WEBSTER COUNTY MHDD SERVICES
APPLICATION FORM

Application Date: ____________________________

SS#: ____________________________ State ID #: ____________________________

Name: ____________________________ Phone#: ____________________________
Last First MI

Sex: [ ] Male [ ] Female Birth Date: ____________________________

Current Address: ____________________________ Date moved to this address: ______________

____________________________ ____________________________
City State Zip Code County

County of Legal Settlement: ____________________________

Ethnic Background: (Circle One): 0. Unknown 1. White 2. African American 3. Native American
4. Asian 5. Hispanic 6. Other ______________

[ ] Guardian [ ] Protective Payee [ ] Conservator
Check any that are appointed and write in name, etc.
Name: ____________________________
Address: ____________________________
Phone: ____________________________

[ ] Guardian [ ] Protective Payee [ ] Conservator
Check any that are appointed and write in name, etc.
Name: ____________________________
Address: ____________________________
Phone: ____________________________

Veteran Status: [ ] Yes [ ] No
Marital Status: 1. Single, never married 2. Married 3. Divorced 4. Separated 5. Widowed
Legal Status: 1. Voluntary 2. Involuntary, Civil 3. Involuntary, Criminal
Living Arrangements: 1. Alone 2. With Relatives 3. With Unrelated Individuals

Residential Arrangements: (Circle Applicable)
1. Private Residence
2. State MHI
3. State Hospital School
4. SCL
5. Foster Care/FLH
6. RCF
7. RCF/MR
8. RCF/PMI
9. ICF
10. ICF/MR
11. ICF/PMI
12. Correctional Facility
13. Homeless/Shelter/Street
14. Other _________

Applicants Primary Diagnosis: (Specify Type)
[ ] 40 Mental Illness ______________
[ ] 41 Chronic Mental Illness ______________
[ ] 42 Mental Retardation ______________
[ ] 43 Developmental Disability ______________
[ ] Other; Describe ______________

Referral Source:(Circle Appropriate)
1. Self
2. Family/Friend
3. Targeted Case Management
4. Other Case Management
5. Community Corrections
6. Social Service Agency
7. Other __________

Education:
Years of Education: ______________
GED [ ] Yes [ ] No
HS Diploma [ ] Yes [ ] No
Degree: ______________

Current Employment Status: (Circle Applicable)
1. Unemployed, available
2. Unemployed, unavailable
3. Employed, FT
4. Employed, PT
5. Retired
6. Student
7. Work Activity
8. Sheltered Work
9. Supported Employment
10. Voc. Rehab.
11. Seasonally Employed
12. Armed Forces
13. Homemaker
14. Other ________
____

Primary Income Source: ____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays first)	Secondary Carrier (pays second)
[ ] Applicant Pays [ ] Medicaid [ ] Medicare [ ] Private Insurance [ ] No Insurance [ ] Medically Needy Company Name ______________________ Address ______________________________ Policy Number ______________________ (or Medicaid/Title 19 or Medicare Number)	[ ] Applicant Pays [ ] Medicaid [ ] Medicare [ ] Private Insurance [ ] No Insurance [ ] Medically Needy Company Name _____________________ Address ____________________________ Policy Number ______________________ (or Medicaid/Title 19 or Medicare Number)

Others in household:

Name	Relationship	Birth Date
______________________	______________________	____________
______________________	______________________	____________
______________________	______________________	____________
______________________	______________________	____________
______________________	______________________	____________

Have you applied for SSDI, SSI, or other benefits? _____________ Outcome? ____________________

Household Monthly Income: _________________________ Source: ______________________________
(Need copies of paychecks, etc/ to verify)

Resources:

(Check Type, Fill in amount)	Applicant amount:	Others In Household Amount:
[ ] Cash	___________________	______________________
[ ] Checking account	___________________	______________________
[ ] Savings account	___________________	______________________
[ ] Certificates of Deposit	___________________	______________________
[ ] Trust Funds	___________________	______________________
[ ] Life Insurance (Cash Value)	___________________	______________________
[ ] Stocks & Bonds	___________________	______________________
[ ] Vehicle	Value: _____________	Year: _________________
[ ] Real Estate	Value: _____________	Location: ______________
[ ] Burial Fund/Trust	___________________	______________________
[ ] Other Resources	___________________	______________________

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

Previous Address: ____
Street Address City State Zip Code County

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

Employer: ______________________ Job: ________________ Dates: ______________

Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Where did you live prior to the above listed address?

Previous Address: ________________________________ Dates __________ to __________
Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Previous Address: ________________________________ Dates __________ to __________
Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Previous Address: ________________________________ Dates __________ to __________
Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Previous Address: ________________________________ Dates __________ to __________
Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Previous Address: ________________________________ Dates __________ to __________
Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Previous Address: ________________________________ Dates __________ to __________
Did you receive mental health or substance abuse services while living at this address? Yes No

Agency ______________ Address __________________ Dates __________ to __________
Agency ______________ Address __________________ Dates __________ to __________

Services Being Requested: (based on ICP or Treatment Plan)

[ ] HCBS/SCL	[ ] ICF/MR	[ ] RCF	[ ] RCF/MR	[ ] Voc./SE
[ ] HCBS/Resp.	[ ] Voc./SW	[ ] Voc.WAC	[ ] Voc./ADC	[ ] Voc./Other
[ ] HCBS /HVM	[ ] Psych. Rehab	[ ] ADT	[ ] Evaluation	[ ] Therapy/Treatmt
[ ] HCBS/Voc.	[ ] Med. Mgmt.	[ ] MHI	[ ] Commitment	[ ] Protective Payee
[ ] HCBS/Other	[ ] Rent Subsidy	[ ] Transp.	[ ] SCL	[ ] Case Managemt
[ ] Pers. Allow.	[ ] Medical	[ ] RCF/PMI	[ ] Respite	[ ] ACT
[ ] Medication	[ ] Other Describe ______________________________			

Agency Requested: ____

Current Case Manager or Social Worker ______________________________

____
Agency Address Phone

Contact:
Name: ______________________ Relationship: ______________________
Address: ______________________ Phone #: ______________________

Person Completing this form (if other than applicant)
Name: ______________________ Relationship: ______________________
Address: ______________________ Phone #: ______________________

[ ] Yes [ ] No My Social Security Number can be used by the CPC as my identification number.

The above listed services 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 the County CPC 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 my legal settlement. I understand that information in this document will remain confidential.

______________________________ ______________________
Applicant's Signature (or Legal Guardian) Date

For CPC use only:
Legal Settlement/Financial Decision: ____________Date:______________Reason for Denial: ______________
Program Decision: ______________________Date:______________Reason for Denial: ______________