Rolling Hills Community Services Region
Application Form

Application Date: _____ **Date Received by RHCS Office:** _____

Last Name: _____ **First Name:** _____ **MI:** _____

Phone #:_____ **Birth Date:**_____ **SSN#**_____ **State ID#**_____

Current Address: _____
Street City State Zip County

Sex: ☐Male ☐Female **Ethnic Background:** ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other _____

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: _____

Veteran Status: ☐**Yes** ☐**No** **Branch & Type of Discharge:** _____**Dates of Service:** _____

Marital Status: ☐Never married ☐Married ☐Divorced ☐Separated ☐Widowed

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

Are you here in the U.S. legally? ☐Yes ☐No **Living Arrangement:** ☐Alone ☐With relatives ☐With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

☐Private Residence	☐State Resource Center	☐Supported Comm. Living	☐State MHI
☐Foster Care/Family Life Home	☐RCF/MR	☐RCF/PMI	☐RCF
☐ICF	☐ICF/PMI	☐Correctional Facility	
☐Homeless/Shelter/Street	☐ICF/ MR	☐Other_____	

Disability Group/Primary Diagnosis:
☐Mental Illness ☐Chronic Mental Illness ☐Mental Retardation ☐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:

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

Education:

Years of Education: _____
GED: ☐Yes ☐No
H.S. Diploma: ☐Yes ☐No
College Degree: _____

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

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 all previous. Use another sheet if more space is needed)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				

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**_____

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)

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)

What is the name and location of your current general physician: _____

What is the name and location of your current Pharmacy? _____

Others in Household:

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

NOTICE: 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:**
☐ 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:_____
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 ☐ 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?**
_____
_____

***Are you considered legally blind?** ☐ **Yes** ☐ **No** **If yes, when was this determined?** _____

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 the RHCS 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 Region in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming residency. 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**

NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR RHCS USE ONLY

Unique ID#:_____ Date Contacted: _____

Disability Group-DX Type: ☐MI ☐ID ☐DD ☐SA ☐OTHER

Determination: ☐Accepted ☐Denied (see comments below) ☐Pending (see comments below)

Funding Secured: ☐YES ☐NO Arranged: _____

Date of Decision: _____ Date NOD sent: _____

If denied, check applicable reason:

☐Over income guidelines
☐Does not meet diagnostic criteria
☐Does Not meet service plan criteria
☐Does not meet plan criteria
☐Not a resident of RHCS Region
☐Applicant desires to stop process
☐Other_____

Other referrals given (DHS, TCM, etc.): _____

Co-payment amount/terms (if applicable): _____

Comments: _____

RHCS staff making determination & Date: _____

EXCEPTION TO POLICY REQUEST / NOTICE OF DECISION
Form F: CONSENT TO OBTAIN RELEASE INFORMATION

Rolling Hills Community Services Region
Authorization to Obtain and/or Disclose Information

Individual Name:	**SSN:**	**DOB:**

"I hereby authorize county staff to obtain and/or disclose oral and/or written information that has been indicated below with the following individual(s) and/or agency(s):"

Address of agency/individual listed above:	**Phone & Fax #'s of agency/individual listed above:**

THIS INFORMATION WILL BE OBTAINED AND/OR DISCLOSED FOR THE FOLLOWING PURPOSE:

☐ Coordination of Services ☐Service Planning ☐Determining Eligibility for Services
☐Monitoring of Services ☐Funding Purposes ☐ Other_____

INFORMATION TO BE OBTAINED AND/OR DISCLOSED:

☐Funding and/or Eligibility _____
☐Evaluation/Assessment_____
☐Educational and/or Vocational Assessment
☐Family and/or Social Data
☐Physical/Mental Status_____
☐Agency(s) and/or Individual(s) participation, annual plans & reviews, social history, progress reporting, discharge summaries, service planning (if applicable)
☐Financial Information _____
☐Other _____
☐Other

SPECIFIC AUTHORIZATION TO OBTAIN AND/OR DISCLOSE INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

"I specifically authorize county staff to obtain and/or disclose data or information relating to the following:"
(Please check and initial appropriate boxes)

☐Mental Health ____ (initial) ☐Substance Abuse____ (initial) ☐HIV-AIDS ____ (initial)

Authorizing Signature	**Date**	**Relationship to Client (if applicable):**

AFFIRMATION OF AUTHORIZATION: "I give region staff permission to obtain and/or disclose the information that I have selected on this form with the individual(s) and/or agency(s) that have been listed and only for the purpose selected. This authorization is valid up to one year unless specified below. I understand that I may revoke this authorization at any time. The revocation will take effect on the date it is received in writing. I understand that I may also refuse to sign this authorization and that revocation or refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. As a client, I have the right to access my treatment or other records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost (see staff for details). I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described may be re-disclosed and no longer protected by the regulations."

This authorization is valid up to one year unless otherwise specified or noted: _____

Authorizing Signature	**Date**	**Relationship to Client (if applicable)**

Witness signature (if applicable)	**Date**

Please send requested information or direct questions to:

Please indicate below if you would like a copy of this Authorization. If you <u>do not</u> indicate either, you will not be given a copy unless you request one verbally.

I request a copy of this Authorization: ☐
I decline a copy of this Authorization: ☐

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 non-profit 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
☐ guardian or conservator of a client (if and to the extent authorized under State law)
☐ personal representative of deceased client
☐ other (specify) _____

Copy sent to Client/Guardian on: _____ (date) at following address: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code Chapter 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

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

REVOCATION SECTION

I hereby revoke this Authorization.

Signed:_____ Date:_____

Copy sent to Client/Guardian on: _____ (date) at following address: _____