

Primary Income Source: _____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays first)

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

Company Name _____

Address _____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays second)

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

Company Name _____

Address _____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)

Others in Household:

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

Monthly Income:

(Check Type, Fill in amount)

Applicant Amount:

Others in Household Amount:

<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	_____	_____

If not currently receiving, has the applicant applied for any of 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 Funds	_____	_____
<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	_____	_____

What are your current living expenses? Rent/House Payment _____ Water _____ Sewer _____
 Garbage _____ Electricity _____ Groceries _____ Medication _____ Cable TV _____ Entertainment _____
 Misc. expenses, please list amount and to who _____

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

1. Previous Address _____

Street Address	City	State	Zip Code	County
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When did you live at this address? _____ / _____ to _____ / _____
 Month Year Month Year

Employer: _____ **Job:** _____ **Dates:** _____

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
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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. Mgmt.	<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"/> Transport.	<input type="checkbox"/> Respite	<input type="checkbox"/> Protective Payee	
<input type="checkbox"/> Pers. Allow.	<input type="checkbox"/> Medical	<input type="checkbox"/> Other: Describe _____			

