Sioux Rivers Regional MHDS Application Form

For individuals living in: Dickinson, Emmet, Lyon, O'Brien, Plymouth, and Sioux 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#_____ **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 Address: _____
Street City State Zip County

Begin Date _____

I live: ☐ Alone ☐ With Relatives ☐With Unrelated persons

☐**Use as current Mailing Address:** ☐**Yes** ☐**No If not,** _____

Previous Address_____
Street City State Zip County

Begin Date_____ End Date_____

Current Service Providers:

	Name	Location
1.		
2.		

Current Residential Arrangement: **(Check applicable arrangement)**

☐**Private Residence** ☐**Foster Care/Family Life Home** ☐**Correctional Facility** ☐**Homeless/Shelter/Street**
☐**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:** _____

Employment History: (list starting with most recent to previous.)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				

Education: 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 ☐Conservator ☐Protective Payee
(Please check those that apply & write in name, address etc.

Name: _____

Address: _____

Phone: _____

List All People In Household:

Name	Age	Relationship	Social Security Number
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. *See attachment A

If you have reported no income above, 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 _____	_____	_____
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:

House including the one you live in?☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?_____ ☐Yes ☐No

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)
Has your application been Approved or Denied?
If denied and you appealed, what is the date of appeal _____
Have you applied for reconsideration?_____
Have you had a hearing with an Administrative Law Judge and what was the date of the scheduled hearing:
_____

☐Social Security_____ ☐SSDI_____ ☐Medicare_____
☐SSI _____ ☐Medicaid_____ ☐DHS Food Assistance:_____
☐Veterans _____ ☐Unemployment_____ ☐FIP _____
☐Other_____

Disability Group/Primary Diagnosis: (If known)

☐Mental Illness ☐Chronic Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Specific Diagnosis determined by:_____ Date:_____
Axis I: _____Dx Code: _____
Axis II:_____ Dx Code:_____

Why are you here today? What services do you NEED? (this section must be completed as part of this application!)

_____

I certify that the above information is true and complete to the best of my knowledge, and I authorize Sioux Rivers Regional MHDS staff to check for verification of the information provided including verification with Iowa county government and the state of Iowa Dept. of Human Services (DHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of Sioux Rivers Region to establish my ability to pay for the services requested, and to assure 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

ATTACHMENT A
Income/Resource/Eligibility Verification
Sioux Rivers Regional Mental Health & Disabilities Services

1. PROOF OF LEGAL RESIDENCE REQUIREMENT

Iowa Code 331,394(1): "County of residence" means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county or state in which the person last resided while the person is present in another county or this state receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.

- A copy of the applicant's driver's license or picture ID that shows current address, **OR**
- A copy of a recent bill or piece of mail with a legible postmark delivered by the US Post Office to the client at their current address, **OR**
- If application is living in a homeless shelter or community living facility, a letter signed and dated by personnel stating the applicant is residing in that facility.

2. HOUSEHOLD INCOME VERIFICATION REQUIREMENTS

For applications 18 years of age and over: Include income of applicant, applicant's spouse or domestic partner, and any children, stepchildren, or wards over the age of 14 that reside with applicant.

For applications under the age of 18: Include income of application (if over 14), applicant's parents (or parent and domestic partner), stepparents, or guardians who reside with applicant.

- Copies of payroll stubs for past 60 days from all employers. If a payroll stub reflects year-to-date earnings, only the most recent payroll stubs will be required.
- If applicant or spouse/domestic partner is self-employed, provide a copy of most recent Federal tax return completed.
- If applicable, a copy of Supplemental Security (SSI) or Social Security Disability (SSDI) determination, pension payment, and child support amount, etc.
- If an application indicates that no one in the household has any income, written documentation is required from all applicable adult household members stating as such and evidence of outside assistance such as food stamps, financial help from relatives, etc. must be provided.

3. RESOURCE VERIFICATION REQUIREMENTS (Applicant and other applicable household members)

- A copy of all checking account statements for past 2 months
- A copy of all savings account statements for past 2 months
- A copy of a statement from all retirements accounts such as IRAs, 401(k), pension plans, annuities, certificates of deposit, stocks, bonds or trust fund accounts dated no earlier than the previous tax year.

NOTE: If applicant or applicable household member has a legal payee, all income and resource verification documents must be obtained from the payee and attached to completed MHDS application.

