



# HEART OF IOWA COMMUNITY SERVICES

## Funding Application

Date Received: \_\_\_\_\_

**NOTICE: A COPY OF YOUR DRIVER'S LICENSE OR PHOTO ID IS REQUIRED WITH THIS APPLICATION**

Application Date: \_\_\_\_\_

LAST Name: \_\_\_\_\_ FIRST Name: \_\_\_\_\_ MI: \_\_\_\_\_

Phone #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN#: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Street City State Zip County

Primary Language:  English  Spanish  Bosnian  Croatian Sex:  Male  Female

Ethnic Background:  White  African American  Native American  Asian  Hispanic  Other \_\_\_\_\_

Guardian/Conservator appointed by the Court?  Yes  No

Protective Payee Appointed by Social Security?  Yes  No

Legal Guardian  Protective Payee  Conservator  
(Please check those that apply & write in name, address etc.)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Legal Guardian  Protective Payee  Conservator  
(Please check those that apply & write in name, address etc.)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Veteran Status:  Yes  No Branch & Type of Discharge: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Are you currently on commitment?  Yes  No If Yes, please explain: \_\_\_\_\_

Marital Status:  Never married  Married  Divorced  Separated  Widowed

Legal Status:  Voluntary  Involuntary-Civil  Involuntary-Criminal  Probation  Parole  Jail/Prison

Are you a US Citizen & residing in the U.S. legally?  Yes  No

Living Arrangement:  Alone  With relatives  With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

- |   |  |                                      |   |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> Private Residence            | <input type="checkbox"/> State Resource Center | <input type="checkbox"/> ICF         | <input type="checkbox"/> Supported Comm. Living |
| <input type="checkbox"/> Foster Care/Family Life Home | <input type="checkbox"/> RCF                   | <input type="checkbox"/> ICF/ MR     | <input type="checkbox"/> Correctional Facility  |
| <input type="checkbox"/> Homeless/Shelter/Street      | <input type="checkbox"/> RCF/MR                | <input type="checkbox"/> ICF/PMI     |   |
| <input type="checkbox"/> State MHI                    | <input type="checkbox"/> RCF/PMI               | <input type="checkbox"/> Other _____ |   |

Disability Group/Primary Diagnosis:

- 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: \_\_\_\_\_

If agency referral, name of agency/contact person and contact information: \_\_\_\_\_

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"/> Hospital / Physician  |
| <input type="checkbox"/> Other Case Management    | <input type="checkbox"/> RCF/ICF               |
| <input type="checkbox"/> Other _____              |  |

Education:

Years of Education: \_\_\_\_\_  
 GED:  Yes  No  
 H.S. Diploma:  Yes  No  
 College Degree: \_\_\_\_\_

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

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**CURRENT EMPLOYMENT:** (Check applicable employment)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Unemployed, available for work | <input type="checkbox"/> Unemployed, unavailable for work | <input type="checkbox"/> Employed, Full time  |
| <input type="checkbox"/> Employed, Part time            | <input type="checkbox"/> Retired                          | <input type="checkbox"/> Student              |
| <input type="checkbox"/> Work Activity                  | <input type="checkbox"/> Sheltered Work Employment        | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Vocational Rehabilitation      | <input type="checkbox"/> Seasonally Employed              | <input type="checkbox"/> Armed Forces         |
| <input type="checkbox"/> Homemaker                      | <input type="checkbox"/> Volunteer                        | <input type="checkbox"/> Other _____          |

**Current Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Dates of employment:** \_\_\_\_\_ **Hourly Wage:** \_\_\_\_\_ **Hours worked weekly:** \_\_\_\_\_

**HAVE YOU APPLIED FOR ANY PUBLIC PROGRAMS listed below?**

(Please check those you have applied for and the status of your referral)

Has your application has been  Approved or  Denied. (If you appealed the denial, advise of the date of appeal: \_\_\_\_\_). Please advise if you have applied for reconsideration. 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 _____        |  |

**HEALTH INSURANCE Information:** (Check all that apply)

**PRIMARY Carrier** (pays 1<sup>st</sup>)

- |  |  |   |
|--|--|---|
| <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"/> HAWK-I          | <input type="checkbox"/> IA Cares             |
| <input type="checkbox"/> Private Insurance (list below): |  |   |

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Policy Number: \_\_\_\_\_

(or Medicaid/Title 19 or Medicare Claim Number)

**SECONDARY Carrier** (pays 2<sup>nd</sup>)

- |  |  |   |
|--|--|---|
| <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"/> HAWK-I          | <input type="checkbox"/> IA Cares             |
| <input type="checkbox"/> Private Insurance (list below): |  |   |

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Policy Number: \_\_\_\_\_

(or Medicaid/Title 19 or Medicare Claim Number)

**What is the name and location of your current psychiatrist/therapist and location:** \_\_\_\_\_

**What is the name and location of your current Pharmacy?** \_\_\_\_\_

**OTHERS IN HOUSEHOLD:**

	Name	Date of Birth	Relationship
1.			
2.			
3.			
4.			
5.			



**THIS APPLICATION WILL NOT BE CONSIDERED UNLESS THE FOLLOWING INFORMATION IS PROVIDED.**

**NOTICE:** Proof of income will be required with this application – a pay-stub(s) or tax-return will be required.

**Gross Monthly Income (before taxes):**

(Check Type & fill in amount)

- Social Security
- SSDI
- SSI
- Veteran's Benefits
- Employment Wages
- FIP
- Child Support
- Workers Compensation
- Short-Term Disability
- Annuity Benefits
- Pension/RR Pension
- Other

**Applicant**

Amount:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Others in Household**

Amount:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Total Monthly Income:** \_\_\_\_\_

**If you have reported NO income above, how do you pay your bills? (DO NOT LEAVE BLANK if no income is reported!)**

\_\_\_\_\_

\_\_\_\_\_

**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 (include car, truck, motorcycle, boat, Recreational vehicle, etc.)

1. Make & Year:		Estimated value:	
2. Make & Year:		Estimated value:	
3. Make & Year:		Estimated value:	

Do you, your spouse or dependent children own or are buying the following:

House including the one you live in  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? \_\_\_\_\_



## THIS APPLICATION WILL NOT BE CONSIDERED UNLESS THE FOLLOWING INFORMATION IS PROVIDED.

1. \_\_\_\_\_  
**CURRENT** Address City State County  
Dates of Residency at this address (month/year): \_\_\_\_\_ to \_\_\_\_\_
2. \_\_\_\_\_  
**PREVIOUS** Address City State County  
Dates of Residency at this address (month/year): \_\_\_\_\_ to \_\_\_\_\_
3. \_\_\_\_\_  
**PREVIOUS** Address City State County  
Dates of Residency at this address (month/year): \_\_\_\_\_ to \_\_\_\_\_

**Contact Person:** (including Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Other Interested person(s):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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 County 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 an Iowa County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal residence. 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**