SEIL staff shall review the application within ten (10) calendar days from the received date stamped on the application to determine if all necessary information is present and complete on the application. If the application is incomplete a request for missing information shall be returned to the applicant giving them ten (10) calendar days to provide the missing information. Failure to respond with necessary information and/or to provide a fully completed application will result in a denial of funding.

A complete application will have all information filled out on the application form, required verifications, a copy of photo identification, releases, verification of insurance coverage and verification of denial of eligibility for other funding sources. If applicable, required verifications may include parole agreements and district court orders. The notice of decision will be issued within ten (10) calendar days of the submitted application being considered complete with all required verifications. An individual who is eligible for other publicly funded services and support must apply for and accept such funding and support.

If a functional assessment and/or other designated enrollment assessment is required it will be completed within ninety (90) days. Once an individual’s assessment is received, the individual will be referred for services to a provider of choice and issued a Notice of Decision within ten (10) days. Emergency and urgent services are not subject to a standardized functional assessment and/or designated enrollment assessment.

Eligibility Requirements:
The individual is at least eighteen years of age and a lawful resident of this state.

Gross household income is at 150% or below the current Federal Poverty Guidelines. Applicants with gross income up to 200% of Federal Poverty Guidelines may be eligible for funding to access preventative outpatient mental health services when they have no other funding source.

An individual cannot have resources greater than $2,000 in countable value for a single-person household or $3,000 in countable value for a multi-person household.

The individual must have a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability.

VERIFICATION REQUIRED FOR A COMPLETE APPLICATION:
1. **APPLICATION** - you must complete all blanks, sign the application and verify and sign HIPAA Notice of Privacy Practices was provided
2. **IDENTIFICATION** - Driver’s License other photo identification
3. **PROOF OF ALL HOUSEHOLD INCOME FOR THE LAST 30 DAYS (3 MONTHS FOR SELF-EMPLOYED)**
   a) Pay stubs or a signed statement from employer verifying gross and net wages including pay dates
   b) Proof unemployment compensation benefits
   c) Proof of FIP benefits
   d) Proof of child support payments
   e) Proof of SSI, Social Security, SSD or pension benefits
   f) Self-employment financial records for the last 3 months
   h) **ANY** other source of income
4. **BANK STATEMENTS FOR ALL ACCOUNTS** - most recent checking statement, most recent savings statement from the financial institution and all other types of bank accounts for all household members
5. **SIGNED RELEASE OF INFORMATION FORMS** - these will be provided with the application or when eligibility is determined
6. **VERIFICATION OF INSURANCE COVERAGE** - you will need to provide copies of your insurance cards, verification you have applied for insurance coverage or verification of denial of eligibility for Medicaid or Market Place insurance coverage
7. **WRITTEN VERIFICATION THAT YOU HAVE APPLIED FOR DISABILITY** (if applicable)
8. **WRITTEN VERIFICATION OF DIAGNOSIS** - a copy of a psychological or psychiatric evaluation or other acceptable verification of diagnosis
SOUTHEAST IOWA LINK
MENTAL HEALTH DISABILITY SERVICES
Application Form

Application Date: __________________________ Date Received by local MHDS Office: __________________________
Agency/contact person completing this form, including contact information: __________________________

First Name: ___________________ Middle Name: ___________________ Last Name: ___________________ Maiden: ___________________

Prefix: ☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms. ☐Prof.  Suffix: ☐D.D. ☐Esq. ☐II ☐III ☐Jr. ☐MD ☐PhD ☐Sr.

SSN#: __________________________ US Citizen: ☐Yes ☐No Date of Birth: __________ Gender: ☐Female ☐Male

Veteran Status: ☐Yes ☐No Military Branch and Type of Discharge: __________________________ Dates: __________________________

Marital Status: ☐Single ☐Married(includes common law) ☐Divorced ☐Separated ☐Widowed

Race: ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Asian or Pacific Islander ☐Other (biracial; Sudanese; etc.) ______________

Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino

Primary Language: ☐English ☐Spanish ☐French ☐German ☐Vietnamese ☐Other: __________________________

Legal Status: ☐Voluntary ☐Involuntary-Civil ☐Involuntary-Criminal ☐Probation ☐Parole ☐Jail/Prison

