

CENTRAL POINT OF COORDINATION (CPC) APPLICATION FORM

Application Date: _____

SS#: _____

Name: _____
Last First MI

Current Address: _____
Street/Apt #/P.O. Box #

Phone #: _____

Gender/Sex: Male Female

Birth Date: _____

When did you move to this address: _____

City State Zip Code County of Residency Month/Year

Electronic Health Records Information Requirement (specific ONLY to Bridgeview CMHC applicants)

Your State of Birth: _____
Your Mother's Maiden Name: _____
Email address: _____
Cell Phone Carrier: _____

Your Preference for the way we Communicate with you (check one):

Email Cell Phone Home Phone Work Phone U.S. Mail Text

Ethnic Background (check one):

0. Unknown 1. White 2. African American 3. Native American 4. Asian 5. Hispanic 6. Other

Guardian/Payee/Conservator (Check any that are appointed and write in their name etc.)

<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Payee	<input type="checkbox"/> Conservator
Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
Phone: _____	Phone: _____	Phone: _____

For the following data (check one):

Veteran: Yes No
Marital Status: 1. Single, never married 2. Married 3. Divorced 4. Separated 5. Widowed
Legal Status: 1. Voluntary 2. Mental Health Commitment 3. Involuntary, criminal
Living Arrangements: 1. Alone 2. With relatives 3. With unrelated individuals 4. Homeless/Shelter/Street

Others in Household (if applicable)

Name of Individual:	Relationship:	Birth Date:

Referral Source: (Circle applicable)

1. Self	5. Community Corrections
2. Family/Friend	6. Social Service agency
3. Target Case Management	7. Other: _____
4. Other Case Management	

Education: (Check applicable)

Years of Education:	
GED:	<input type="checkbox"/> Yes <input type="checkbox"/> No
H.S Diploma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Degree (write above line)	

Current Employment: (Check applicable)

1. Unemployment	7. Vocational Rehabilitation	12. Armed forces member.
2. Unemployed, unavailable for work	8. Sheltered work employment	13. Homemaker
3. Employed, Full time	9. Supported employment	14. Other/Not applicable
4. Employed, Part time	Voc Re-habilitation	
5. Retired	Seasonally employed	
6. Student		

Health Insurance Information (check applicable):

INSURANCE BENEFITS:	MEDICARE BENEFITS:	SSI BENEFITS:
<input type="checkbox"/> No insurance	<input type="checkbox"/> Medicare A	<input type="checkbox"/> Title 19
<input type="checkbox"/> Iowa care	<input type="checkbox"/> Medicare B	<input type="checkbox"/> MEPD
<input type="checkbox"/> Private Insurance:	<input type="checkbox"/> Medicare D	<input type="checkbox"/> Medically Needy/Spend-down
Policy (write # above):	Medicare (write # above):	Title XIX #(write # above):

If you are not already receiving any benefits, have you applied for any of the following?

<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Social Security	<input type="checkbox"/> Title 19	<input type="checkbox"/> SSI
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> RR Pension	<input type="checkbox"/> FIP	<input type="checkbox"/> Veteran's Benefit
What is the status of your benefit application(s)?			
<input type="checkbox"/> Approved, but not started	<input type="checkbox"/> Denied	<input type="checkbox"/> Pending	

FINANCIAL PAGE

Monthly Income: GROSS (Check Type, Fill in amount)	Applicant \$ Amount	Others in Household \$ Amount (if applicable)	Allowable Monthly Expenses (to be considered for deductions)	
			Type:	Amount \$:
<input type="checkbox"/> Employment Wages-Monthly			Insurance premiums:	
<input type="checkbox"/> 2. FIP/Family Investment Program			Childcare:	
<input type="checkbox"/> 3. SSDI			Work Expenses:	
<input type="checkbox"/> 4. SSI/ T19			Medication Co-pays:	
<input type="checkbox"/> 5. Social Security			Other Expenses- Please list for our determination:	
<input type="checkbox"/> 6. Veterans Benefits				
<input type="checkbox"/> 7. Child Support/received				
<input type="checkbox"/> 9. Dividends, Interest, Etc				
<input type="checkbox"/> 9. Other- please specify:				
<input type="checkbox"/> Other-Unemployment:				

Resources:	Please check appropriate box:	Applicant's	Others in Household
		\$ Amount	\$ Amount
1. Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Checking Account	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Savings Account	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Certificates of Deposit	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Trust funds/must provide a copy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Whole Life Insurance (Cash Value)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Term Life insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Stocks & Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Burial Fund/Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Other Resources:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
1. Vehicle	Value:	Year:	
2. Vehicle	Value:	Year:	
Real Estate	Value:		

Yes No May your Social Security Number be used by the CPC office as your unique identifier?

