Central Point of Coordination Application

Name (First, MI, Last): _____

Previous surnames/maiden name: _____ Date of Birth: _____ Male / Female

Social Security #:_____ County of Residence:_____

Current Address: _____
Street Address City State Zip

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

How long have you lived at current address?:_____ How long in current county? : _____

Have you received any previous Mental Health, Developmental disability or Substance abuse treatment?: No Yes
Date of First treatment: _____ Have you received continuous treatment since that time?: No Yes

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 Other _____

Who gave you this application? _____

Ethnicity: 0 Unknown 1 White, not Hispanic 2 African-American, not Hispanic
3 American Indian or Alaskan Native 4 Asian or Pacific Islander 5 Hispanic
6 Other (i.e. Multiracial, Indochinese, etc.)

Guardian/Payee/Conservator: (check any that are appointed and write in name, etc.)
[ ] None appointed [ ] Legal Guardian [ ] Protective Payee [ ] Conservator

Name: _____ Phone Number: _____
Address: _____

Marital Status: 1 Single, never married 2 Married (includes common-law) 3 Divorced
4 Separated 5 Widowed

Legal Status: (circle one) 1 Voluntary 2 Involuntary, civil commitment 3 Involuntary, criminal

Veteran: No Yes
Branch Dates

Living Situation: (circle one)
1 Alone 2 With relatives 3 With unrelated individuals

Applicant's Primary Diagnosis: (specify type)
[ ] 40 Mental Illness _____
[ ] 41 Chronic Mental Illness _____
[ ] 42 Mental Retardation _____
[ ] 43 Developmental Disability _____
[ ] Other: Describe _____
_____

Residential Arrangement: (circle applicable)
1. Private Residence
2. State MHI
3. State Hospital School
4. Supported Comm. Living
5. Foster Care/ FLH
6. Residential Care Facility
7. RCF/MR
8. RCF/PMI
9. Intermediate Care Facility
10. ICF/MR
11. ICF/PMI
12. Correctional Facility
13. Homeless/Shelter/Street
14. Other _____

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

Revised June 2007

Health Insurance Information: (check all that apply)

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

Carrier #1 _____ Carrier # 2 _____
Address _____ Address _____
_____ _____
Policy Number _____ Policy # _____
(**or Medicaid/Title 19 or Medicare Claim Number**) (**or Medicaid/Title 19 or Medicare Claim Number**)

Primary Income Source: _____

Number of People in Household: _____

Monthly Income: (Check type, fill in *gross* amount – before any deductions)

	Applicant Amount	**Others in Household Amount**
[ ] 1. Employment wage - reported as	[ ] hourly Wage _____ # hours per week _____ [ ] monthly Amount _____ [ ] annually Amount _____	[ ] hourly Wage _____ # hours per week _____ [ ] monthly Amount _____ [ ] annually Amount _____
[ ] 2. Public Assistance	_____	_____
[ ] 3. Social Security	_____	_____
[ ] 4. SSDI	_____	_____
[ ] 5. SSI	_____	_____
[ ] 6. Veterans Benefits	_____	_____
[ ] 7. Railroad Pension	_____	_____
[ ] 8. Child Support	_____	_____
[ ] 9. Dividends, Interest, Etc.	_____	_____
[ ] 10. Other _____	_____	_____

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 _____

Resources: (Check and fill in amount and agency)

Type		Amount		Bank, Trustee, or Company
[ ] Cash		_____		_____
[ ] Checking Account		_____		_____
[ ] Savings Account		_____		_____
[ ] Certificate of Deposit		_____		_____
[ ] Trust Funds		_____		_____
[ ] Life Insurance (cash value)		_____		_____
[ ] Stocks and Bonds		_____		_____
[ ] Vehicle	Value:	_____	Year:	_____
[ ] Real Estate	Value:	_____	Location:	_____
[ ] Burial Fund/Trust		_____		_____
[ ] Other Resources		_____		_____

Name: ______________________________________

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

In order to determine which Iowa county has funding responsibility for you, please complete the following information with as much detail as possible. This does not affect your eligibility for funding; it only determines who is responsible. Begin with your current address. Continue completing each address section in full until it is clear at which address you have been for 12 months *without* receiving any of the services listed.

