Northwest Iowa Care Connections
Application Form
For individuals living in: Clay, Dickinson, 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**

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

Name: ____________________________________

Address: __________________________________

Phone: ___________________________________

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

☐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.		

<u>INCOME: Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.</u>
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:**
☐ Social Security	____________________	____________________
☐ SSDI	____________________	____________________
☐ SSI .	____________________	____________________
☐ Veteran's Benefits	____________________	____________________
☐ Employment Wages	____________________	____________________
☐ FIP	____________________	____________________
☐ Child Support	____________________	____________________
☐ Rental Income	____________________	____________________
☐ Dividends, Interest, Etc	____________________	____________________
☐ Pension	____________________	____________________
☐ Other	____________________	____________________
Total Monthly Income:	____________________	____________________

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.)

Make & Year: ______ Estimated value:______ ______

Make & Year: ______ Estimated value:______ ______

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)

☐ Applicant Pays ☐ Medicaid ☐ Family Planning only
☐ Medicare A,B D ☐ Medically Needy ☐ MEPD
☐ No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name ______

Address ______

______

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

Start Date: ______ Any limits? ☐ Yes ☐ No
Spend Down: ______ Deductible: ______

Secondary Carrier (pays 2nd)

☐ Applicant Pays ☐ Medicaid- ☐ Family Planning only
☐ Medicare A,B, D ☐ Medically Needy ☐ MEPD
☐ No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name ______

Address ______

______

Policy Number______
(or Medicaid/Title 19 or Medicare Claim Number)

Start Date: ______ Any limits? ☐ Yes ☐ No
Spend Down: ______ Deductible: ______

Referral Source:

☐ Self ☐ Community Corrections ☐ Family/Friend ☐ Social Service Agency
☐ Targeted Case Management ☐ Other ______ ☐ 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:______

☐ **Social Security**______	☐ **SSDI**______	☐ **Medicare**______
☐ **SSI** ______	☐ **Medicaid**______	☐ **DHS Food Assistance:**______
☐ **Veterans** ______	☐ **Unemployment**______	______
☐ **FIP** ______	☐ **Other**______	☐ **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 office 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

O'Brien County
155 S. Hayes Ave/PO Box 525
Primghar, IA 51245
Phone: 712-957-5985
Fax: 712-336-4961
Email:bwill@co.dickinson.ia.us

Osceola County
Phone: 712-754-4209
Fax: 712-336-4916
Email: bwill@co.dickinson.ia.us

Palo Alto County
Phone: 712-336-0775
Fax: 712-336-4961
Email:bwill@co.dickinson.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