Have you ever lived outside of Clinton County? Yes No

If No, skip page 4 (this page) and go to page 5.

If Yes, provide the following information:

For what reason: Military School Job Other: _____

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

I. Previous Residence

Dates(Month/Year)

From: _____ To: _____

Address: _____

City/State/Zip _____

Employer/Job Title: _____

Did you receive mental health or substance abuse services while at this address? Yes No

Agency Name: _____

Address/City/State: _____

1. _____

2. _____

3. _____

Where did you live prior to the above listed address?

II. Previous Address (Street/State/Zip): _____

Dates (Month and Year)

From: _____ To: _____

1. _____

2. _____

3. _____

4. _____

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

Title of Agency: _____

Dates (Month and Year)

From: _____ To: _____

1. _____

2. _____

3. _____

4. _____

Current Case Manger or Social Worker:

Agency: _____

Address/City/State: _____

Phone#: _____

Person Completing the Form (if other than applicant)

Name: _____

Relationship: _____

Address/City/State: _____

Phone#: _____

PLEASE REVIEW BEFORE SIGNING BELOW:

As a signatory of this document, I certify that the 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. If it is determined that your legal settlement is in another county or with the State of Iowa this application will be forwarded to that county or the Department of Human Services for further processing.

- I AGREE TO INFORM THE CENTRAL POINT OF COORDINATION OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION WITHIN 10 DAYS OF THE CHANGE.
- I UNDERSTAND I MAY BE EXPECTED TO HELP CONTRIBUTE TOWARD THE COST OF MY CARE AFTER RECEIVING NOTICE OF THIS REQUIREMENT AND THE CONTRIBUTION AMOUNT

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF IT IS DETERMINED THAT I WILLFULLY MISREPRESENTED ANY FACTS TO OBTAIN ASSISTANCE, THEN THIS APPLICATION CAN BE DENIED FOR THAT REASON.

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN

DATE

THE ANSWERS AND INFORMATION THAT YOU PROVIDE ON THIS APPLICATION GIVES US THE FACTS WE NEED IN ORDER TO DETERMINE YOUR COUNTY OF LEGAL SETTLEMENT AND IF YOU ARE ELIGIBLE FOR ASSISTANCE FROM THE COUNTY TO PAY FOR MH/MR/DD SERVICES. YOU MAY BE REQUIRED TO SIGN ADDITIONAL RELEASES OF INFORMATION FORMS SO THAT VERIFICATION INFORMATION CAN BE OBTAINED.

PROHIBITION AGAINST DISCRIMINATION

WE SHALL CONSIDER THIS APPLICATION WITHOUT REGARDS TO RACE, GENDER, SEXUAL ORIENTATION, MENTAL OR PHYSICAL HANDICAP, RELIGION, NATIONAL ORIGIN, OR POLITICAL BELIEF.

RIGHT OF APPEAL UNDER CPC PROCESS

IF YOU ARE NOT SATISFIED WITH THE ACTION OF THIS OFFICE AND IF YOU ARE APPLYING IN CLINTON COUNTY, YOU MAY APPEAL TO THE CLINTON COUNTY BOARD OF SUPERVISORS AT THE CLINTON COUNTY ADMINISTRATION BUILDING IN CLINTON, IOWA.

YOU WILL RECEIVE A NOTICE OF DECISION THAT WILL EXPLAIN THE APPEAL PROCESS.

PLEASE RETURN COMPLETED APPLICATION TO:

REBECCA ESKILDSEN, CPC COMMUNITY SUPPORTS DEPT CLINTON COUNTY ADMIN BLDG PO BOX 2957 CLINTON, IA 52733-2957	Phone: 563-244-0563 extension 5522 Fax: 563-243-9027 Email: BEskildsen@clintoncounty-ia.gov
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To be completed by Therapist:

DSM-IVR # (40) MI (41) CMI (42) MR (43) DD