State ID #: __________________ Legal Issues: ☐Yes ☐No If yes, please specify: __________________________

Blind Determination: ☐Yes ☐No Determination Date: __________

Home Phone: __________ Work/Other Phone: __________ Cell Phone: __________ Email: __________

Current Address: ________________________________________________________________

Street __________ City __________ State __________ Zip __________ County __________

Dates of Residency at this address: __________to __________ # Roommates: __________

Current Residential Arrangement: (Check applicable arrangement)

☐ Private Residence/Household – Alone ☐ Private Residence/Household – With Relatives
☐ Private Residence/Household – With Unrelated Persons ☐ Foster Care/Family Life Home
☐ Correctional Facility ☐ Substance-Related Treatment Facility ☐ 24-Hour Habilitation Home
☐ 24-Hour Supported Community Living Home ☐ Residential Care Facility(RCF) ☐ RCF/ID ☐ RCF/PMI
☐ Intermediate Care Facility(ICF)/Nursing Home ☐ ICF/ID ☐ State MHI ☐ State Resource Center
☐ Homeless/Shelter/Street ☐ Other: Explain __________________________

Mailing Address: ☐ Same ☐ Other: ________________________________________________________________

Street __________ City __________ State __________ Zip __________ County __________

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 ☐ Other __________________________

Employment History: (list starting with most recent to all previous. Use another sheet if more space is needed)

<table>
<thead>
<tr>
<th>Employer</th>
<th>Position</th>
<th>Phone</th>
<th>City, State</th>
<th>Start/End Date</th>
<th>Hrs.</th>
<th>Hrly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Education:

- **Years of Education:** ___________________
- **GED:** □ Yes □ No
- **H.S. Diploma:** □ Yes □ No
- **College Degree:** ___________________

### Interested Persons/Emergency Contact:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Guardian/Payee/Conservator:

- □ Legal Guardian □ Protective Payee □ Conservator
- (Check any that are appointed and write in name etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Others in Household:

<table>
<thead>
<tr>
<th>First Name and Last Name</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Gross Monthly Income (before taxes):

- **Applicant**
  - Veterans Benefits: ___________________
  - Social Security/SSDI: ___________________
  - SSI: ___________________
  - Employment Wages: ___________________
  - Workers Comp: ___________________
  - Public or General Assistance: ___________________
  - Private Relief Agency: ___________________
  - Food Assistance: ___________________
  - Family and Friends: ___________________
  - Child Support: ___________________
  - FIP: ___________________
  - R/R Pension: ___________________
  - Other (Unemployment, etc): ___________________

- **Others in Household**
  - Veterans Benefits: ___________________
  - Social Security/SSDI: ___________________
  - SSI: ___________________
  - Employment Wages: ___________________
  - Workers Comp: ___________________
  - Public or General Assistance: ___________________
  - Private Relief Agency: ___________________
  - Food Assistance: ___________________
  - Family and Friends: ___________________
  - Child Support: ___________________
  - FIP: ___________________
  - R/R Pension: ___________________
  - Other (Unemployment, etc): ___________________

- **Total Monthly Income:** ___________________

**NOTICE:** 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!)

---

### Household Resources: (Check and fill in amount and agency):

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
<th>Bank, Trustee, or Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking Account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash on Hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Certificates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burial Fund/Plot/Life Ins(cash value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDs (cash value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks/Bonds(cash value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividend Interest(cash value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement Funds(cash value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 3 of 9
Total Resources: ____________________

Motor Vehicles: □ Yes □ No
Make, Model & Year: ____________________ Value: ____________________
(include car, truck, motorcycle, etc.)
Make, Model & Year: ____________________ Value: ____________________

Do you, your spouse or dependent children own or have interest in the following:
□ House including the one you live in □ Any other real-estate or land □ Other ______________
If yes to any of the above, please explain: ____________________________________________________________

