed the denial, advise of the date of appeal: _____. Please advise if you have applied for reconsideration. 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_____	

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 ☐ HAWK-I ☐ IA Cares
☐ Private Insurance (list below):

Company Name _____

Address _____

_____

Policy Number: _____

(or Medicaid/Title 19 or Medicare Number)

SECONDARY Carrier (pays 2nd)

☐ Applicant Pays ☐ Medicaid ☐ Family Planning only
☐ Medicare A-B-D ☐ Medically Needy ☐ MEPD
☐ No Insurance ☐ HAWK-I ☐ IA Cares
☐ Private Insurance (list below):

Company Name _____

Address _____

_____

Policy Number: _____

(or Medicaid/Title 19 or Medicare Number)

What is the name and location of your current psychiatrist/therapist: _____

_____

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

OTHERS IN HOUSEHOLD:

Name	*Date of Birth*	*Relationship*
1.		
2.		
3.		
4.		
5.		

THIS APPLICATION WILL NOT BE CONSIDERED UNLESS THE FOLLOWING INFORMATION IS PROVIDED.

NOTICE: Proof of income will be required with this application – a pay-stub(s) or tax-return will be required.

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		
☐ Workers Compensation		
☐ Short-Term Disability		
☐ Annuity Benefits		
☐ Pension/RR Pension		
☐ Other		
Total Monthly Income:		

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 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.)

1. Make & Year:		Estimated value:	
2. Make & Year:		Estimated value:	
3. Make & Year:		Estimated value:	

Do you, your spouse or dependent children own or are buying 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: _____

_____

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?_____

THIS APPLICATION WILL NOT BE CONSIDERED UNLESS THE FOLLOWING INFORMATION IS PROVIDED.

1. _____

CURRENT Address City State County

Dates of Residency at this address (month/year): _____ **to** _____

2. _____

PREVIOUS Address City State County

Dates of Residency at this address (month/year): _____ **to** _____

3. _____

PREVIOUS Address City State County

Dates of Residency at this address (month/year): _____ **to** _____

Contact Person: (Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc.)

Name: _____ Relationship: _____

Address: _____ Phone: _____

Other Interested person(s):

Name: _____ Relationship: _____

Address: _____ Phone: _____

NOTICE: A COPY OF YOUR DRIVER'S LICENSE OR PHOTO ID IS REQUIRED WITH THIS APPLICATION

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 Heart of Iowa Community Services 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 an Iowa County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal residence. 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**