

## **HOW OUR SYSTEM WORKS**

Our office is called the Central Point of Coordination (CPC). We act as the gatekeeper for our County's system of services and supports for persons with mental disabilities. We take applications, determine your eligibility and need, and provide funds for needed services and supports. We report directly to the Henry County Board of Supervisors. We contract with many agencies that provide a wide range of services. Most providers can assist you in applying to our office for funds to pay for services and supports that you need. You can find a list of our providers in the Strategic Plan Section of the Policy Manual.

## **HOW DO I QUALIFY**

You are eligible for funding assistance if you meet our basic requirements. You must be a citizen of the United States of America or a legal alien. You must reside in or have legal settlement in Henry County. You must be diagnosed with a disability that our plan covers. These are mental illness, chronic mental illness, mental retardation, and developmental disabilities. You can find definitions of these disabilities on page 1 of the Policy Manual. You must meet our income and resource guidelines. A copy of the current income guidelines will be provided upon request. You must need a service that is covered in our plan. We feel that we offer funding for a wide variety of services and supports. These are listed in the Strategic Plan Section of the Policy Manual.

## **HOW DO I APPLY**

To start the process, you must complete a written application. You can do this at our office (106 North Jackson Mt Pleasant), or at any of the providers listed as access points on page 11 of the Policy Manual. We can also mail the application to you. If you like, you can get assistance from a friend or family member familiar with your personal matters. You will be asked to provide information about your disability, health, education, work history, income, benefits, insurance and other matters. We also need information about others who live in your household, or those who are responsible for your support. We also want to know where you have lived in the past so we can determine if Henry County has responsibility for payment of services or supports you need. A copy of our application is found in the Appendix to the Policy Manual. We will assure that your privacy is respected and protected. No personal information will be shared with others unless you give us written permission or we are required by law to do so. You will be asked to sign release forms that allow us to talk with other people and agencies and to exchange information and records about you. In medical and psychological emergencies, you may be unable to give your consent to release necessary information. When this happens, our first priority will be to see that you receive emergency services. We will only release what is necessary and required by law to address your crisis. Information about confidentiality is found on page 15-16 of the Policy Manual. After we receive your application and verifications, we will decide whether or not you are eligible to receive funding assistance from Henry County. You will receive a written Notice of Decision. If you are found eligible, the notice will list each service for which you are eligible, the amount of each service, and the monthly cost of each service. The notice will also list any co-payment that you are required to make to receive that service or support. If you are not eligible for funding assistance, your notice will explain the reasons why we could not honor your request. It may provide alternative choice(s). You have the right to appeal any part of either decision. The appeals process is discussed beginning on page 19 of the Policy Manual.

## **HOW DO I DECIDE WHAT SERVICES ARE NECESSARY**

Once you have been found eligible for funding, the next step is to develop a plan of services and supports that meet your unique needs and circumstances. To accomplish this, we need to assess your strengths and areas of needed improvements. If you are eligible for Medicaid (Title 19) you will work with a case manager to develop a comprehensive plan that is tailored to your specific strengths, abilities, and needs. If you do not receive Medicaid (Title 19) you will work with our service coordinator to develop a similar plan. We will authorize service funding up to a maximum of 180 days at which time your service coordinator, case manager, or service provider will review your progress and make a new request for continued funding.

## **WHAT DO I HAVE TO DO TO REMAIN ELIGIBLE**

We will continue to work with you to make sure that your services and supports continue to meet your changing needs. We are always open to suggestions and welcome comments on how we can better serve you and others in our system. We will ask your input through a yearly survey so we have a formal record of input. We require that you update your record twice per year so that we can be sure that you remain eligible for funding assistance. These update forms will be mailed to you and you will receive new notices of decision with each review form filed in our office. We ask that you report any changes in your circumstances to our office as soon as possible so we can maintain your eligibility. We will keep an individual record of services authorized and payments made in our office. We ask that you participate in developing the Policy Manual and assist us in developing services and supports that meet everyone's changing needs. We ask that you attend our quarterly Stakeholders Meeting to provide input and remain informed of changes within our system. We ask that you work and make progress on the goals you developed in your individual plan. We ask that if you are able, you seek employment and cooperate in getting any other kind of assistance for which you are eligible. Please feel free to contact us if you have any questions, complaints or compliments about us, your providers, or about anyone else involved in Henry County's mental health, mental retardation and developmental disability service system: Henry County CPC, 106 N Jackson St, Suite 102, Mt Pleasant, IA 52641 telephone number 319-385-4050, fax 319-385-1948 and email address [skaufman@henrycountyiowa.us](mailto:skaufman@henrycountyiowa.us).

