

KEOKUK COUNTY COMMUNITY SERVICES

CENTRAL POINT OF COORDINATION (CPC) APPLICATION

APPLICANT INFORMATION:

TODAY'S DATE: _____

NAME: _____ PHONE: _____
 ADDRESS _____ SOCIAL SECURITY NUMBER: _____
 _____ BIRTHDATE: _____
 COUNTY: _____ GENDER: _____ Female _____ Male STATE ID IF HAVE ONE: _____

ETHNICITY

_____ (0) Unknown; _____ (1) White, not Hispanic _____ (2) African American, not Hispanic _____ (3) American Indian
 _____ (4) Asian or Pacific Islander _____ (5) Hispanic _____ (6) Other (e.g. Biracial, Sudanese, etc.)

LIVING ARRANGEMENT: _____ (1) Lives alone _____ (2) Lives with relatives _____ (3) Lives with person unrelated

RESIDENTIAL ARRANGEMENT

_____ (1) Private residence _____ (2) State MHI _____ (3) State Resource Center _____ (4) CSALA
 _____ (5) Foster Care / Family Life Home _____ (6) RCF _____ (7) RCF / MR _____ (8) RCF / PMI _____ (9) ICF
 _____ (10) ICF/MR _____ (11) ICF / PMI _____ (12) Correctional facility _____ (13) Shelter _____ (14) Other

MARITAL STATUS

_____ (1) Single _____ (2) Married _____ (3) Divorced _____ (4) Separated _____ (5) Widowed

SPOUSE / SIGNIFICANT OTHER NAME: _____ Relationship: _____ Total number in household _____

OTHERS IN HOUSEHOLD (list additional household members on additional paper if more than three)

NAME	RELATIONSHIP	BIRTHDATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEGAL GUARDIAN: _____ (1) Self _____ (2) Other _____ (3) Guardian _____ (4) Conservator _____ (5) Payee

GUARDIAN: _____ ADDRESS: _____ PHONE: _____

EDUCATION: __ Grade school (8) __ High school (12) __ Trade/Technical __ College (16+)

Name of school if currently attending _____ __Full-time OR __Part-time

VETERAN STATUS YES _____ NO _____ Branch: _____ Dates: _____

REFERRED BY: _____ Self _____ Local DHS _____ Public Health Nurse _____ Sheriff/Police _____ Private agency
 _____ Family or Friends _____ Case Manager _____ General Relief _____ Doctor/Clinic

LEGAL STATUS: _____ (1) Voluntary _____ (2) Involuntary, civil commitment _____ (3) Involuntary, criminal commitment

SERVICES CURRENTLY RECEIVING:

Type (Mental Health or Substance Abuse)	Provider	City	From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FINANCIAL INFORMATION – List income for ALL household members and identify who has that income.

Current Monthly Income of ALL Household Members:

Resources for ALL Household Members:

Employment wages (give hours per week and amount paid per hour):	\$ _____
Public Assistance:	\$ _____
Social Security:	\$ _____
Social Security Disability:	\$ _____
SSI:	\$ _____
Veterans benefits:	\$ _____
Railroad pension	\$ _____
Child support:	\$ _____
Dividends / interest:	\$ _____
Other:	\$ _____
TOTAL INCOME:	\$ _____

Cash on hand:	\$ _____
Checking:	\$ _____
Savings:	\$ _____
Stocks / bonds:	\$ _____
CDs:	\$ _____
Trust fund(s):	\$ _____
Property:	\$ _____
Other:	\$ _____
Other:	\$ _____
Other:	\$ _____
TOTAL RESOURCES:	\$ _____

EMPLOYMENT STATUS

- (1) Unemployed, Looking for work
 (2) Unemployed, Not looking for work
 (3) Employed, full-time
 (4) Employed, part-time
 (5) Retired
 (6) Student
 (7) Work activity
 (8) Sheltered work
 (9) Supported employment
 (10) Vocational Rehabilitation
 (11) Other

EMPLOYMENT HISTORY (list from current or most recent to previous) Please use the back of this page to list more employers if needed.

EMPLOYER	CITY, STATE	JOB DUTIES	FROM	TO
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If unemployed, and you have no source of income, please explain how you are managing to live, pay your utilities, buy food, etc: _____

**** You will need to provide proof of income that can include pay stubs, income tax returns, verification statement from employer, etc.

SERVICES / ASSISTANCE REQUESTING:

- | | | | |
|--------------------------------------|-------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Housing | <input type="checkbox"/> Employment/Skill development | <input type="checkbox"/> Transportation | <input type="checkbox"/> Substance Abuse treatment |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Financial support | <input type="checkbox"/> In-home services | <input type="checkbox"/> Personal assistance |
| <input type="checkbox"/> Education | <input type="checkbox"/> Family support | <input type="checkbox"/> Case / service management | <input type="checkbox"/> Other (please describe) |

HEALTH INSURANCE

- (1) Self-insured
 (2) Insured by employer
 (3) Medicare
 (4) Medicaid
 (5) No insurance
- Policy number: _____ Company name: _____

Keokuk County Central Point of Coordination

Legal Settlement Form

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.

