

DICKINSON COUNTY GENERAL ASSISTANCE APPLICATION

1802 Hill Avenue
SPIRIT LAKE, IOWA 51360

Applicants First Name Middle Last Social Security Number

Street Address City State Zip Code

Mailing Address (If Different) Telephone Number

How long have you been at the above address? Years Months Days

Previous Address How long

List Each Person living in the household and include yourself.

Name	Birthdate	SS Number	Education	Relationship to applicant
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Have you listed all in the household? Yes No If no, explain

RESOURCES

Does anyone in your home have any of the following resources? Check Yes or No for each item.

	Amount	Location	Name or Names of Persons
Cash on Hand Yes No			
Checking Account Yes No			
Savings Account Yes No			
Stocks or Bonds Yes No			
Time Certificates Yes No			
Trust Fund Yes No			
IRA Yes No			
Other - List			
	Make/Year	Value	Amount Owed
Automobiles Yes No			
Truck/Motorcycle Yes No			
Snowmobile/Boat Yes No			
Mobile Home Yes No			

Do you or anyone in your home have life or other death benefit insurance?

Yes _____ No _____ If yes, complete the following:

List Persons Covered	Company Name	Face Value	Yr. Purchased	Beneficiary
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INCOME

Does anyone in your home receive any of the following income? Check yes or no for each item. Complete the information line on items checked yes.

	Amount	How Often Received	Name of Receiver
Self Employment Yes _____ No _____			
Employment Yes _____ No _____			
Student Loan/ Grant Yes _____ No _____ Training Allowance, JTPA			
Job Insurance Yes _____ No _____ Workers' Compensation			
Social Security Yes _____ No _____			
Supplemental Yes _____ No _____ Security Income (SSI)			
Veteran's Benefits Yes _____ No _____			
Child Support/ Yes _____ No _____ Alimony			
Military Dependency Yes _____ No _____			
Disability Insurance Yes _____ No _____			
FIP Yes _____ No _____			
Food Stamps Yes _____ No _____			
IPERS, Civil Service Yes _____ No _____			
Other Pension Yes _____ No _____			
Money from other Yes _____ No _____ persons, gifts			
Money from Yes _____ No _____ Interest			
Room and Board Yes _____ No _____			
Commissions Yes _____ No _____			
Other (Explain) Yes _____ No _____			

Has anyone in your home received or tried to get any item listed above during the last six months? Yes _____ No _____

If yes, Explain _____

Was anyone in your home off work due to a strike this month? Yes _____ No _____

If yes, who _____ Date strike started or ended _____

Are you or someone else in your home paying child support or alimony to someone outside the home? Yes _____ No _____

If yes, whom _____ Amount _____

Does anyone else pay any of your living expenses? Yes _____ No _____

If yes, explain _____

Are you or anyone in your home selling real estate on contract? Yes_____ No_____

Are you or any member of your family employed now or did they get a pay check during the month? Yes_____ No_____

If yes, complete the following:

Name of Person Employed	Name of Employer	Employer's Address

Do you or anyone in your home receive something other than money in exchange for work performed? Yes_____ No_____

(Example, working off your rent) If yes, explain _____

Did anyone in your home receive a gift of money in the last 30 days? Yes_____ No_____

If yes, explain _____

Did anyone in your home receive a loan in the last 30 days? Yes_____ No_____

If yes, explain _____

Did anyone in your home win any money in the last 30 days? Yes_____ No_____

If yes, explain _____

Are you registered at Job Service? Yes_____ No_____

How often do you contact Job Service? _____

Has Job Service contacted you about any job openings? Yes_____ No_____

Have you followed up on Job Service contacts? Yes_____ No_____

If no, explain _____

Are you willing to make job searches? Yes_____ No_____

If no, explain _____

Is anyone in training under JTPA or Vocational Rehabilitation? Yes_____ No_____

Do all members of your household who are required to be registered for work and participate in employment and training sessions agree to do so? Yes_____ No_____

Has anyone in your household quit a job in the last 6 months? Yes_____ No_____

If yes, explain _____

Are there students in your household who are 1) between the ages of 18 and 60; and 2) not in high school? Yes_____ No_____

