



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 Genderqueer/Non-Binary _____

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.

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

HOUSEHOLD RESOURCES:	Amount	Location
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 _____	\$ _____	_____
TOTAL RESOURCES	\$ _____	

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OUTCOMES ASSESSMENT

Housing : 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"/>
Medical Care : 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?
Employment : 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 _____
Community Integration : 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:					
School Attendance : I consistently attend school	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly Agree	
School Performance : 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) What is the disability? (circle one) Mental Illness/SED Intellectual Disability Developmental Disability Brain Injury If the individual self-reported a diagnosis, please list it here: _____ Primary Case Worker _____ (if this is blank, no case worker will be assigned in CSN)
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