Dallas County Community Services

FUNDING APPLICATION

Please write legibly

OFFICE USE ONLY	
Date Received: _____	Mail _____
Date Complete: _____	Walk-In _____

Date of Application: _____

GENERAL INFORMATION

- **Applicant's Name:** _____ • **Phone** *(with area code)*: _____
- **Address** *(street, city, state, & zip)*: _____
- **When did you move to this address?** *Residence date:* _____
- **Soc. Sec. Number:** _____ • **Date of Birth:** _____ • **Gender:** ☐ Male ☐ Female
- **Primary Language:** ☐ English ☐ Spanish ☐ Other: _____
- **Are you a U.S. Citizen?** ☐ Yes ☐ No
- **Ethnicity** *(optional)*: ☐ Caucasian ☐ African-American ☐ American Indian ☐ Latino ☐ Other: _____
- **Marital Status:** ☐ Single, never married ☐ Widowed ☐ Married ☐ Separated ☐ Divorced
- **Living Arrangements:** ☐ Lives Alone ☐ Homeless ☐ Lives with family ☐ Lives with persons unrelated
- **Is Applicant Blind?** ☐ Yes ☐ No
- **Are you a Veteran?** ☐ Yes ☐ No
- **Disability Group:** ☐ Mental Illness ☐ Chronic Mental Illness ☐ Intellectual Disability ☐ Substance Abuse ☐ Developmental Disability ☐ Other: _____
- **Referred by:** ☐ Self ☐ Family Member ☐ Agency ☐ Friend(s) ☐ Targeted Case Management

  Referrer Name: _____ **Relationship:** _____
- **Name of person completing this form if other than the applicant:** _____

  Address: _____

INTERESTED PERSONS

- **Emergency Contact:** _____ **Relationship:** _____

  Address *(street, city, state, zip)*: _____
- **Guardian:** _____ **Relationship:** _____

  Address *(street, city, state, zip)*: _____
- **Legal Payee:** _____ **Relationship:** _____

  Address *(street, city, state, zip)*: _____
- **Other Contact:** _____ **Relationship:** _____

  Address *(street, city, state, zip)*: _____

LEGAL SETTLEMENT INFORMATION

Beginning with your present address, list each place you have lived from the time you turned 18 to today. Below the address in the space provided, please indicate any Mental Health Services or Substance Abuse Services you have received while living at that address. If you did not receive services while at an address please leave the services received line blank and continue with the application. Please include another sheet if you need additional space.

Failure to complete this application will result in the form being returned to you and delay the processing of your application.

- **Address:** _____ **Date Moved In:** MO ____ YR ____
  Services Received: _____ **Date Moved Out:** MO ____ YR ____

- **Address:** _____ **Date Moved In:** MO ____ YR ____
  Services Received: _____ **Date Moved Out:** MO ____ YR ____

- **Address:** _____ **Date Moved In:** MO ____ YR ____
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  Services Received: _____ **Date Moved Out:** MO ____ YR ____

NEEDS

What are you applying for? *(Example: therapy, general assistance, transportation, etc.)*

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FINANCIAL INFORMATION

- **Health Insurance:** ☐ Self-Insured ☐ Insured by employer ☐ Title XIX (#: _____)
  ☐ Medicare (#: _____) ☐ Other (Company: _____ Policy #: _____)
- **Are you employed?** ☐ Yes ☐ No **If yes, with whom?** _____
- **How many people live in your household (including yourself)?** _____

CURRENT MONTHLY INCOME

	Your Income	*Spouse's Income*
Employment Wages:	_____	_____
Public Assistance Payments:	_____	_____
Social Security:	_____	_____
Social Security Disability:	_____	_____
Supplemental Security Income:	_____	_____
Veterans Administration Benefits:	_____	_____
Child Support:	_____	_____
Dividends, Interest, Etc.:	_____	_____
Other (_____):	_____	_____
Total Monthly Income:	_____	_____

RESOURCES

	Amount	*Location*
Checking:	_____	_____
Savings:	_____	_____
Stocks/Bonds:	_____	_____
CD's:	_____	_____
Trust Fund(s):	_____	_____
Primary Residence:	_____	_____
Other Property:	_____	_____
IRA (401K):	_____	_____
Other (_____):	_____	_____
Total Resources:	_____	_____

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MEDICAL INFORMATION

- **What is your Primary Diagnosis?** _____
- **Are you seeking Substance Abuse Treatment?** ☐ **Yes** ☐ **No**

  If yes, for what drug? *(alcohol, meth, etc.)* _____
- **What Prescription Medication(s) are you presently taking?**

Name of Medication	*Dosage*	*Prescribing Doctor*

- **Doctors** *(Name & Phone Number):*

  Primary Physician: _____

  Psychiatrist: _____

  Pharmacist: _____

CASE WORKER INFORMATION

- **Do you have a Caseworker:** ☐ Yes ☐ No **If yes, what is their name and phone number?**

  Name: _____ **Phone:** _____

SPECIFIC AUTHORIZATION FOR RELEASE

I authorize the release of the following information, which requires specific consent under Federal or State of Iowa law. I understand that the information obtained by Dallas County Community Services will be used to verify information provided on this application. I authorize the release of any information supplied on this application to the appropriate county if it appears I have legal settlement in that county.

Type of Information	***AUTHORIZED INITIALS***
Mental Health Evaluation and/or Treatment	
AIDS/HIV Related	
Substance Abuse	

PLEASE READ BEFORE SIGNING

I do solemnly swear or affirm that the above information is true, and correct to the best of my knowledge. I do further authorize Dallas County Community Services' staff to investigate and verify this information, if needed.

_____ _____

Signature of Applicant or Legal Guardian *Date*