

Primary Income Source: _____

Current/previous Employer _____ Job: _____ Dates: _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays first)

Secondary Carrier (pays second)

Applicant Pays Title-19 Medicaid Medicare
 Private Insurance No Insurance Medically Needy

Applicant Pays Title-19 Medicaid Medicare
 Private Insurance No Insurance Medically Needy

Company Name _____

Company Name _____

Policy Number: _____

Policy Number: _____

(or Medicaid/Title19 or Medicare Claim Number)

(or Medicaid/Title19 or Medicare Claim Number)

Others in Household:

Name	Relationship	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Monthly Income:

(Check Type, Fill in amount)

Applicant Amount:

Others in Household Amount:

Name

<input type="checkbox"/> 1. Employment Wages	_____	_____	_____
<input type="checkbox"/> 2. Public Assistance	_____	_____	_____
<input type="checkbox"/> 3. Social Security	_____	_____	_____
<input type="checkbox"/> 4. SSDI	_____	_____	_____
<input type="checkbox"/> 5. SSI	_____	_____	_____
<input type="checkbox"/> 6. Veterans Benefits	_____	_____	_____
<input type="checkbox"/> 7. Railroad Pension	_____	_____	_____
<input type="checkbox"/> 8. Child Support	_____	_____	_____
<input type="checkbox"/> 9. Dividends, Interest, Etc.	_____	_____	_____
<input type="checkbox"/> 10. Other	_____	_____	_____
<input type="checkbox"/> 11. FIP/AFDC	_____	_____	_____

If not currently receiving, has the applicant applied for any or the following benefits?

- 1. Unemployment Compensation 2. Social Security Disability
- 3. SSI 4. FIP (AFDC)

What is the status of any such application?

- Approved, but not started Denied Pending

Resources: (Check and fill in amount and agency)

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 Fund	_____	_____
<input type="checkbox"/> Life Insurance (cash value)	_____	_____
<input type="checkbox"/> Stocks and Bonds	_____	_____
<input type="checkbox"/> Vehicle	Value: _____	Year: _____
<input type="checkbox"/> Real Estate	Value: _____	Location: _____
<input type="checkbox"/> Burial Fund/Trust	_____	_____
<input type="checkbox"/> Other Resources	_____	_____

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

1. Previous Address _____
Street Address City State Zip Code County

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

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

Agency Name Address

Where did you live prior to the above listed address?

Previous Address: _____ Dates (Month and Year) _____
_____ to _____
_____ to _____
_____ to _____
_____ to _____

List any previous services such as hospitalization, group homes, mental health center, social service, etc. Use separate sheet if necessary.

_____ to _____
_____ to _____
_____ to _____
_____ to _____

Current Case Manager or Social Worker _____

Agency Address Phone

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

- | | | | | | |
|---------------------------------------|-----------------------------------------------|----------------------------------|-------------------------------------|--------------------------------------------|-------------------------------------|
| <input type="checkbox"/> HCBS/SCL | <input type="checkbox"/> ICF/MR | <input type="checkbox"/> RCF | <input type="checkbox"/> RCF/MR | <input type="checkbox"/> RCF/PMI | <input type="checkbox"/> SCL |
| <input type="checkbox"/> HCBS/Resp. | <input type="checkbox"/> Voc/SW | <input type="checkbox"/> Voc/WAC | <input type="checkbox"/> Voc/ADC | <input type="checkbox"/> Voc/SE | <input type="checkbox"/> Voc./Other |
| <input type="checkbox"/> HCBS/HVM | <input type="checkbox"/> Psych Rehab | <input type="checkbox"/> ADT | <input type="checkbox"/> Evaluation | <input type="checkbox"/> Therapy/Treatment | |
| <input type="checkbox"/> HCBS/Voc. | <input type="checkbox"/> Med Mgm. | <input type="checkbox"/> MHI | <input type="checkbox"/> Commitment | <input type="checkbox"/> Case Management | |
| <input type="checkbox"/> HCBS/Other | <input type="checkbox"/> Rent Subsidy | <input type="checkbox"/> Transp. | <input type="checkbox"/> Respite | <input type="checkbox"/> Protective Payee | |
| <input type="checkbox"/> Pers. Allow. | <input type="checkbox"/> Medical/State Papers | | <input type="checkbox"/> Utilities | <input type="checkbox"/> Burial | <input type="checkbox"/> Other |

Specify Services Requested

1. Type of Service _____ Agency _____
 Units requested _____ Unit = hour day month other (circle one) _____
 Expected Unit Cost _____ COA # _____
 Expected Start Date _____ Expected End Date _____

Expected Outcomes: Describe what you expect to happen as a result of this service. _____

2. Type of Service _____ Agency _____
 Units requested _____ Unit = hour day month other (circle one) _____
 Expected Unit Cost _____ COA # _____
 Expected Start Date _____ Expected End Date _____

Expected Outcomes: Describe what you expect to happen as a result of this service. _____

Contact:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Person Completing the 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 Community Services 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 legal settlement. I understand that information in this document will remain confidential.

X _____
 Applicant's Signature (or Legal Guardian) Date

I understand that failure to provide requested information will result in my application being denied or current benefits being canceled. I also agree to make every effort to secure employment, which will enable me to support my family or myself.

You are required to report all changes in your circumstances, such as income, resources, living arrangements, etc; which may effect continued eligibility for County General Assistance. These changes shall be reported within 10 days of the date of the change. Failure to report these changes may result in denial of continued eligibility for County General Assistance.

X _____
 Signature of Applicant Date

For CPC Use only:

Legal Settlement/Financial Decision: _____ Date: _____ Reason for Denial: _____

Program Decision: _____ Date: _____ Reason for Denial: _____