CONSENT TO OBTAIN AND RELEASE INFORMATION

Sioux Rivers Regional MHDS

Authorization for Use or Disclosure of Protected Health Information

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

Authorization Section:

Name of Client:		
Date of Birth:	SS#:	Medical Record#:
Daytime Phone #:	Evening Phone #:	
City:	State:	Zip Code:

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above-named client, with the following provider or agency:

Name of Person or Agency

Complete Mailing Address

Information to be released, obtained and/or shared may include:

❒ Psychiatric Evaluation/Assessment/Admit Report	❒ Individual Comprehensive Plan
❒ Social History	❒ Agency participation, plans, and progress reports
❒ Psychiatric History	❒ Financial Information
❒ Medical record information (including diagnosis information, medications, allergies, and medical history)	
❒ Psychological Evaluation/Report	❒ Face Sheet
❒ Discharge Summaries	
❒ Other (Please specify):	

Information being released will be used for the following purpose:

○ Coordination of Treatment ○ Continuation of Care ○ Determination of Benefit eligibility
○ Referral for New Services ○ Monitoring of Services
○ Other (Please specify):_____

I understand this information shall be kept confidential and shall be used for the delivery of my services. I understand that I have a right to see this information at any time. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

❒ Substance Abuse (including alcohol/drug abuse)
❒ Mental Health (other than Psychotherapy Notes)
❒ HIV related information (including AIDS related testing)

X _____ _____
Signature of Client/Parent/Legal Guardian Date

This authorization shall expire on:_____

I understand that I may revoke my consent to this release at any time by providing written notification to:

Sioux Rivers-Dickinson/O'Brien Co.
1802 Hill Ave, Ste. 2502
Spirit Lake, IA 51360
Phone: 712-336-0775

Sioux Rivers-Lyon County
315 First Ave., #200
Rock Rapids, IA 51246
Phone: 712-472-8240

Sioux Rivers-Plymouth Co.
19 2nd Ave. NW
LeMars, IA 51031
Phone: 712-546-4352

Sioux Rivers Sioux County
210 Central Ave., SW, Box 233
Orange City, IA 51041
Phone: 712-737-2999

How to Appeal a Decision of the County Service Coordinator

Applicants for regional funding of services have the right to appeal a decision of the Services Coordinator if deemed adverse. Adverse decisions may include decisions involving eligibility determinations, funding and/or service levels, placements on waiting list for services. The Service Coordinator, or designee, makes initial decisions regarding eligibility for services and whether a person may be placed on a wait list for the requested service. These Notices of Decision shall be in writing and shall explain the reasons for the decision. If a decision is subject to appeal, the Notice of Decision will inform the applicant of his/her right to appeal, and how to file the appeal.

Step One: Filing the Appeal

As stated above, applicants/consumers or their representatives (with consent of the consumer) may appeal an adverse decision by the Service Coordinator. The appeal must be in writing and must be filed with the Sioux Rivers Regional Mental Health & Disabilities Services CEO within fifteen (15) business days of the date of the decision. If the appeal is filed late, it cannot be considered, except in situations that are out of the applicant's control. The appeal shall state: (1) the reasons why the Service Coordinator's decision should be reversed; (2) the relief requested; (3) applicant's name, address, and telephone number and the name, address, and telephone number of a representative if appointed.

Step Two: Discussing the Problem

After the appeal is filed, the Sioux Rivers CEO will contact the applicant to schedule a meeting to discuss the appeal. This meeting must be held within 10 business days, unless the parties agree to extend the time to meet. The applicant may bring someone to the meeting to help explain his/her position. The applicant and the CEO may ask another person to serve as a mediator. At the meeting, the CEO will explain the reason for the decision. The applicant may ask questions or give the CEO other information deemed important. The applicant should provide the CEO with a proposed resolution. If an agreement is reached, the County Service Coordinator will issue a revised Notice of Decision within 10 business days. At the end of the meeting, the applicant and the CEO will sign a status form, indicating whether there is a resolution or whether the appeal will continue. A revised Notice of Decision will be issued.