INSTRUCTIONS: Please complete this form in its entirety to assist Keokuk 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 Keokuk County Authorization for Obtaining Information and/or Authorization for Disclosure 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. These are located at the end of this packet. Please make copies as needed.

PLEASE USE ADDITIONAL PAPER IF MORE ROOM IS NEEDED

Name: _____
Last First MI

Date Completed: _____
Month/Day/Year

Birth Date: _____

Social Security Number: _____

#1

Current 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.

#2

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.

#3

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

#4

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.

NOTE: FOR MENTAL HEALTH CENTER/PSYCHIATRIST/HOSPITAL REQUESTING SERVICES

APPLICANT'S NEED FOR ASSISTANCE: MUST HAVE BEFORE APPROVAL BY CPC!

Substance Abuse and / or Mental Health Diagnosis as determined by Mental Health Center (CODE & NAME): _____

DETERMINATION MADE BY: _____ **TITLE:** _____

IMPORTANT! PLEASE READ BEFORE SIGNING

Your signature below signifies the information included in this application is true and correct. I do solemnly swear or affirm that the above information is true and correct. I do further authorize the County Central Point of Coordination Administrator to investigate and verify this information, if needed.

_____ Date
Applicant or Legal Representative's Signature

AUTHORIZATION: CPC may use Social Security Number as a unique identifier: ___ Yes ___ No

NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR CPC USE ONLY

UNIQUE ID#: _____ DATE CONTACTED: _____

DISABILITY GROUP-PRIMARY DX: ___MI ___CMI ___MR ___DD ___SA ___OTHER

COUNTY OF LEGAL SETTLEMENT: _____

DETERMINATION: ___ACCEPTED ___DENIED FUNDING SECURED: ___YES ___NO

DATE OF DECISION: _____ DATE NOD SENT: _____

IF DENIED, REASON:

___OVER INCOME GUIDELINES ___DOES NOT MEET COUNTY PLAN CRITERIA

___DOES NOT MEET DX GROUP CRITERIA, IF NOT WHAT IS DX (FROM ABOVE): _____

___DOES NOT MEET SERVICE PLAN CRITERIA ___OTHER COUNTY LEGAL SETTLEMENT: _____

___APPLICANT DESIRES TO STOP PROCESS: _____

___OTHER _____

OTHER REFERRALS (DHS, TCM, OTHER): _____

NAME/TITLE OF CPC STAFF MAKING DETERMINATION & DATE: _____

KEOKUK COUNTY COMMUNITY SERVICES

MENTAL HEALTH/SUBSTANCE ABUSE GENERAL ASSISTANCE

Authorization to Obtain and/or Disclose Information

Individual Name:	SSN:	DOB:
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"I hereby authorize Keokuk County Community Services (KCCS) to obtain and/or disclose oral and/or written information that has been indicated below with the following individual(s) and/or agency(s):"

THIS INFORMATION WILL BE OBTAINED AND/OR DISCLOSED FOR THE FOLLOWING PURPOSE:

- Coordination of Services Service Planning Determining Eligibility for Services
 Monitoring of Services Funding Purposes Other _____

INFORMATION TO BE DISCLOSED BY KCCS:

- Funding & Eligibility _____
 Family and/or Social Data
 KCCS participation, annual plans & reviews, social history, reporting progress, discharge summaries, service planning (if applicable)
 Other _____

INFORMATION TO BE OBTAINED BY KCCS:

- Evaluation/Assessment _____
 Educational and/or Vocational Assessment
 Family and/or Social Data
 Physical/Mental Status _____
 Agency(s)/Individual(s) participation, annual plans & reviews, social history, progress reporting, discharge summaries, service planning (if applicable)
 Financial Information _____
 Other _____

SPECIFIC AUTHORIZATION TO DISCLOSE AND/OR OBTAIN INFORMATION PROTECTED BY STATE OR FEDERAL LAW

"I specifically authorize KCCS to obtain and/or disclose data or information relating to the following:"
(Please check and initial appropriate boxes)

- Mental Health (initial)
 Substance Abuse (initial)
 HIV-AIDS (initial)

Authorizing Signature	Date	Relationship to Client (if applicable):
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Affirmation of Authorization: "I give KCCS permission to disclose and/or obtain the information that I have selected on this form from the individual (s) and/or agency(s) I have named and only for the purpose selected. This authorization is valid up to one year unless specified below. I understand that I may revoke this authorization at any time. The revocation will take effect on the date it is received in writing. I understand that I may also refuse to sign this authorization and that revocation or refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. As a client, I have the right to access my treatment or other records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost (see staff for details). I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described may be re-disclosed and no longer protected by the regulations."

This authorization is valid up to one year unless otherwise specified or noted:

Authorizing Signature	Date	Relationship to Client (if applicable)
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Please send requested information or direct questions to:

- Client requests copy of Authorization:
 Client refuses copy of Authorization:

Jesse Hornback, Keokuk Co. CPC/GA Director
 Keokuk County Courthouse
 101 South Main Street
 Sigourney, Iowa 52591
 Ph: 641-622-2383 / Fax: 641-622-2166
 Email: cpc@keokukcountyia.com

KEOKUK COUNTY COMMUNITY SERVICES

MENTAL HEALTH/SUBSTANCE ABUSE GENERAL ASSISTANCE

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 Other _____

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