Sioux Rivers Regional MHDS Application Form

For individuals living in: Plymouth, Sioux and Woodbury Counties

Application Date: _____ **Date Received by Office:** _____

First Name: _____ **Last Name:** _____ **MI:** _____

Nickname: _____ **Maiden Name:** _____ **Birth Date:** _____

Ethnic Background: ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other _____

Sex: ☐Male ☐Female **US Citizen:** ☐Yes ☐No **If you are not a citizen, are you in the country legally?** ☐Yes ☐No

SSN#_____ **Marital Status:** ☐Never married ☐Married ☐Divorced ☐Separated ☐Widowed

Legal Status: ☐Voluntary ☐Involuntary-Civil ☐Involuntary-Criminal ☐Probation ☐Parole ☐Jail/Prison

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

Primary Phone #: _____ **May we leave a message?** ☐Yes ☐No

Current Address: _____
Street City State Zip County

I live: ☐ Alone ☐ With Relatives ☐With Unrelated persons

☐**Use as current Mailing Address:** ☐Yes ☐No **If not,** _____

Previous Address_____
Street City State Zip County
Begin Date_____ End Date_____

Current Service Providers:

	Name	Location
1.		
2.		

Current Residential Arrangement: **(Check applicable arrangement)**

☐**Private Residence** ☐**Foster Care/Family Life Home** ☐**Correctional Facility** ☐**Homeless/Shelter/Street**
☐**Other**_____

Veteran Status: ☐Yes ☐No **Branch & Type of Discharge:** _____**Dates of Service:** _____

Current Employment: **(Check applicable employment)**

☐Unemployed, available for work	☐Unemployed, unavailable for work	☐Employed, Full time
☐Employed, Part time	☐Retired	☐Student
☐Work Activity	☐Sheltered Work Employment	☐Supported Employment
☐Vocational Rehabilitation	☐Seasonally Employed	☐Armed Forces
☐Homemaker	☐ Volunteer	☐Other _____

Current Employer: _____ **Position:** _____
Dates of employment: _____ **Hourly Wage:** _____ **Hours worked weekly:** _____

Employment History: (list starting with most recent to previous.)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				

Education: What is the highest level of education you achieved? _____ **# of years** _____ **Degree**

Emergency Contact Person:

Name: _____ **Relationship:** _____

Address:_____ **Phone:** _____

Guardian/Conservator appointed by the Court? ☐**Yes** ☐**No**
☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
(Please check those that apply & write in name, address etc.)

Name: _____

Address: _____

Phone: _____

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: _____

List All People In Household:

Name	Age	Relationship	Social Security Number
1.			
2.			
3.			
4.			
5.			

INCOME: **Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.** *SEE ATTACHMENT A

If you have reported no income above, 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:**
☐ **Social Security**		
☐ **SSDI**		
☐ **SSI**		
☐ **Veteran's Benefits**		
☐ **Employment Wages**		
☐ **FIP**		
☐ **Child Support**		
☐ **Rental Income**		
☐ **Dividends, Interest, Etc**		
☐ **Pension**		
☐ **Other**		
Total Monthly Income:		

Household Resources: (Check and fill in amount and location):

Type	**Amount**	**Bank, Trustee, or Company**
☐Cash		
☐Checking Account		
☐Savings Account		
☐Certificates of Deposit		
☐Trust Funds		
☐Stocks and Bonds (cash value?)		
☐Burial Fund/Life Ins (cash value?)		
☐Retirement Funds (cash value?)		
☐Other _____		
Total Resources:		

Motor Vehicles: ☐Yes ☐No (include car, truck, motorcycle, boat, recreational vehicle, etc.)

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? ☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?_____ ☐Yes ☐No

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?**

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐Applicant Pays ☐Medicaid ☐Family Planning only
☐Medicare A, B, D ☐Medically Needy ☐ MEPD
☐No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name _____

Address _____
_____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No

Spend down: _____ Deductible: _____

Secondary Carrier (pays 2nd)

☐Applicant Pays ☐Medicaid ☐ Family Planning only
☐Medicare A, B, D ☐ Medically Needy ☐ MEPD
☐No Insurance ☐Private Insurance ☐ HAWK-I

Company Name _____

Address _____
_____

Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No

Spend down: _____ Deductible: _____

Referral Source:

☐Self ☐Community Corrections ☐Family/Friend ☐Social Service Agency
☐Targeted Case Management ☐Other _____ ☐Other Case Management

Have you applied for any of the public programs listed below?

