215 West 4th Street Suite 6
Spencer, IA 51301
phone: 712-264-3945
fax: 712-262-9206

EMAIL: intake@ccnia.org

INTAKE & DEMOGRAPHICS

Application Date:

First Name: Last Name: MI:

Nickname: Birthdate:

U.S. Citizen: ☐ Yes ☐ No If you are not a citizen, are you in the country legally? ☐ Yes ☐ No

SSN# Primary Phone #:

Current Address: _____ _____ ____ _____ _____
Street City State Zip Code County

Address begin date:

Did you move to this address for the purpose of attending college? ☐ Yes ☐ No

Are you currently a student? ☐ Yes ☐ No Use as current mailing address: ☐ Yes ☐ No
If not, what is your current mailing address:

Current Residential Arrangement (please check one): ☐ Private Residence ☐ Foster Care/Family LifeHome
☐ Correctional Facility ☐ Homeless/Shelter/Street ☐ Other

Emergency Contact Person:

Name:_____

Phone:_____Relationship:_____

Guardian appointed by the Court? ☐ Yes ☐ No Payee Appointed by Social Security? ☐ Yes ☐ No
Address: Phone:
Name:_____ Name:_____

Health Insurance Information (Check all that apply) ☐ Medicaid ☐ Medicare A, B,D ☐ No Insurance
☐ Private Insurance Company Name

Disability Group/Primary Diagnosis (if known): ☐ Mental Illness ☐ Intellectual Disability
☐ Developmental Disability ☐ Substance Abuse ☐ Brain Injury

Referral Source: Phone:

What services are you applying for?

I certify that the above information is true and complete to the best of my knowledge, and I authorize regional or county staff to check for verification of the information provided including verification with other Iowa Regions and County Government and the state of Iowa Department of Human Services (DHS) and the Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the Region or County in establishing my ability to pay for services requested, and in ensuring that appropriate of services requested. I understand the 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

Crisis Services, Information & Referral services, Transitional Services, Commitment Fees-Sheriff and Attorney, Jail-Based Services, Block Grant Funds

Clay · Kossuth · Osceola · Palo Alto · Winnebago · Worth

Care Connections exists to support improved access to behavioral healthcare through local resources to promote full citizenship for people with mental illness and intellectual disabilities.

Authorization for the Use or Disclosure of Confidential Information

Counties 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 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 or Regions to perform related duties on behalf of the counties or 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, Regions or other entities: _____.

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions 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 or Regions to perform related duties on behalf of the counties or 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 assisting with state and federal reporting requirements.
To Iowa counties 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 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

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

REVOCATION SECTION

I hereby revoke this Authorization.

Signed:_____ Date:_____

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