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)
[ ] Applicant Pays
[ ] Medicaid
[ ] Medicare
[ ] Private Insurance
[ ] No Insurance
[ ] Marketplace Choice
Company Name ____________________
Address ____________________
Policy Number: ____________________
(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays 2nd)
[ ] Applicant Pays
[ ] Medicaid
[ ] Medicare
[ ] Private Insurance
[ ] No Insurance
[ ] Marketplace Choice
Company Name ____________________
Address ____________________
Policy Number: ____________________
(or Medicaid/Title 19 or Medicare Claim Number)

Have you applied for all other public programs? (Please indicate dates applied and decision if applicable):
□ Social Security ____________________ □ SSI ____________________ □ Medicaid ____________________
□ Veterans ____________________ □ Unemployment ____________________ □ Food Assistance ____________________
□ FIP ____________________ □ Other ____________________ □ Other ____________________

Disability Group/Primary Diagnosis:
□ 40-Mental Illness □ 42-Intellectual Disability □ 43-Developmental Disability □ 47-Brain Injury □ 35-Substance Abuse

Specific Diagnosis determined by: __________________________________ Date: ____________________

Axis I: __________________________________ Dx Code: ____________________
Axis II: __________________________________ Dx Code: ____________________
Axis III: __________________________________ Dx Code: ____________________
Axis IV: __________________________________ Dx Code: ____________________
Axis V: (GAF Score & date given): ____________________

Do you receive any current mental health or substance abuse services (include provider name, location, & dates):
________________________________________________________________________________________________________

Do you take any psychotropic medications? Who prescribed them and what was the date? ____________________
________________________________________________________________________________________________________

Allergies: __________________________________________________________________________________________

Why are you here today? What services do you need? (this section must be completed as part of this application):
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Page 4 of 9
Referral Source:

☐ Self  ☐ Community Corrections  ☐ Family/Friend(s)  ☐ Social Service Agency  ☐ Targeted Case Management  
☐ IHH Care Coordinator  ☐ Hospital  ☐ Physician  ☐ RCF/ICF  ☐ Other ____________________________

The above listed services have been discussed with me and are requested with my knowledge and consent. As a signatory of this document, I certify that the above information is true and complete to the best of my knowledge, and I authorize the regional and/or local MHDS staff to check for verification of the information provided including, but not limited to, verification with local and/or state Iowa Dept. of Human Services (DHS) staff. I understand that the information gathered in this document is for the use of the regional and/or local MHDS in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming residency. I understand that information in this document will remain confidential.

Applicant’s Signature (or Legal Guardian) ___________________________ Date ____________

HIPAA Notice of Privacy Practice Provided: ☐ Yes ☐ No Signature:

NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR MHDS USE ONLY

Unique ID#: ___________________________ Date Contacted: ___________________________

Disability Group-DX Type: ☐ MI ☐ ID ☐ DD ☐ BI ☐ SA
Residency: ___________________________ (Attach Residency Checklist if needed)

Determination: ☐ Accepted ☐ Denied (see comments below) ☐ Pending (see comments below)

Funding Secured: ☐ YES ☐ NO Arranged: ___________________________

Date of Decision: ___________________________ Date NOD sent: ___________________________

If denied, check applicable reason:

☐ Over income/resource guidelines  ☐ Other county of residence ___________________________
☐ Does not meet diagnostic criteria  ☐ Applicant desires to stop process ___________________________
☐ Does not meet plan criteria  ☐ Other ___________________________
☐ Assessment does not meet criteria

Other referrals given (DHS, TCM, IHH, etc.): ___________________________

MHDS staff making determination & date: ___________________________

Comments: ____________________________________________________________

__________________________________________

__________________________________________

Henry County Access Office
106 N Jackson Street, Suite 102
Mt Pleasant, IA 52641
Phone: 319-385-4050 Fax: 319-385-1948
Email: sberndt@henrycountyiowa.us
G. Appeals Processes

(I.C 331.393(4); IAC 441-25.21(1))

Non Expedited Appeal Process

IAC 441-25.21(1)(1)

Individuals, family members and individual representatives (with the consent of the individual) may appeal the decisions of SEIL or any of its contractors at any time. Such individuals may also file a grievance about the actions or behavior of a party associated with the SEIL managed system of care at any time.

How to Appeal:

A written appeal must be submitted to the county service office issuing the notice of decision within ten (10) calendar days of receipt of the Notice of Decision. The written appeal should include a clear description of the appeal, a mailing address, a telephone number and a copy of the notice of decision. Assistance in completing the appeal shall be provided upon request.