(Please check those you have applied for and the status of your referral) Has your application been Approved or Denied? If denied and you appealed, what is the date of appeal _____ ? Have you applied for reconsideration_____. Have you had a hearing with an Administrative Law Judge and what was the date of the scheduled hearing: _____

☐Social Security_____ ☐SSDI_____ ☐Medicare_____

☐SSI _____ ☐Medicaid_____ ☐Food Assistance: _____

☐Veterans _____ ☐Unemployment_____ ☐FIP _____

☐Other_____ ☐Other_____

Disability Group/Primary Diagnosis: (If known)

☐Mental Illness ☐Chronic Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Specific Diagnosis determined by:_____ Date:_____
Axis I: _____Dx Code: _____
Axis II:_____ Dx Code: _____

Why are you here today? What services do you NEED? (this section must be completed as part of this application!)

_____
_____
_____

I certify that the above information is true and complete to the best of my knowledge, and I authorize Sioux Rivers Regional MHDS staff to check for verification of the information provided including verification with Iowa county government and the state of Iowa Dept. of Human Services (DHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the Sioux Rivers Region to establish my ability to pay for the services requested, and to assure the appropriateness of services requested. 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

AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Client
Name:_____ Date of Birth: _____/_____/_____ SS#:_____/_____/_____

I authorize the Sioux Rivers Region, the Iowa Department of Human Services and the following individuals or agencies to share written and oral information about my needs and the services I receive:

Name or Agency to release and /or receive information:

Siouxland Mental Health; Cherokee MHI; Independence MHI; Creative Living Center, Plain Area Mercy Medical Center; St. Luke's Unity Point; Jackson Recovery Centers; Synergy Center; Mercy Behavioral Care; Associates for Psychiatric Services; Dean & Associates; Office of the Woodbury County Clerk of District Court; Siouxland Community Health Center; The Pride Group; Mosaic Council Bluffs Integrated Health Home; Magellan; IME; Social Security Administration; Community Services Network

The Information released or shared may include:

( ) Psychiatric Evaluation / Assessment /Admit Report **( ) Individual Comprehensive Plan** **( ) Social History**
( ) Agency participation, plans, and progress reporting **( ) Financial Information** **( ) Psychological Evaluation/Report**
( ) Physical Status (including medical, dental) **( ) Psychiatric and Medical History** **( ) Discharge Summary**
( ) Face Sheet **( ) Motor Vehicle Information** **( ) Other (please specify)**
Note exceptions or limits to this release:_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I SPECIFICALLY AUTHORIZE the release of confidential information relating to:

Type of Information	***Authorizing Initials***
Mental Health evaluation/treatment	
Substance Abuse	
AIDS/HIV-related	

I understand that information obtained shall be used for the purpose of determining legal residence and eligibility for funding assistance from Sioux Rivers or the State of Iowa and for the planning and delivery of mental health services. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment; however my refusal to sign may affect the ability of Sioux Rivers to obtain the information needed for determining funding eligibility and care planning.

I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR Part 2) and Iowa Code (Chapters 125, 228, 229 and Section 141A.9) and cannot be disclosed without my written consent unless otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I have the right to inspect the disclosed information at any time.

Federal and/or Iowa law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization as indicated below. I further understand that the Iowa Department of Human Services and Sioux Rivers, WITHOUT FURTHER AUTHORIZATION, may redisclose said information to all individuals/agencies listed above. I SPECIFICALLY AUTHORIZE and consent to the disclosure and redisclosure as described above.

I understand that if the person or organization that receives the information is not a health plan or health care provider, Federal Privacy Regulations may no longer protect the released information. This Authorization is effective for 12 months after the date it is signed. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the healthcare provider and record keeper. A photocopy, or exact reproduction of this signed Authorization shall have the same force and effect as this original. I have read this form, or it has been explained to me, and I understand its content. I hereby authorize the release of information as indicated above.

