



# COUNTY SOCIAL SERVICES APPLICATION

Today's Date: \_\_\_\_\_

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Name: \_\_\_\_\_ SSN: \_\_\_\_--\_\_\_\_--\_\_\_\_ U.S. Citizen?  Yes  No

I identify my gender as:  Male  Female  Non-Binary  Not listed: \_\_\_\_\_

Pronouns: \_\_\_\_\_ Are you under the care of a mental health professional?  Yes  No

If yes, what is the name of your current provider? \_\_\_\_\_

If no, are you interested in having assistance finding a provider?  Yes  No

Current Address: \_\_\_\_\_ County: \_\_\_\_\_  
Street Address City State Zip

When did you move to this address? \_\_\_\_/\_\_\_\_/\_\_\_\_ Preferred phone number: \_\_\_\_\_  
Month Day Year

Residence Type:  Private Residence  Correctional Facility  Homeless/Shelter  24-Hour Habilitation or Waiver Setting  
 Foster Care/Family Life Home  Residential Care Facility  Other (Please Specify) \_\_\_\_\_

Previous Address: \_\_\_\_\_ County: \_\_\_\_\_  
Street Address City State Zip

Begin Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

Residence Type:  Private Residence  Correctional Facility  Homeless/Shelter  24-Hour Habilitation or Waiver Setting  
 Foster Care/Family Life Home  Residential Care Facility  Other (Please Specify) \_\_\_\_\_

Race \_\_\_\_\_ Marital Status \_\_\_\_\_ Veteran?  Yes  No

### Health Insurance Information:

Primary Insurance (pays first)	Secondary Insurance (pays second)
<input type="checkbox"/> Iowa Health & Wellness <input type="checkbox"/> Iowa Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Third Party <input type="checkbox"/> I do not have insurance	<input type="checkbox"/> Iowa Health & Wellness <input type="checkbox"/> Iowa Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Third Party
MCO or other Carrier Name: _____	MCO or other Carrier Name: _____
Medicaid State ID# or Policy#: _____	Medicaid State ID# or Policy#: _____

Level of Education:  Currently in school  None  H.S. Diploma  GED  Associates  Bachelors or higher

### CURRENT EMPLOYMENT STATUS (if minor, this would be parent/guardian employment status)

\_\_\_\_ Unemployed      \_\_\_\_ Student      \_\_\_\_ Retired  
\_\_\_\_ Employed (Circle one)      \_\_\_\_ Supported Employment      \_\_\_\_ Other (please specify below)  
    Full Time    Part Time/Seasonal      \_\_\_\_ Prevocational Work Services

Employer Name: \_\_\_\_\_ Hours/Week \_\_\_\_\_ Hourly Wage \$ \_\_\_\_\_

### LIST ALL PEOPLE LIVING IN HOUSEHOLD: (must list dates of birth for dependents) Use back if more room needed

Name	Relationship	Date of Birth
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Are you waiting for a Social Security Disability determination?  No  Yes

Do you have a Social Security Representative Payee?  No  Yes If yes, who is your payee?

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**Do you have a Legal Guardian?** (Parent info if applicant is a minor)     No     Yes    **If yes, who is your guardian?**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Who is your emergency contact?**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*Note: Others in Household Income Amount should include whoever is claiming the applicant as a dependent on their tax return, if applicable.

<b>GROSS MONTHLY INCOME</b> (before taxes):	<b>Applicant Amount</b>	<b>*Others in Household Amount</b>
Employment Wages	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
SSI	\$ _____	\$ _____
SSDI	\$ _____	\$ _____
Veteran's Benefits	\$ _____	\$ _____
Child Support	\$ _____	\$ _____
FIP	\$ _____	\$ _____
Pension	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Workers Compensation	\$ _____	\$ _____
Family/Friends	\$ _____	\$ _____
Dividends, Interest, Etc.	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>

<b>HOUSEHOLD RESOURCES:</b>	<b>Amount</b>	<b>Location</b>
Cash	\$ _____	_____
Checking Account	\$ _____	_____
Savings Account	\$ _____	_____
Stocks and Bonds	\$ _____	_____
Certificates of Deposit	\$ _____	_____
Life Insur. (cash value)	\$ _____	_____
Trust Funds	\$ _____	_____
Burial Contracts	\$ _____	_____
Recreational Vehicles	\$ _____	_____
Real Estate (non-residence)	\$ _____	_____
Other _____	\$ _____	_____
<b>TOTAL RESOURCES</b>	<b>\$ _____</b>	

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### OUTCOMES ASSESSMENT

<b>Housing</b> : Are you residing in safe, affordable, accessible housing?	<input type="checkbox"/> Homeless	<input type="checkbox"/> In Placement	<input type="checkbox"/> Staying w/friends or family	<input type="checkbox"/> Housed	Safe?    Yes <input type="checkbox"/> No <input type="checkbox"/> Affordable? Yes <input type="checkbox"/> No <input type="checkbox"/> Accessible? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Medical Care</b> : How often do you see a primary care physician?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than once a year	<input type="checkbox"/> Once a year	<input type="checkbox"/> More than once a year	If never or less than once a year, why?
<b>Employment</b> : Are you successfully employed?	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Pre-vocational	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Community Employment	Hourly Wage: \$ _____ Hours / Week _____
<b>Community Integration</b> : Are you participating in integrated community activities?	<input type="checkbox"/> Clubs/Social Groups	<input type="checkbox"/> Church	<input type="checkbox"/> Community Activities/Events	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Other : describe _____
Please complete if applicant is a minor or is an adult who is still in school:					
<b>School Attendance</b> : I consistently attend school	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly Agree	
<b>School Performance</b> : I take responsibility for completing my school assignments	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly Agree	

I hereby attest that the information I have provided is true and I also give County Social Services permission to release this information to verify and/or communicate eligibility for the assistance requested. I also understand that this is a government document and I may be subject to prosecution if knowingly provide false information.

I also acknowledge I have been given a copy of the County Social Services Notice of Privacy Practices. \_\_\_\_\_  
(please initial)

**Applicant's (or Guardian's) Signature:** X \_\_\_\_\_  
(Application **must** be signed or witnessed and dated to be considered for assistance.)

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**For Staff Use Only**

<input type="checkbox"/> Assisted with Iowa Health & Wellness Plan enrollment (if applicable) <b>What is the disability?</b> (circle one)    Mental Illness/SED    Intellectual Disability    Developmental Disability    Brain Injury <b>If the individual self-reported a diagnosis, please list it here:</b> _____ <b>Primary Case Worker</b> _____ (if this is blank, no case worker will be assigned in CSN)
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