If yes, who _____

Are you willing to reimburse the county for assistance given? Yes_____ No_____

If no, explain _____

EXPENSES

A. Dependent Care

Does anyone in your household pay for someone to babysit or care for a child or a disabled adult, so that a member can work, attend training or look for a job? Yes_____ No_____

How much do you pay _____ How often _____ To whom _____

B. Shelter

Are you renting? Yes_____ No_____ Are your utilities included? Yes_____ No_____ Rent Amount _____

If you are renting, give the landlord's name _____

Address _____ Social Security Number _____

If you are buying, or own your home:	Remaining Mortgage	\$ _____	per _____
	Assessed Value	\$ _____	per _____
	Insurance	\$ _____	per _____
	Special Assessment	\$ _____	per _____
	Property Taxes	\$ _____	per _____

C. Utilities

Check the box next to the utility costs you pay and list the amount you are billed. Have receipts or bills available.

		Amount	How often billed?
City Utility (Electric, water, sewage, garbage, etc.)	Yes_____ No_____		
Telephone	Yes_____ No_____		
Electricity	Even pay plan? Yes_____ No_____ Yes_____ No_____		
Water and Sewage	Yes_____ No_____		
Garbage and Trash	Yes_____ No_____		
Gas	Even pay plan? Yes_____ No_____ Yes_____ No_____		
Other (Specify Utility)	Yes_____ No_____		

Does any other agency, organization or person outside your household pay or help pay any of the shelter, utilities or dependent care costs you've listed? Yes_____ No_____

If yes, who pays? _____ Which Bills? _____ How Much? _____

D. Medical Expenses

Person's Name	Type of Medical Expenses	Amount of Expenses

Do you have health insurance? Yes_____ No_____ If yes, give name of Company _____

Do you have title 19? Yes_____ No_____ Do you have Medicare? Yes_____ No_____

Name of Doctor _____ Name of Drug Store _____

E. Other Debts, Credit Cards, Etc.

Whom Debt With	Reason for Debt	Amount

MILITARY SERVICE RECORD

Name	Date Enlisted	Date Discharged	Type/Discharge	Branch

GUARDIANSHIP

Do you have a legally appointed conservator, guardian or payee? Yes_____ No_____

If yes, give Name _____ Address _____

WHAT TYPE OF ASSISTANCE ARE YOU REQUESTING? WHY? _____

ANY CHANGES IN ANSWERS TO QUESTIONS IN THIS APPLICATION MUST BE REPORTED IMMEDIATELY, IF ANY ASSISTANCE IS BEING CONSIDERED AT THE PRESENT OR FUTURE!

Certification Statement:

I understand that I assume full responsibility for the accuracy of the statements on this form and I understand the Dickinson County General Assistance Department will use these statements to determine my eligibility for General Assistance. If I provide false statements on this application, or give false statements to the General Assistance Office, this can be considered fraud and may be referred to the County Attorney. I am aware that this General Assistance information may be verified and investigated.

Release of Information:

You are authorized to discuss my situation with any Federal, State, County, City or private agency regarding my General Assistance request. I also do hereby forever release and discharge you from any liability for divulging such information whether such information is deemed confidential or not.

Legal Claim:

I understand that the Code of Iowa provides that "Any county having expended any money for relief or support of a poor person, under the provisions of the chapter may recover the same from any of his kindred mentioned herein, from such poor person should he become able or from his estate; from relatives by action brought within three years from the payment of such expenses, from such person's estate by filling the claim as provided by law." (252.13)

Signature or mark of applicant

Date

Disposition:

You will receive a decision as to the disposition of your application in writing within seven (7) working days unless more information is required. The applicant/client has the right to appeal a local decision relative to the administration and interpretation of the policies of the General Assistance Ordinance.

FOR AGENCY USE ONLY:

Date _____

Disposition of request:

Approved by _____

Authorization for the Use or Disclosure of Confidential Information

Counties, Disability Access Points, and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 35B, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: _____ Date of Birth: _____ Client #: _____

Address: _____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties, Disability Access Points ("DAPs"), or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties, DAPs, or Regions to perform related duties on behalf of the counties, DAPs, Regions, law enforcement agencies, and community non-profit agencies providing financial assistance (a list of the current affiliated case management entities, law enforcement agencies, community non-profit agencies providing financial assistance and other providers is available upon request), and these specifically identified entities: _____, with the exception of the following Iowa counties, DAPs, Regions or other entities: _____.