Signature of Patient / Applicant or Legal Guardian:	**Relationship, if NOT the patient:**	**Date:**

ATTACHMENT A

Income ● Resource ● Eligibility Verification

Sioux Rivers Regional Mental Health & Disabilities Services

1. PROOF OF LEGAL RESIDENCE REQUIREMENT

Iowa Code 331.294(1): *"County of residence" means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county in which the person last resided while the person is present in another county receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.*

- A copy of the applicant's driver's license or picture I.D. that shows current address, **OR**
- A copy of a recent bill or piece of mail with a legible postmark delivered by the U.S. Post Office to the client at their current address, **OR**
- If applicant is living in a homeless shelter or community living facility, a letter signed and dated by personnel stating the applicant is residing in that facility.

2. HOUSEHOLD INCOME VERIFICATION REQUIREMENTS

For applicants 18 years of age and over: Include income of applicant, applicant's spouse or domestic partner, and any children, stepchildren, or wards over the age of 14 that reside with applicant.

For applicants under the age of 18: Include income of applicant (if over 14), applicant's parents (or parent and domestic partner), stepparents, or guardians who reside with applicant.

- Copies of payroll stubs for past 60 days from all employers. If a payroll stub reflects year-to-date earnings, only the most recent payroll stubs will be required.
- If applicant or spouse/domestic partner is self employed, provide a copy of most recent Federal tax return completed.
- If applicable, a copy of Supplemental Security (SSI) or Social Security Disability (SSD) determination, pension payment, and child support amount, etc.
- If an applicant indicates that no one in the household has any income, written documentation is required from all applicable adult household members stating as such and evidence of outside assistance such as food stamps, financial help from relatives, etc., must be provided.

3. RESOURCE VERIFICATION REQUIREMENTS (Applicant and other applicable household members)

- A copy of all checking account statements for past 2 months
- A copy of all savings account statements for past 2 months
- A copy of a statement from all retirement accounts such as IRAs, 401(k), pension plans, annuities, certificates of deposit, stocks, bonds or trust fund accounts dated no earlier than the previous tax year.

NOTE: If applicant or applicable household member has a legal payee, all income and resource verification documents must be obtained from the payee and attached to completed MHDS application.

Authorization for the Use or Disclosure of Confidential Information

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 125, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: _____ Date of Birth: _____ Client #: _____

Address: _____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and with Polk County Health Services (a list of the current affiliated case management entities and other providers is available upon request), **with the exception of the following Iowa counties, Regions or other entities: _____.**

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Information to be disclosed includes:	**For the following purposes:**
Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance described in Iowa Code § 252.25.	Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations and abiding by state and federal reporting requirements.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby specifically authorize the release and sharing of information relating to: (check and sign any that apply)

☐ HIV/AIDS Related Testing Information

X_____
Client signature required

☐ Mental Health Information (**NOTE**: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

X_____
Client signature required

☐ Chemical Dependency (Drug/Alcohol) Treatment Information. (Note: In addition to the individuals and organizations identified by name or title in this Authorization, I specifically authorize the release of drug or alcohol abuse patient information to the following individuals or organizations (by name or title)):

_____

_____

X_____
Client signature required

Concerning the care of the above client from (select one):

☐ Any and all dates; or

☐ Dates ____/____/_____to ____/____/_____.

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:

☐ ____/____/_____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client

☐ guardian or conservator of a client (if and to the extent authorized under State law)

☐ personal representative of deceased client

☐ other (specify) _____

REVOCATION SECTION

I hereby revoke this Authorization.