## Henry County Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**If you have any questions about this Notice, please contact our Privacy Officer who is Darin Stater, phone 319 385 0752.**

### I. Our duty to safeguard your Protected Health Information:

Protecting the privacy and confidentiality of information about our consumers is very important to Henry County. Henry County maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of consumer information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records. We expect our employees to respect personal information. Henry County employees who misuse information are subject to disciplinary action.

*Individually Identifiable Health Care Information* is considered to be "Protected Health Information". Protected Health Information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental condition and related health services. Henry County is required by law to extend certain protections to your **PHI** and to give you this **Notice of Privacy Practices**. This **Notice** explains, how, when and why we may use or disclose your **PHI**. Henry County will use or disclose only the minimum **PHI** to accomplish the purpose of the use or disclosure. Henry County is required to follow the privacy practices described in this **Notice**, although Henry County reserves the right to change its policy practices and the terms of this **Notice** at any time. If this is done, a new **Notice of Privacy Practices** will be posted at the Henry County Courthouse. You may also request a copy of the new **Notice** from **Darin Stater, County Attorney's office, Henry County Courthouse, Mt. Pleasant, Iowa, phone 319 385-0752.**

### II. How we may use and disclose your Protected Health Information

We may use and disclose your **PHI** for a variety of reasons. For most uses / disclosures we must obtain your consent. For others, we must have written authorization. However, the law provides that we are permitted to make some uses / disclosures without your consent or authorization. The following are descriptions and examples of our potential uses / disclosures of your **PHI**.

**Generally, Henry County must have your consent for:**

- **Uses and disclosures relating to the determination of eligibility for Henry County funding assistance.** For example, Henry County may request documentation of a mental diagnosis from a medical doctor or Qualified Mental Health Professional to determine your eligibility for funding assistance for mental health services.
- **Uses and disclosures to facilitate referrals for services.** For example, in the process of making referrals and securing services that meet your needs, Henry County may share relevant information with other agencies such as Vocational Rehabilitation, Department of Human Services, Social Security Administration, Mental Health Center, and other community agencies (business associates) that provide services to Henry County consumers.

**Uses and disclosures relating to payment of services.** Henry County may exchange information with other agencies for the purpose of making payment for services provided to you.

- **Uses and disclosures related to provision of services.** For example, Henry County is a direct provider of Case Management, Service Coordination, and Residential Care services.
- **Appointment reminders and necessary paperwork.** Unless you provide us with alternative instructions, we may send you appointment notices and other paperwork

necessary to conduct business related to funding eligibility, service referral and provision, and payment for services.

- **Uses and disclosures related to quality assurance.** We may exchange information with agencies that provide services to you and are funded by Henry County for the purpose of evaluating the appropriateness and quality of service provision and assessing documentation compliance, successful outcomes and consumer satisfaction.
- **Exceptions:** *Although your consent is usually required for the use / disclosure of your PHI for the activities described above, the law allows us to use / disclose your PHI if needed in emergency situations or if required by law.*
- **Uses and disclosures requiring authorization:** For uses / disclosures beyond funding eligibility determination, referrals for services, payment for services, quality assurance, and provision of County services, we are required to have your written authorization, *unless the use / disclosure falls within one of the exceptions described below:*

**When required by law:** We may disclose **PHI** when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity or in response to a Court order. We must also disclose **PHI** to authorities who monitor compliance with these privacy requirements.

**For health oversight activities:** We may disclose **PHI** to agencies, such as Protection and Advocacy, that are responsible for monitoring the health care system for purposes of reporting or investigating of unusual circumstances and rights violations.

**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose **PHI** as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

**For specific government functions:** We may disclose **PHI** of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the U.S. President.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 C.F.R. section 164.500 et. Seq.

### III. Your rights regarding your Protected Health Information

**To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your **PHI**. We will consider your request but are not legally bound to agree to the restriction. To the extent that we agree to any restrictions on our use / disclosure of your **PHI**, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses / disclosures that are required by law.

**To choose how we contact you:**

You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably convenient for us to do so.