Step Three: The Appeal

If the parties are unable to resolve the problem at the meeting, within 10 business days of the date of the meeting, the CEO will contact an Administrative Law Judge at the Department of Inspections and Appeals (Iowa Code § 10A.801 - Judge). The CEO shall arrange for payment of the cost of the Judge. The Judge will set a pre-hearing conference to discuss hearing procedures and set a time for the hearing. The Judge will provide written notice of the pre-hearing conference, and the hearing. The applicant has the right to present evidence and argument at the hearing. The Judge will consider the evidence and will issue a written ruling. The decision of the Judge is final. Applicants have the right to receive notification in an accessible format and may receive assistance with the appeal. This could be an attorney, an organizational representative, or a friend. The Service Coordinator's office may help locate someone to assist the applicant with the appeal. The Sioux Rivers CEO will not provide legal assistance. Two places that may provide legal assistance include:

- Legal Aid: 1-800-532-1275
- Disability Rights Iowa Law Center
  For Protection and Advocacy: 1-800-779-2502

Authorization for the Use or Disclosure of Confidential Information

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity") NOTE:

A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 35B, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: _____ Date of Birth: _____ Client #: _____

Address: _____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, law enforcement agencies, and community nonprofit agencies providing financial assistance (a list of the current affiliated case management entities, law enforcement agencies, community non-profit agencies providing financial assistance and other providers is available upon request), **with the exception of the following Iowa counties, Regions or other entities: _____.**

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Information to be disclosed includes:	**For the following purposes:**
To law enforcement agencies, providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and/or community non-profit agencies providing financial assistance: Care Team information, Address type, Insurance information, Events, All applications, Employment information, Resources and Income, and Name of person and entity that entered your information. **This does not include any information related to HIV/AIDS related testing, mental health, or substance use disorder treatment information.**	In keeping with national, state and local efforts to enhance care coordination, parties will access/disclose records for the purposes of: coordinating treatment/care, determining benefit eligibility, obtaining authorizations, jail based service coordination, coordinating the funding for services and other benefits available to you, and assisting with state and federal reporting requirements.
To Iowa counties and Regions listed on Exhibit A and/or case management agencies: Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance and county commissions of veteran affairs described in Iowa Code § 252.25 and § 35B.10.	Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations, jail based service coordination, funding for services and abiding by state and federal reporting requirements.
SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW I hereby specifically authorize the release and sharing of information with Iowa Counties and Regions listed on Exhibit A and/or case management agencies, relating to: (check any that apply) **NOTE: This authorization for release of information does not authorize the release and/or sharing of information relating to substance use disorder treatment.**	

☐ HIV/AIDS Related Testing Information

☐Mental Health Information (**NOTE**: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below: ☐ _____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client ☐ personal representative of deceased client

Iowa Counties:			Iowa Mental Health and Disability Services Regions:
Adair	Floyd	Monroe	
Adams	Franklin	Montgomery	Central Iowa Community Services
Allamakee	Fremont	Muscatine	County Rural Offices of Social Services
Appanoose	Greene	O'Brien	
Audubon	Grundy Guthrie	Osceola	County Social Services
Benton	Hamilton	Page	
Black Hawk	Hancock	Palo Alto	Eastern Iowa MHDS
Boone	Hardin	Plymouth	Heart of Iowa
Bremer	Harrison	Pocahontas	
Buchanan	Henry	Polk	MHDS of the East Central Region
Buena Vista	Howard	Pottawattamie	North West Iowa Care Connection
Butler	Humboldt	Poweshiek	
Calhoun	Ida	Ringgold	Polk County Health Services
Carroll	Iowa	Sac	Rolling Hills Community Services
Cass	Jackson	Scott	Sioux Rivers MHDS
Cedar	Jasper	Shelby	South Central Behavioral Health
Cerro Gordo	Jefferson	Sioux	Southeast Iowa Link
Cherokee	Johnson	Story	
Chickasaw	Jones	Tama	Southern Hills Regional Mental Health
Clarke	Keokuk	Taylor	Southwest Iowa MHDS
Clay	Kossuth	Union	
Clayton	Lee	Van Buren	
Clinton	Linn	Wapello	
Crawford	Louisa	Warren	
Dallas	Lucas	Washington	
Davis	Lyon	Wayne	
Decatur	Madison	Webster	
Delaware	Mahaska	Winnebago	
Des Moines	Marion	Winneshiek	
Dickinson	Marshall	Woodbury	
Dubuque	Mills	Worth	
Emmet	Mitchell	Wright	
Fayette	Monona		

REVOCATION SECTION

I hereby revoke this Authorization.

_____

Copy sent to Client/Guardian on: _____ (date) at following address: _____ v14, Approved 6.26.19