If you are 20 years of age or younger, please refer to your parents address and any services received by parents.

EXAMPLE: 205 Northwest Tylor St., Wiota, IA From: 06 / 14 / 01 to 06 / 18 / 07

Received the following services while at this address:	**Agency**	**Dates of Service**
[X] Mental Health outpatient counseling or inpatient treatment	**XYZ Mental Health**	**6/2001-9/2001, 7/2005 - current**
[ ] Substance Abuse counseling/treatment by a licensed professional		
[ ] Community Services – Case Management or Social Worker		
[ ] Residential or Vocational support Services		
[ ] Probation, parole, prison, jail		

Current Address: ______________________________ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address:	**Agency**	**Dates of Service**
[ ] Mental Health outpatient counseling or inpatient treatment		
[ ] Substance Abuse counseling/treatment by a licensed professional		
[ ] Community Services – Case Management or Social Worker		
[ ] Residential or Vocational support Services		
[ ] Probation, parole, prison, jail		

Address: ______________________________ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address:	**Agency**	**Dates of Service**
[ ] Mental Health outpatient counseling or inpatient treatment		
[ ] Substance Abuse counseling/treatment by a licensed professional		
[ ] Community Services – Case Management or Social Worker		
[ ] Residential or Vocational support Services		
[ ] Probation, parole, prison, jail		

Address: ______________________________ From: ___ / ___ / ___ to ___ / ___ / ___

Received the following services while at this address:	**Agency**	**Dates of Service**
[ ] Mental Health outpatient counseling or inpatient treatment		
[ ] Substance Abuse counseling/treatment by a licensed professional		
[ ] Community Services – Case Management or Social Worker		
[ ] Residential or Vocational support Services		
[ ] Probation, parole, prison, jail		

Address: ______________________________ From: ___ / ___ / ___ to ___ / ___ / ___

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[ ] Probation, parole, prison, jail		

Address: ______________________________ From: ___ / ___ / ___ to ___ / ___ / ___

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[ ] Residential or Vocational support Services		
[ ] Probation, parole, prison, jail		

Emergency Contact: (or someone who knows how to reach you)
Name: _____ Relationship: _____
Address: _____ Phone Number: _____

Person Completing the Form: (if other than applicant)
Name: _____ Relationship: _____
Address: _____ Phone Number: _____

Reason for Application:
[ ] Civil Commitment:
[ ] Substance Abuse (ch 125) [ ] Mental Impairment (ch 229) [ ] Dual filing
[ ] Outpatient Mental Health Treatment from _____
[ ] Seeking Funding for:
[ ] Residential Services [ ] Vocational Services [ ] Other _____

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 and/or designee to investigate and verify this information, if needed, including mental health/substance abuse treatment. ***Initial***_____

Signature: _____ **Date**: _____

Please remember that all information must be complete before the application will be considered.

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

Date received in CPC office:

Unique ID# |

Disability group, primary diagnosis (COA code, first two digits) Check one:

(40) Mental Illness (42) Mental Retardation (44) Other
(41) Chronic Mental Illness (43) Developmental Disability (45) Brain Injured

County of Legal Settlement

Eligibility for funding will be per the Cass County Managed Care Plan. Funding requests are required for all services other than committals.

Application Outcome Decision: APPLICANT ACCEPTED APPLICANT DENIED **Date of Decision:**

Denial Reason, if applicant denied. Check one:

(01) Over income guidelines
(02) Does not meet County Plan criteria: (2a) Legal Settlement in another County (2b) State Case
(03) Does not meet Diagnostic Group criteria: (3a)Brain Injury (3b)Alzheimer's (3c)Substance Abuse (3d) Other
(04) Does not meet Service Plan criteria
(05) Applicant desires to discontinue process: (5a) Consumer failure to return requested information

CPC or Personnel Making Eligibility Determination

Phone Number: (712) 243-4424

Notes:_____