**To inspect and copy your PHI:**

Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within thirty days of receiving your request. If we deny your request, we will give you written reasons for the denial and explain your right to have the denial reviewed. If you want copies of your **PHI**, a charge for photocopying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information regarding the cost of copying.

**To request amendment of your PHI:**

If you believe that there is a mistake or missing information in our record of your **PHI**, you may request, in writing, that we correct or add to the record. We will respond within sixty

days of receiving the request. We may deny the request if we determine that the **PHI** is: (a) correct and complete; (b) not created by us and / or not part of our records; (c) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the denial reviewed. Any statement in response from you will be appended to your record. If your request to amend your **PHI** is approved, we will change the **PHI** and inform you and others that need to know about the change in your **PHI**.

**To find out what disclosures have been made:**

You have a right to get a list of when, to whom, for what purpose, and what content of your **PHI** has been released. The list will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities. We will respond to your written request within sixty days of receiving it. Your request can relate to disclosures going as far back as (five or six) years. There will be no charge for up to one list per year. There may be a charge for more frequent requests.

**To receive a copy of this Notice:** You have a right to receive a paper copy of this **Notice** upon request.

**IV. How to file a complaint:**

If you believe your privacy rights may have been violated or you disagree with a decision we made regarding your **Protected Health Information**, you may file a complaint with **Darin Stater, phone 319 385-0752**. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

**V. Effective Date:**

This **Notice of Privacy Practices** was effective on **April 14, 2003**.

**MENTAL HEALTH ASSISTANCE FUNDING APPLICATION**

**Henry County Iowa**

Today's date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Applicant**

FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

**Current Address** \_\_\_\_\_ CITY \_\_\_\_\_ IA ZIP \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security #** \_\_\_\_\_

**Sex** (Circle one)      M    F

**Ethnicity** (Circle one) 1) White 2) African American 3) American Indian or Alaskan Native  
4) Asian or Pacific Islander 5) Hispanic 6) Other \_\_\_\_\_.

**Marital Status** (Circle one) 1) Single 2) Married 3) Separated 4) Divorced 5) Widowed

**Referred by** (Circle one)      1) Self 2) Family 3) Case Management 4) Corrections 5) DHS  
6) Other \_\_\_\_\_

**Are you a Veteran** Y N if yes list your Service Branch \_\_\_\_\_ Dates of Service \_\_\_\_\_

**Are you**      **Blind** Y N      **Disabled** Y N      **a Student** Y N

**Do you have a** (Circle) **Guardian**      **Power of Attorney**      **Conservator**      **Payee**

**Education** What is the highest grade you have completed? \_\_\_\_\_

**Have you ended employment voluntarily in the last sixty (60) days?** Y N

**Are you under Civil Commitment** Y N

If YES, where were you committed? \_\_\_\_\_

**Person to contact in case of emergency**

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_

**What is your diagnosis** (if known) \_\_\_\_\_

**List ALL the members of your household**

| Name | Relationship | Social Security # | Date of Birth |
|------|--------------|-------------------|---------------|
|      |              |                   |               |
|      |              |                   |               |
|      |              |                   |               |
|      |              |                   |               |

**Employment History** List your most recent work experiences and dates of employment

| Employer | Address | Started | Ended |
|----------|---------|---------|-------|
|          |         |         |       |
|          |         |         |       |
|          |         |         |       |

List all current **GROSS** monthly income for **ALL HOUSEHOLD MEMBERS:**

| Type of Income             | Amount | Amount | Amount | Amount | Amount |
|----------------------------|--------|--------|--------|--------|--------|
| Name of Wage Earner        |        |        |        |        |        |
| Earnings from work         |        |        |        |        |        |
| FIP/ADC/TANF               |        |        |        |        |        |
| Social Security            |        |        |        |        |        |
| Social Security Disability |        |        |        |        |        |
| SSI                        |        |        |        |        |        |
| Veterans Benefits          |        |        |        |        |        |
| IPERS                      |        |        |        |        |        |
| Railroad Pensions          |        |        |        |        |        |
| Child Support              |        |        |        |        |        |
| Interest/Dividends/ETC.    |        |        |        |        |        |
| Self Employment            |        |        |        |        |        |
| Other (Explain)            |        |        |        |        |        |

