



# 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

Protective Payee Appointed by Social Security?  Yes  No

Legal Guardian  Conservator  Protective Payee  
(Please check those that apply & write in name, address etc.)

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

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

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

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)

<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!)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.				

**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 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:**

<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>	_____	

**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 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.

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:

- |  |  |
|--|--|
| <input type="checkbox"/> Over income guidelines              | <input type="checkbox"/> Not a resident of RHCS Region     |
| <input type="checkbox"/> Does not meet diagnostic criteria   | <input type="checkbox"/> Applicant desires to stop process |
| <input type="checkbox"/> Does Not meet service plan criteria | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Does not meet plan criteria         |  |

Other referrals given (DHS, TCM, etc.): \_\_\_\_\_

Co-payment amount/terms (if applicable): \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

**RHCS staff making determination & Date:** \_\_\_\_\_