

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

Education:

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

Health Insurance Information: (check all that apply)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Title-19	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare
<input type="checkbox"/> Private Insurance	<input type="checkbox"/> No Insurance	<input type="checkbox"/> 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
<input type="checkbox"/> 1. Employment wage - reported as	<input type="checkbox"/> hourly Wage _____ # hours per week _____	<input type="checkbox"/> hourly Wage _____ # hours per week _____
	<input type="checkbox"/> monthly Amount _____	<input type="checkbox"/> monthly Amount _____
	<input type="checkbox"/> annually Amount _____	<input type="checkbox"/> annually Amount _____
<input type="checkbox"/> 2. Public Assistance	_____	_____
<input type="checkbox"/> 3. Social Security	_____	_____
<input type="checkbox"/> 4. SSDI	_____	_____
<input type="checkbox"/> 5. SSI	_____	_____
<input type="checkbox"/> 6. Veterans Benefits	_____	_____
<input type="checkbox"/> 7. Railroad Pension	_____	_____
<input type="checkbox"/> 8. Child Support	_____	_____
<input type="checkbox"/> 9. Dividends, Interest, Etc.	_____	_____
<input type="checkbox"/> 10. Other _____	_____	_____

Current Employment: (Circle applicable)

- | | |
|------------------------------------|------------------------------|
| 1 Unemployed, available for work | 8 Sheltered Work Employment |
| 2 Unemployed, unavailable for work | 9 Supported Employment |
| 3 Employed, full-time | 10 Vocational Rehabilitation |
| 4 Employed, part-time | 11 Seasonally Employed |
| 5 Retired | 12 Armed Forces |
| 6 Student | 13 Homemaker |
| 7 Work Activity | 14 Other _____ |

Resources: (Check and fill in amount and agency)

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

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: 515 5th Avenue, Council Bluffs, IA From: 06/14/01 to 06/18/07
51502

Received the following services while at this address:		Agency	Dates of Service
<input checked="" type="checkbox"/>	Mental Health outpatient counseling or inpatient treatment	XYZ Mental Health	6/2001-9/2001, 7/2005 - current
<input type="checkbox"/>	Substance Abuse counseling/treatment by a licensed professional	_____	_____
<input type="checkbox"/>	Community Services – Case Management or Social Worker	_____	_____
<input type="checkbox"/>	Residential or Vocational support Services	_____	_____
<input type="checkbox"/>	Probation, parole, prison, jail	_____	_____

Current Address: _____ From: ___/___/___ to ___/___/___

Received the following services while at this address:		Agency	Dates of Service
<input type="checkbox"/>	Mental Health outpatient counseling or inpatient treatment	_____	_____
<input type="checkbox"/>	Substance Abuse counseling/treatment by a licensed professional	_____	_____
<input type="checkbox"/>	Community Services – Case Management or Social Worker	_____	_____
<input type="checkbox"/>	Residential or Vocational support Services	_____	_____
<input type="checkbox"/>	Probation, parole, prison, jail	_____	_____

Address: _____ From: ___/___/___ to ___/___/___

Received the following services while at this address:		Agency	Dates of Service
<input type="checkbox"/>	Mental Health outpatient counseling or inpatient treatment	_____	_____
<input type="checkbox"/>	Substance Abuse counseling/treatment by a licensed professional	_____	_____
<input type="checkbox"/>	Community Services – Case Management or Social Worker	_____	_____
<input type="checkbox"/>	Residential or Vocational support Services	_____	_____
<input type="checkbox"/>	Probation, parole, prison, jail	_____	_____

Address: _____ From: ___/___/___ to ___/___/___

Received the following services while at this address:		Agency	Dates of Service
<input type="checkbox"/>	Mental Health outpatient counseling or inpatient treatment	_____	_____
<input type="checkbox"/>	Substance Abuse counseling/treatment by a licensed professional	_____	_____
<input type="checkbox"/>	Community Services – Case Management or Social Worker	_____	_____
<input type="checkbox"/>	Residential or Vocational support Services	_____	_____
<input type="checkbox"/>	Probation, parole, prison, jail	_____	_____

Address: _____ From: ___/___/___ to ___/___/___

Received the following services while at this address:		Agency	Dates of Service
<input type="checkbox"/>	Mental Health outpatient counseling or inpatient treatment	_____	_____
<input type="checkbox"/>	Substance Abuse counseling/treatment by a licensed professional	_____	_____
<input type="checkbox"/>	Community Services – Case Management or Social Worker	_____	_____
<input type="checkbox"/>	Residential or Vocational support Services	_____	_____
<input type="checkbox"/>	Probation, parole, prison, jail	_____	_____

Address: _____ From: ___/___/___ to ___/___/___

Received the following services while at this address:		Agency	Dates of Service
<input type="checkbox"/>	Mental Health outpatient counseling or inpatient treatment	_____	_____
<input type="checkbox"/>	Substance Abuse counseling/treatment by a licensed professional	_____	_____
<input type="checkbox"/>	Community Services – Case Management or Social Worker	_____	_____
<input type="checkbox"/>	Residential or Vocational support Services	_____	_____
<input type="checkbox"/>	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, <u>primary</u> 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	<i>Eligibility for funding will be per the Page County Managed Care Plan. Funding requests are required for all services other than committals.</i>	
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) 542-3584

Notes: _____

