

**FRANKLIN COUNTY COMMUNITY SERVICES
APPLICATION FORM**

Application Date: _____

SS #: _____

State ID#: _____

Resident Alien Card # : _____

Name: _____
 Last First MI

Phone #: _____

Sex: Male Female

Birth Date: _____

Current Address: _____ **How Long at this Address:** _____

City State Zip County

Ethnic Background: (circle one) 0. Unknown; 1. White; 2. African American; 3. Native American;
 4. Asian; 5. Hispanic; 6. Other

Birthplace: _____

U.S. Citizen Yes No

Guardian/Payee/Conservator:

Legal Guardian Protective Payee Conservator
 (Check any that are appointed and write in name etc.)

Name: _____

Address: _____

Phone: _____

Legal Guardian Protective Payee Conservator
 (Check any that are appointed and write in name etc.)

Name: _____

Address: _____

Phone: _____

Veteran: Yes No Enlistment Date: ___/___/___ Discharge Date: ___/___/___
 Honorable Discharge: Yes No

Marital Status: (Circle one) 1. Single, never married; 2. Married; 3. Divorced; 4. Separated; 5. Widowed

Legal Status: (Circle one) 1. Voluntary; 2. Involuntary, civil; 3. Involuntary, criminal

Living Arrangement: (Circle one) 1. Alone; 2. With relatives; 3. With unrelated individuals

Residential Arrangement: (circle applicable)

1. Private Residence	8. RCF/PMI
2. State MHI	9. ICF
3. State Resource Center	10. ICF/MR
4. Supported Comm Living	11. ICF/PMI
5. Foster Care/FLH	12. Correctional Facility
6. RCF	13. Homeless/Shelter/Street
7. RCF/MR	14. Other

Rent/Mortgage per month: \$ _____

Applicant's Primary Diagnosis(specific type)

40 Mental illness _____

41 Chronic Mental illness _____

42 Mental Retardation _____

43 Developmental Disability _____

Other - Describe: _____

50 General Assistance _____

54 Substance Abuse _____

Referral Source: (circle applicable)

1. Self	5. Community Corrections
2. Family/Friend	6. Social Service Agency
3. Targeted Case Management	7. Other _____
4. Other Case Management	

Education:

Years of education _____

GED Yes No H.S. Diploma Yes No

Degree _____

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

Primary Income Source: _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays first)

Secondary Carrier (pays second)

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

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

Company Name _____

Company Name _____

Policy Number: _____

Policy Number: _____

(or Medicaid/Title19 or Medicare Claim Number)

(or Medicaid/Title19 or Medicare Claim Number)

Others in Household:

Name	Relationship	Birth Date	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Monthly Income:

(Check Type, Fill in amount)

Applicant Amount:

Others in Household Amount:

Name

<input type="checkbox"/> 1. Employment Wages	_____	_____	_____
<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	_____	_____	_____
<input type="checkbox"/> 11. FIP/AFDC	_____	_____	_____
<input type="checkbox"/> Unemployment	_____	_____	_____
<input type="checkbox"/> Rent Subsidy	_____	_____	_____
<input type="checkbox"/> Heat Assistance	_____	_____	_____
<input type="checkbox"/> Food Stamps	_____	_____	_____
<input type="checkbox"/> Ministerial Fund	_____	_____	_____

If not currently receiving, has the applicant applied for any of the following benefits?

- | | | |
|---|--|---|
| <input type="checkbox"/> 1. Unemployment Compensation | <input type="checkbox"/> 3. Social Security Disability | <input type="checkbox"/> 5. Energy Assistance |
| <input type="checkbox"/> 2. SSI | <input type="checkbox"/> 4. FIP (AFDC) | <input type="checkbox"/> 6. Ministerial Fund |

What is the status of any such application?