The undersigned authorizes the entities listed on Exhibit A, and/or the case management agencies and other providers who are affiliated with the entities listed on Exhibit A, to share the following information with each other for the purposes identified below.

Information to be disclosed includes:	For the following purposes:
To law enforcement agencies, providers or agencies who have arranged with the counties, DAPs, or Regions to perform related duties on behalf of the counties, DAPs, Regions, and/or community non-profit agencies providing financial assistance: Care Team information, Address type, Insurance information, Events, All applications, Employment information, Resources and Income, and Name of person and entity that entered your information. This does not include any information related to HIV/AIDS related testing, mental health, or substance use disorder treatment information.	In keeping with national, state and local efforts to enhance care coordination, parties will access/disclose records for the purposes of: coordinating treatment/care, determining benefit eligibility, obtaining authorizations, jail based service coordination, coordinating the funding for services and other benefits available to you, and
To Iowa counties, DAPs, and Regions listed on Exhibit A; case management agencies; and/or the specifically identified entities from above: Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance and county commissions of veteran affairs described in Iowa Code § 252.25 and § 35B.10.	Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations, jail based service coordination, funding for services and abiding by state and federal reporting requirements.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby specifically authorize the release and sharing of information with Iowa counties, DAPs, and Regions listed on Exhibit A; case management agencies; and/or the specifically identified entities from above, relating to: (check any that apply)

NOTE: This authorization for release of information does not authorize the release and/or sharing of information relating to substance use disorder treatment.

☐ HIV/AIDS Related Testing Information

☐ Mental Health Information (**NOTE:** This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:

☐ ____/____/____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to _____, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client

☐ guardian or conservator of a client (if and to the extent authorized under State law)

☐ personal representative of deceased client

☐ other (specify) _____

Copy sent to Client/Guardian on: _____ (date) at following address: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code Chapter 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

<u>Iowa Counties:</u>	Floyd	Monroe	<u>Iowa Mental Health and Disability Services Regions and Disability Access Points:</u>
Adair	Franklin	Montgomery	Care Connections of Northern Iowa
Adams	Fremont	Muscatine	Central Iowa Community Services
Allamakee	Greene	O'Brien	County Social Services
Appanoose	Grundy	Osceola	Eastern Iowa MHDS
Audubon	Guthrie	Page	Heart of Iowa Community Services
Benton	Hamilton	Palo Alto	Mental Health Agency of Southeast Iowa
Black Hawk	Hancock	Plymouth	MHDS of the East Central Region
Boone	Hardin	Pocahontas	Polk County Behavioral Health and Disability Services
Bremer	Harrison	Polk	Rolling Hills Community Services
Buchanan	Henry	Pottawattamie	Sioux Rivers MHDS
Buena Vista	Howard	Poweshiek	Southwest Iowa MHDS
Butler	Humboldt	Ringgold	District 1 - Western Iowa Services Collaborative
Calhoun	Ida	Sac	District 2 - Collaborative Individual and Community Supports
Carroll	Iowa	Scott	District 3 - Collaborative Individual and Community Supports
Cass	Jackson	Shelby	District 4 - Western Iowa Services Collaborative
Cedar	Jasper	Sioux	District 5 - Behavioral Health and Disability Services
Cerro Gordo	Jefferson	Story	District 6 - Collaborative Individual and Community Supports
Cherokee	Johnson	Tama	District 7 - Eastern Iowa Disability Alliance
Chickasaw	Jones	Taylor	
Clarke	Keokuk	Union	
Clay	Kossuth	Van Buren	
Clayton	Lee	Wapello	
Clinton	Linn	Warren	
Crawford	Louisa	Washington	
Dallas	Lucas	Wayne	
Davis	Lyon	Webster	
Decatur	Madison	Winnebago	
Delaware	Mahaska	Winneshiek	
Des Moines	Marion	Woodbury	
Dickinson	Marshall	Worth	
Dubuque	Mills	Wright	
Emmet	Mitchell		
Fayette	Monona		

REVOCATION SECTION

I hereby revoke this Authorization.

Signed: _____

Date: _____

Copy sent to Client/Guardian on: _____ (date) at following address: _____