

# \_\_\_\_\_ COUNTY COMMUNITY SERVICES

## Application Form

**Application Date:** \_\_\_\_\_ **Date Received by CPC 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

**Protective Payee Appointed by Social Security?**  Yes  No

<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Protective Payee (Please check those that apply & write in name, address etc.)  Name: _____  Address: _____  Phone: _____
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<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Protective Payee <input type="checkbox"/> Conservator (Please check that apply & write in name, address etc.)  Name: _____  Address: _____  Phone: _____
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**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)

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

<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"/> Other _____
<input type="checkbox"/> Other Case Management	

**Education:**

Years of Education: _____
GED: <input type="checkbox"/> Yes <input type="checkbox"/> No
H.S. Diploma: <input type="checkbox"/> Yes <input type="checkbox"/> 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:** \_\_\_\_\_

**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.				
4.				
5.				

**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: ? \_\_\_\_\_

<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>)**

**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"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number: _____		
(or Medicaid/Title 19 or Medicare Claim Number)		

<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"/> Private Insurance	<input type="checkbox"/> 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 above, how do you pay your bills? (Do not leave blank if no income is reported!)**

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Gross Monthly Income (before taxes): (Check Type & fill in amount)	Applicant Amount:	Others in Household Amount:
<input type="checkbox"/> Social Security	_____	_____
<input type="checkbox"/> SSDI	_____	_____
<input type="checkbox"/> SSI	_____	_____
<input type="checkbox"/> Veteran's Benefits	_____	_____
<input type="checkbox"/> Employment Wages	_____	_____
<input type="checkbox"/> FIP	_____	_____
<input type="checkbox"/> Child Support	_____	_____
<input type="checkbox"/> Rental Income	_____	_____
<input type="checkbox"/> Dividends, Interest, Etc	_____	_____
<input type="checkbox"/> Pension	_____	_____
<input type="checkbox"/> Other	_____	_____
<b>Total Monthly Income:</b>	_____	_____

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 _____	_____	_____
<b>Total Resources:</b>	_____	

<b>Motor Vehicles:</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_

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**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?**

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**Legal Settlement:** Legal Settlement is the term used to determine what county will provide funding for requested services. This is determined by a person residing twelve consecutive months (six months for persons considered legally blind) within a county without receiving treatment and/or other support type services, including prescription medications, for Mental Health, Mental Retardation, Developmental Disabilities, Brain Injury, Substance Abuse and/or Jail or imprisonment. Please complete the following information in its entirety as much as possible to assist us in determining your county of legal settlement. If you need more space, you may copy the following sheet and/or use another sheet of paper to provide this information.

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

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\_\_\_\_\_  
Current Address City State County

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

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\_\_\_\_\_  
Previous Address City State County

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

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\_\_\_\_\_  
Previous Address City State County

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

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\_\_\_\_\_  
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Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

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Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
Previous Address City State County

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

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

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

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