Signed:_____ Date:_____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of Substance Abuse Treatment Information: This information may have been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2), and Iowa Code Chapter 125. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code § 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

Iowa Counties:			Iowa Mental Health and Disability Services Regions:
Adair	Floyd	Monroe	Central Iowa Community Services
Adams	Franklin	Montgomery	County Rural Offices of Social Services
Allamakee	Fremont	Muscatine	County Social Services
Appanoose	Greene	O'Brien	Eastern Iowa MHDS
Audubon	Grundy	Osceola	Heart of Iowa
Benton	Guthrie	Page	MHDS of the East Central Region
Black Hawk	Hamilton	Palo Alto	North West Iowa Care Connection
Boone	Hancock	Plymouth	Polk County Health Services
Bremer	Hardin	Pocahontas	Rolling Hills Community Services
Buchanan	Harrison	Polk	Sioux Rivers MHDS
Buena Vista	Henry	Pottawattamie	South Central Behavioral Health
Butler	Howard	Poweshiek	Southeast Iowa Link
Calhoun	Humboldt	Ringgold	Southern Hills Regional Mental Health
Carroll	Ida	Sac	Southwest Iowa MHDS
Cass	Iowa	Scott	
Cedar	Jackson	Shelby	
Cerro Gordo	Jasper	Sioux	
Cherokee	Jefferson	Story	
Chickasaw	Johnson	Tama	
Clarke	Jones	Taylor	
Clay	Keokuk	Union	
Clayton	Kossuth	Van Buren	
Clinton	Lee	Wapello	
Crawford	Linn	Warren	
Dallas	Louisa	Washington	
Davis	Lucas	Wayne	
Decatur	Lyon	Webster	
Delaware	Madison	Winnebago	
Des Moines	Mahaska	Winneshiek	
Dickinson	Marion	Woodbury	
Dubuque	Marshall	Worth	
Emmet	Mills	Wright	
Fayette	Mitchell		
	Monona		

Copy sent to Client/Guardian on: _____ (date) at following address: _____ v11, Approved 1.19.16

PATIENT BILL OF RIGHTS

Sharing Your Medical Information with Other Iowa Counties and Regions to Improve Your Care

Purpose of Letter

The purpose of this letter is to provide you with information about the reason sharing your medical information is necessary. You have an option to not sign this medical information release but doing so may prevent us from having a complete picture of your complete health.

Iowa Law

Iowa's Disclosure of Mental Health and Psychological Information, Chemical Substance Abuse, and Acquired Immune Deficiency Syndrome (AIDS) laws provide protection of your mental health, chemical and substance abuse history, and AIDS testing information. The law is very restrictive on who may see your mental health, chemical and substance abuse history, and AIDS testing information. If you receive services from multiple counties, Iowa Law prevents the counties from sharing this health information.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) provides federal protection for individually identifiable health information. However, the rule also allows entities to disclose health information needed for patient care and other purposes, like the ability to bill for the care provided to you.

The Iowa laws protecting mental health, chemical and substance abuse history, and AIDS testing information were passed before HIPAA. Iowa law is more protective than HIPAA and it prevents providers and other health care entities from sharing necessary information to provide you complete care.

Sharing Your Mental Health, Chemical and Substance Abuse History, and AIDS Testing Information Helps Iowa Counties Have a More Complete Picture of Your Health

By signing this agreement you are allowing Iowa counties and regions to share your mental health, chemical and substance abuse history, and AIDS testing information in order to provide better care for you. We do have important safeguards in place to make sure all of your mental health, chemical and substance abuse history, and AIDS testing information is safe. Only authorized individuals will have access to your information. Nothing in this release allows improper use of your mental health, chemical and substance abuse history, and AIDS testing information.

You Can Choose Not to Sign This Agreement

Your privacy is important to us, so we will respect your choice on whether you want us to share your mental health, chemical and substance abuse history, and AIDS testing information with other Iowa counties and regions. You have the right to revoke this authorization at any time.

You May Request a Copy of Your Record

You may request a copy of your CSN record at any time, except for psychological test materials and psychotherapy notes. This includes a list of disclosures of your CSN record. The county or region may impose a reasonable, cost-based fee. That fee may consist of labor for copying your CSN record, supplies for making the copy (such as paper and ink), postage to mail your CSN record to you, and preparing an explanation or summary of your medical information.

Questions

If you have questions or concerns about this agreement, you can bring it up next time you're receiving care from your county. Questions should be directed to your county or region's Privacy Officer.