	C	L	M
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County Rural Offices of Social Services (CROSS) Region

For individuals living in: Clarke, Decatur, Lucas, Monroe, Ringgold & Wayne

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

Begin Date ______________________________

☐ **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. ____
3. ____

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.

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)	**Secondary Carrier (pays 2nd)**
☐Applicant Pays ☐Medicaid ☐Iowa Health and Wellness	☐Applicant Pays ☐Medicaid ☐Iowa Health and Wellness
☐Medicare A, B, D ☐Medically Needy ☐MEPD	☐Medicare A, B, D ☐Medically Needy ☐MEPD
☐No Insurance ☐Private Insurance ☐HAWK-I	☐No Insurance ☐Private Insurance ☐HAWK-I
Company Name ______________________	Company Name ______________________
Address ______________________	Address ______________________
Policy Number: ______________________ (or Medicaid/Title 19 or Medicare Claim Number)	Policy Number______________________ (or Medicaid/Title 19 or Medicare Claim Number)
Start Date: __________ Any limits? ☐ Yes ☐ No	Start Date: __________ Any limits? ☐ Yes ☐ No
Spend down: _________ Deductible: __________	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**______________ ☐**DHS 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 County 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 county in establishing my ability to pay for services requested, and in assuring 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**

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