**Resources** List **ALL** resources as of the first day of the month:

| Type of Resource          | Amount | Location |
|---------------------------|--------|----------|
| Cash                      |        |          |
| Checking Accounts         |        |          |
| Savings Accounts          |        |          |
| CD's                      |        |          |
| Stocks/Bonds              |        |          |
| IRA'S                     |        |          |
| Life Insurance Cash Value |        |          |
| Trust Accounts            |        |          |
| Burial Accounts           |        |          |
| Property                  |        |          |
| Other (Explain)           |        |          |

**Have you transferred or given away anything of value in the last year?**

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**Health Insurance Information;** Are you covered by any of the following: (Circle all that apply)

(If YES, Please list Company name and Policy Number for each type of coverage you have)

Insurance paid for by yourself Name of Insurance Company \_\_\_\_\_

Insurance paid for by your Employer Name of Insurance Company \_\_\_\_\_

Medicare Medicare Identification Number \_\_\_\_\_

Medicaid Medicaid Identification Number \_\_\_\_\_

Insurance provided by someone else Name of Insurance Company \_\_\_\_\_

Other Explain \_\_\_\_\_

NO INSURANCE COVERAGE

**Circle all of the following services which you are requesting funding assistance:**

Evaluation and Testing    Transportation    Psychotropic Prescription Assistance

Therapy and Counseling    Medication Management    Supported Community Living

RCF    ICF/MR    Supported Employment    Workshop Services

Respite Care    Home or Vehicle Modifications    Payee Services

Skill Development (cooking, laundry,, etc.)    Case Management

Legal Services Assistance (involuntary commitments only)    Hospitalization (Including MHI)

Other \_\_\_\_\_

Describe any services or supports you are currently receiving \_\_\_\_\_

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF IT IS DETERMINED THAT I WILLFULLY MISREPRESENTED THESE FACTS, THEN THIS APPLICATION CAN BE DENIED ON THOSE GROUNDS.

I AM AWARE THAT THE INFORMATION REPORTED ON THIS APPLICATION MAY BE VERIFIED AND INVESTIGATED. IF I DO NOT HAVE LEGAL SETTLEMENT IN HENRY COUNTY A COPY OF THIS APPLICATION MAY BE PROVIDED TO THE COUNTY OR DEPARTMENT OF HUMAN SERVICES (STATE CASES) WHERE MY LEGAL SETTLEMENT IS DETERMINED TO BE. I HEREBY AUTHORIZE THE HENRY COUNTY CPC ADMINISTRATOR OR DESIGNEE AUTHORITY TO OBTAIN OR RELEASE PERTINENT INFORMATION TO DETERMINE MY ELIGIBILITY FOR FUNDING ASSISTANCE ACCORDING TO REQUIREMENTS CONTAINED IN THE HENRY COUNTY MENTAL HEALTH SERVICES MANAGEMENT PLAN. THE RELEASE TO INVESTIGATE THE INFORMATION CONTAINED IN THIS APPLICATION IS GOOD FOR 60 DAYS FROM THE DATE OF MY SIGNATURE.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE HENRY COUNTY NOTICE OF PRIVACY PRACTICE.

**Signature of Applicant**

\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_ Phone \_\_\_\_\_

**PROHIBITION AGAINST DISCRIMINATION**

We shall consider this application without regards to race, color, sex, handicap, religion, national origin, or political belief. Every applicant, whether granted assistance or not, has the right to appeal to the Henry County Board of Supervisors and may represent him/her self or may be represented by legal counsel at his/her own expense. The written appeal or communication shall be made to the Henry County CPC Administrator at 106 North Jackson Mt Pleasant IA 52641 within ten (10) days of written notification regarding benefits. This communication shall include the applicants name, current address, and phone number if applicable, and shall state the reason for appeal. A face to face consultation with the CPC Administrator shall be scheduled. If you are granted Mental Health Assistance Funding by the terms of the Henry County Management Plan, you may be required to repay all or part of the monies paid on your behalf by Henry County. Henry County provides, as well as purchases, the following services: transportation, case management and residential care facility services. Thus the potential for a conflict of interest exists when Henry County decides whether or not to authorize payment for services. Henry County is committed to making payment decisions solely on the basis of applicant eligibility, service needs, and cost analyses without favoring County provided services. Applicants are encouraged to appeal any decision felt to be influenced by this potential conflict of interest.

