

Bremer County

FUNDING APPLICATION FORM

Application Date: _____

SS #: _____ **State ID# :** _____

Name: _____ **Phone #:** _____
Last First MI

Sex: [] Male [] Female **Birth Date:** _____

Current Address: _____ **How Long at this Address:** _____
Street/P.O. Box #

City _____ State _____ Zip _____ County _____

County of 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:

[] 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: (Circle one) 1. Single, never married; 2 Married; 3. Divorced; 4. Separated; 5. Widowed

Legal Status: (Circle one) 1. Voluntary; 2. Involuntary, civil; 3. Involuntary, criminal

Living Arrangement: (Circle one) 1. Alone; 2. With relatives; 3. With unrelated individuals

Residential Arrangement: (Circle applicable)

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

Applicant's Primary Diagnosis(specify type)

- [] 40 Mental Illness _____
- [] 41 Chronic Mental Illness _____
- [] 42 Mental Retardation _____
- [] 43 Developmental Disability _____
- [] General Assistance _____
- [] Other: Describe: _____

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. DHS
- 8. Other _____

Education:

Years of education _____
H.S. Diploma [] Yes [] No
GED [] Yes [] No
Degree _____

Current Employment: (Circle applicable)

- 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 _____

Primary Income Source: _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays first)

Secondary Carrier (pays second)

Applicant Pays Title-19/Medicaid Medicare
 Private Insurance No Insurance Medically Needy

Company Name _____
Address _____

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

Applicant Pays Title-19/Medicaid Medicare
 Private Insurance No Insurance Medically Needy

Company Name: _____
Address _____

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

Others in Household:

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

Monthly Income:

Applicant Amount:

Others in Household Amount:

(Check Type, Fill in amount)

<input type="checkbox"/> 1. Employment Wages	_____	_____
<input type="checkbox"/> 2. Public Assistance	_____	_____
<input type="checkbox"/> 3. Social Security	_____	_____
<input type="checkbox"/> 4. SSDI	_____	_____
<input type="checkbox"/> 5. SSI	_____	_____
<input type="checkbox"/> 6. Veterans Benefits	_____	_____
<input type="checkbox"/> 7. Railroad Pension	_____	_____
<input type="checkbox"/> 8. Child Support	_____	_____
<input type="checkbox"/> 9. Dividends, Interest, Etc.	_____	_____
<input type="checkbox"/> 10. Other	_____	_____

If not currently receiving, has the applicant applied for any of the following benefits?

1. Unemployment Compensation 2. Social Security Disability 3. SSI
 4. FIP(AFDC) 5 Medicaid/Title 19

What is the status of any such application?

- Approved Approved, but not started Denied Pending

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"/> Life Insurance (cash value)	_____	_____
<input type="checkbox"/> Stocks and Bonds	_____	_____
<input type="checkbox"/> Vehicle Value:	_____	Year: _____
<input type="checkbox"/> Vehicle Value:	_____	Year: _____
<input type="checkbox"/> Real Estate Value:	_____	Year: _____
<input type="checkbox"/> Burial Fund/Trust	_____	_____
<input type="checkbox"/> Other Resources	_____	_____

Where did you live before you moved to your current address?

1. Previous Address _____

Street Address	City	State	Zip Code	County
When did you live at this address? _____		To _____		
	Month	Year	Month	Year
Employer: _____	Job: _____		Dates: _____	
Did you receive mental health or substance abuse services while at this address? [] Yes [] No				
Agency Name	Address			
_____	_____			
_____	_____			
_____	_____			

Where did you live prior to the above listed address?

Previous Address: _____	Dates (Month and Year)
_____	To _____
_____	To _____
_____	To _____
_____	To _____

List any previous services such as hospitalization, group homes, mental health center, social service, etc. Use separate sheet if necessary.

_____	To _____
_____	To _____
_____	To _____
_____	To _____

Current Case Manager or Social Worker _____

Agency	Address	Phone
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Services Being Requested: (based on ICP or Treatment Plan)

[] HCBS/SCL [] ICF/MR [] RCF [] RCF/MR [] RCF/PMI [] SCL

[] HCBS/Resp. [] Voc./SW [] Voc./WAC [] Voc./ ADC [] Voc./SE [] Voc./Other

[] HCBS/HVM [] Psych Rehab [] A Day Care [] Evaluation [] Therapy/Treatment

[] HCBS/Voc. [] Med. Mgm. [] MHI [] Commitment [] Case Management

[] HCBS/Other [] Rent [] Transport [] Respite [] Protective Payee

[] Medication [] Medical [] Other: Describe _____

Specify Services Requested:

1. Type of Service _____ Agency _____
Units requested _____ Unit = hour day month other (circle one)
Expected Unit Cost _____ COA # _____
Expected **Start** Date _____ Expected **End** Date _____

Expected Outcomes: Describe what you expect to happen as a result of this service. _____

2. Type of Service _____ Agency _____
Units requested _____ Unit = hour day month other (circle one)
Expected Unit Cost _____ COA # _____
Expected **Start** Date _____ Expected **End** Date _____

Expected Outcomes: Describe what you expect to happen as a result of this service. _____

3. Type of Service _____ Agency _____
Units requested _____ Unit = hour day month other (circle one)
Expected Unit Cost _____ COA # _____
Expected **Start** Date _____ Expected **End** Date _____

Expected Outcomes: Describe what you expect to happen as a result of this service. _____

Contact:

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

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IF APPLICANT IS A MINOR OR TURNED 18 LESS THAN A YEAR AGO OR WHILE RECEIVING SERVICES, INFORMATION SHOULD BE FILLED IN ON PARENTS