Reconsideration – The Coordinator of Disability Services located in the county that sent the Notice of Decision in coordination with the CEO shall review appeals and grievances. After reviewing an appeal, the Coordinator shall contact the appellant not more than ten (10) calendar days after the written appeal is received. If necessary, the Coordinator of Disability Services/CEO shall collect additional information from the appellant and other sources. This information shall be received within ten (10) calendar days in order to receive a reconsideration decision. Following a review of additional information and all relevant facts, a written decision shall be issued no later than ten (10) calendar days following the contact with the appellant. If the information is not received within the ten (10) calendar days, the original decision will stand. A copy of the decision shall be sent to the appellant and/or representative by regular mail. This information will be used for quality management and improvement.

If a resolution is not agreed upon through Reconsideration, then the appellant can pursue a hearing through a state Administrative Law Judge (ALJ). A copy of the written appeal and decision issued by the Coordinator/CEO shall be forwarded to the ALJ. The decision of the state ALJ shall be the final decision.

Southeast Iowa Link shall not pay legal fees for an appellant. If you cannot afford legal representation, you may contact Legal Services of Iowa at 1-800-532-1275 or http://www.iowalegalaid.org/.

Expedited Appeals Process

IC 331.394(3); (IAC 441-25.21(1)(1)

This appeals process shall be performed by a mental health professional who is either the Administrator of the Division of Mental Health and Disability Services of the Iowa Department of Human Services or the Administrator’s designee. The process is to be used when the decision of Southeast Iowa Link concerning an individual varies from the type and amount of service identified to be necessary for the individual in a clinical determination made by a mental health professional and the mental health professional believes that the failure to provide the type and amount of service identified could cause an immediate danger to the individual’s health and safety.

How to Appeal to the Department of Human Services:

The written appeal should include a clear description of the appeal, a mailing address, a telephone number and copy of the notice of decision. The appeal should then be submitted to the Department of Human Services:

MHDS Division Administrator
Hoover State Office Building
1305 E. Walnut Street
Des Moines, Iowa

1. The appeal shall be filed within 5 days of receiving the notice of decision by Southeast Iowa Link. The expedited review, by the Division Administrator or designee shall take place within 2 days of receiving the request, unless more information is needed. There is an extension of 2 days from the time the new information is received

2. The Administrator shall issue an order, including a brief statement of findings of fact, conclusions of law, and policy reasons for the order, to justify the decision made concerning the expedited review. If the decision concurs with the contention that there is an immediate danger to the individual’s health or safety, the order shall identify the type and amount of service, which shall be provided for the individual. The Administrator or designee shall give such notice as is practicable to individuals who are required to comply with the order. The order is effective when issued.

3. The decision of the Administrator or designee shall be considered a final agency action and is subject to judicial review in accordance with section 17A.19.
Your Information. Your Rights. Our Responsibilities.

This notice describes Henry County may use or disclose protected health information or personally identifiable information about you and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

• Get a copy of your paper or electronic medical information
• Correct your paper or electronic medical information
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

• Tell family and friends about your condition
• Provide disaster relief
• Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

• Authorize funding for you
• Run our organization
• Help with public health and safety issues
• Comply with the law
• Work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your information

• You can ask to see or get an electronic or paper copy of your medical information and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your information

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may deny your request if we did not create the information you want changed.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say “yes” to all reasonable requests.
Ask us to limit what we use or share
  • You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
  • You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
  • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
  • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
  • You can complain if you feel we have violated your rights by contacting us using the information on page 1.
  • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
  • We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
  • Share information with your family, close friends, or others involved in your care
  • Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
  • Marketing purposes
  • Sale of your information
  • Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Run our organization
  We can use and share your health information to authorize funding, improve your access to services, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice
- This notice became effective January 1, 2014
- Contact the Henry County CPC by calling 319-385-4050 or email sberndt@henrycountyiowa.us.
- You can view our complete HIPAA Policy by going to http://henrycountyiowa.us/offices/cpc/index.htm
- We never market or sell personal information.
- We will never share any mental health or substance abuse treatment information without your written permission.