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 HOUSEHOLD SIZE \_\_\_\_\_

**LIST THE LAST TWO MONTHS BILLS FOR THE FOLLOWING:**

| Expense Item                            | Month 1 Amount | Month 2 Amount | For Office Use Do Not Complete |
|---|----------------|----------------|--------------------------------|
| RENT                                    |                |                |                                |
| MORTGAGE                                |                |                |                                |
| PROPERTY TAXES                          |                |                |                                |
| HOMEOWNERS INSURANCE                    |                |                |                                |
| ELECTRICITY                             |                |                |                                |
| HEATING                                 |                |                |                                |
| SEWER/WATER                             |                |                |                                |
| PRESCRIPTIONS                           |                |                |                                |
| DOCTOR VISITS                           |                |                |                                |
| HEALTH INSURANCE PREMIUMS               |                |                |                                |
| FOOD (DO NOT INCLUDE FOOD STAMPS SPENT) |                |                |                                |
| CLOTHING                                |                |                |                                |
| CHILDCARE                               |                |                |                                |
| WORK RELATED EXPENSES                   |                |                |                                |
| TRANSPORTATION                          |                |                |                                |

**DO YOU HOUSEHOLD HAVE ANY OUTSTANDING FINES/COURT COSTS FOR WHICH YOU ARE LIABLE? Y N**

IF YES, TOTAL AMOUNT DUE \_\_\_\_\_

I THE UNDERSIGNED CERTIFY THAT THE ABOVE NOTED COSTS ARE TRUE AND ACCURATE

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY, DO NOT COMPLETE THIS SECTION**

Gross Income \$ \_\_\_\_\_ Total Monthly Expense \$ \_\_\_\_\_ = Net Countable  
 Income \$ \_\_\_\_\_ Household Income Limit \$ \_\_\_\_\_ Repay YES NO

CPC SIGNATURE \_\_\_\_\_

**Legal Settlement Worksheet**

Name: \_\_\_\_\_ Previous surnames/maiden name: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Veteran: Y or N

Insurance (including Medicaid): Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

In order to determine which Iowa county has funding responsibility for you, please complete the following information with as much detail as possible. This does not affect your eligibility for funding, it only determines who is responsible. Begin with your current address. Continue completing each address section in full until it is clear at which address you have been for 12 months *without* receiving any of the services listed.

Current Address: \_\_\_\_\_ From: \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Received the following services while at this address: Where and when  
 Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist \_\_\_\_\_  
 Substance Abuse counseling/treatment by a licensed professional \_\_\_\_\_  
 Community Services – General Assistance, Case Management, Social Worker \_\_\_\_\_  
 Probation, parole, prison, jail \_\_\_\_\_

Address: \_\_\_\_\_ From: \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Received the following services while at this address: Where and when  
 Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist \_\_\_\_\_  
 Substance Abuse counseling/treatment by a licensed professional \_\_\_\_\_  
 Community Services – General Assistance, Case Management, Social Worker \_\_\_\_\_  
 Probation, parole, prison, jail \_\_\_\_\_

Address: \_\_\_\_\_ From: \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Received the following services while at this address: Where and when  
 Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist \_\_\_\_\_  
 Substance Abuse counseling/treatment by a licensed professional \_\_\_\_\_  
 Community Services – General Assistance, Case Management, Social Worker \_\_\_\_\_  
 Probation, parole, prison, jail \_\_\_\_\_

Address: \_\_\_\_\_ From: \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Received the following services while at this address: Where and when  
 Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist \_\_\_\_\_  
 Substance Abuse counseling/treatment by a licensed professional \_\_\_\_\_  
 Community Services – General Assistance, Case Management, Social Worker \_\_\_\_\_  
 Probation, parole, prison, jail \_\_\_\_\_

Address: \_\_\_\_\_ From: \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Received the following services while at this address: Where and when  
 Mental Health counseling/treatment by a physician, social worker, psychologist, or psychiatrist \_\_\_\_\_  
 Substance Abuse counseling/treatment by a licensed professional \_\_\_\_\_  
 Community Services – General Assistance, Case Management, Social Worker \_\_\_\_\_  
 Probation, parole, prison, jail \_\_\_\_\_

Your signature below signifies the information included in this application is true and correct.  
I do solemnly swear or affirm that the above information is true and correct. I do further authorize the County Central Point of Coordination Administrator and/or designee to investigate and verify this information, if needed, including mental health/substance abuse treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Who, besides you, can we contact to verify the above information (name and ph #): \_\_\_\_\_