- Approved, but not started Denied Pending

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"/> Certificates of Deposit	_____	_____
<input type="checkbox"/> Trust Fund	_____	_____
<input type="checkbox"/> Life Insurance (cash value)	_____	_____
<input type="checkbox"/> Stocks and Bonds	_____	_____
<input type="checkbox"/> Vehicle	Value: _____	Make & Year: _____
<input type="checkbox"/> Real Estate	Value: _____	Location: _____
<input type="checkbox"/> Burial Fund/Trust	_____	_____ Irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other Resources	_____	_____

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

1. Previous Address _____
Street Address City State Zip Code County

When did you live at this address? ____/____/____ To ____/____/____
Month Year Month Year

Did you receive mental health, mental retardation or or substance abuse services while at this address?

Yes No

Agency Name

Address

Where did you live prior to the above listed address?

Previous Address:

Dates (Month and Year)

_____ to _____
_____ to _____
_____ to _____
_____ to _____

List any previous services such as hospitalization, group homes, mental health center, social service, substance abuse services, etc. Use backside of this sheet if necessary. Include dates.

SERVICES:

DATES:

_____ to _____
_____ to _____
_____ to _____
_____ to _____

Current Case Manager or Social Worker: _____

Agency Address Phone

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Person Completing the Form (if other than applicant)

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Yes My social security number can be used by the CPC as my identification number.

Service(s) Being Requested: (based on ICP or Treatment Plan)

- | | | | | |
|--|---|---|--|------------------------------------|
| <input type="checkbox"/> HCBS/SCL | <input type="checkbox"/> RCF | <input type="checkbox"/> Sheltered Work | <input type="checkbox"/> Therapy/Treatment | <input type="checkbox"/> Rent |
| <input type="checkbox"/> HCBS/Resp. | <input type="checkbox"/> RCF/MR | <input type="checkbox"/> Work Activity | <input type="checkbox"/> Med. Management | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> HCBS/HVM | <input type="checkbox"/> RCF/PMI | <input type="checkbox"/> Supported Employment | <input type="checkbox"/> Evaluation | <input type="checkbox"/> Burial |
| <input type="checkbox"/> HCBS/Voc. | <input type="checkbox"/> ICF/MR | <input type="checkbox"/> Habilitation | <input type="checkbox"/> Commitment | <input type="checkbox"/> Medical |
| <input type="checkbox"/> HCBS/Other | <input type="checkbox"/> Respite | <input type="checkbox"/> Other Day Program | <input type="checkbox"/> MHI | |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Supported Community Living | | <input type="checkbox"/> Transportation | <input type="checkbox"/> Other |

Specify Service(s) Requested

Type of Service _____ Agency _____
 Units requested _____ Unit = hour day month other (circle one)
 Expected Unit Cost _____ COA # _____
 Expected Start Date _____ Expected End Date _____

Expected Outcomes: Describe what you expect to happen as a result of this service. _____

The services listed above have been discussed with me and are requested with my knowledge and consent. 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 Community Services staff to check for verification of the information provided. I understand that the information gathered in this document is for the use of the County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal settlement. I understand that information in this document will remain confidential.

X _____
 Applicant's Signature (or Legal Guardian) Date

I understand that failure to provide requested information may result in my application being denied or current benefits being canceled. I also agree to make every effort to secure employment, which will enable me to support myself or my family. I hereby authorize any banking or savings institution, employer, firm, corporation, or persons to disclose to a representative of Community Services of Franklin County any information which is desired in order to document or verify that information which I have provided in connection with this application. I also understand that the information may routinely be shared with the Department of Human Services, the Department of Employment Services, the Social Security Administration, and federal, state, and county staff for auditing.

I understand that I am required to report all changes in my circumstances, such as income, resources, living arrangements, etc; which may affect continued eligibility for County General Assistance. These changes shall be reported within 10 days of the date of the change. Failure to report these changes may result in denial of continued eligibility for County General Assistance.

X _____
 Signature of Applicant Date

For CPC or Community Services Use Only:
County of Legal Settlement/Financial Decision: _____ **Date:** _____ **Reason for Denial:** _____
Program Decision: _____ **Date:** _____ **Reason for Denial:** _____

RETURN THIS FORM TO:
 Franklin County Community Services
 123 1st Avenue S.W.
 P.O. Box 58
 Hampton, IA 50441
 PHONE: 641-456-2128 FAX: 641-456-2852