

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:**

- | | | |
|---|-------|-------|
| <input type="checkbox"/> Social Security | _____ | _____ |
| <input type="checkbox"/> SSDI | _____ | _____ |
| <input type="checkbox"/> SSI | _____ | _____ |
| <input type="checkbox"/> Veteran's Benefits | _____ | _____ |
| <input type="checkbox"/> Employment Wages | _____ | _____ |
| <input type="checkbox"/> FIP | _____ | _____ |
| <input type="checkbox"/> Child Support | _____ | _____ |
| <input type="checkbox"/> Rental Income | _____ | _____ |
| <input type="checkbox"/> Dividends, Interest, Etc | _____ | _____ |
| <input type="checkbox"/> Pension | _____ | _____ |
| <input type="checkbox"/> Other | _____ | _____ |

Total Monthly Income: _____

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

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"/> Stocks and Bonds (cash value?)	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins (cash value?).	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
Total Resources:	_____	

Motor Vehicles: Yes No Make & Year: _____ Estimated value: _____
 (include car, truck, motorcycle, boat, Make & Year: _____ Estimated value: _____
 Recreational vehicle, etc.) 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)

Secondary Carrier (pays 2nd)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A,B D	<input type="checkbox"/> Medically Needy	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number: _____		
(or Medicaid/Title 19 or Medicare Claim Number)		
Start Date: _____ Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spend Down: _____ Deductible: _____		

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid-	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A,B, D	<input type="checkbox"/> Medically Needy	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number _____		
(or Medicaid/Title 19 or Medicare Claim Number)		
Start Date: _____ Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spend Down: _____ Deductible: _____		

Referral Source:

<input type="checkbox"/> Self	<input type="checkbox"/> Community Corrections	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Social Service Agency
<input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Other _____	<input type="checkbox"/> 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: _____

<input type="checkbox"/> Social Security _____	<input type="checkbox"/> SSDI _____	<input type="checkbox"/> Medicare _____
<input type="checkbox"/> SSI _____	<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> DHS Food Assistance: _____
<input type="checkbox"/> Veterans _____	<input type="checkbox"/> Unemployment _____	
<input type="checkbox"/> FIP _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> 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: rockhill@co.lyon.ia.us

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

Osceola County
Lisa Rockhill
300 7th St.
Sibley, IA 51249
Phone: 712-754-4209
Fax: 712-754-2479
Email: rockhill@osceolaia.org

Palo Alto County
Maureen Sandberg
1010 Broadway/PO 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
- Diagnosis Sheet
- Verification of All Household Resources