Iowa Department of Human Services

STATE PAYMENT PROGRAM CONSENT FOR ELIGIBILITY DETERMINATION AND RELEASE OF INFORMATION

PART 1: COUNTY OFFICE REQUEST I hereby apply for the state payment program for adults for:

Consumer			Veteran ☐ Yes ☐ No
Birth Date	Social Security Number		Medicaid ☐ Yes ☐ No If Yes, #:
DHS Worker	County DHS	Telephone Number	Date

DHS WORKER: THE CONSUMER MUST **RE-SIGN** THIS FORM AT **EACH ANNUAL REVIEW**.

PART 2: CONSUMER'S CONSENT AND RELEASE OF INFORMATION I give my consent to this application for state payment program funding for services to adults. I understand that determining my eligibility may require Iowa to investigate my personal assets, holdings, and entitlements, and that efforts may be made to secure payment from responsible organizations, programs, or persons for services provided to me. I hereby authorize the Iowa Department of Human Services and its behavioral health contractor(s) to release to and/or obtain from my past, present, and future service providers the information needed to coordinate, monitor and fund my services. This information includes, but is not limited to, health and financial information. I understand this information will be used for planning and delivering my services. I understand I have the right to see this information at any time. This consent is valid for information already in existence and information generated during service involvement. This consent shall remain valid until my **annual review** for this program, unless I revoke it by giving written notification to DHS. I understand that state payment program funding for my services ends on the date this consent expires, or the date I terminate services, whichever comes first. After an effective revocation, no information shall be disclosed. However, information disclosed prior to revocation may be used for the purposes stated in this authorization. I have read this form or it has been read to me and I understand its content. A photocopy of this signed form shall have the same force and effect as the original. By **initialing below** I specifically authorize the release of information relating to:

☐ **Mental health** ___________ *(required)* ☐ Substance abuse ___________ ☐ HIV ___________
initials initials initials

Consumer's Signature	Date
Consumer's Legal or Personal Representative (if required)	Date

PART 3: LICENSED PROFESSIONAL'S OPINION (Optional here **if** a signed diagnosis is provided separately.)
The consumer named above has the following conditions (include DSM-IV numeric codes and names):

	☐ Axis I
	☐ Axis II
	☐ Axis III
	☐ Other
Print or Type Your Name	☐ LISW/LMSW ☐ Physician
Your Signature	☐ Psychiatrist ☐ Psychologist

PART 4: DHS CENTRAL OFFICE CERTIFICATION – DO NOT WRITE IN THE AREA BELOW
I have reviewed this consumer's application and have determined that:

A. ☐ This consumer does not have legal settlement in the state of Iowa.
☐ This consumer has legal settlement in ______________________ County, Iowa.

B. ☐ This consumer **is** eligible for the state payment program for services to adults, effective __________________.
☐ This consumer **is not** eligible for the state payment program for services to adults.

COMMENTS:

Administrator of DHS Division of MH/DD	Date

APPLICATION CHECKLIST

Legal reference: 441 Iowa Administrative Code 153.53(3)

- ☐ 470-0604, *State Payment Program Eligibility Determination*.

- ☐ 470-3443, *State Payment Application Cover Memo*, which includes:
  - A statement that the applicant has not gained legal settlement in an Iowa county.
  - A statement of the names and types of providers and the specific services needed.
  - A statement that the applicant meets the financial and service eligibility guidelines of the county management plan in the applicant's county of residence.
  - For each service, a statement the county provides the service for eligible persons with legal settlement there.
  - For each provider, a statement that the provider either:
    - ◊ Has a valid contract with the Department's Iowa Plan contractor to serve MI-CMI population, or
    - ◊ Has a special mental health-mental retardation county contract agreement with the Department to serve MR-DD population, or
    - ◊ Has submitted form 470-3336, *State Payment Provider Information* to serve MR-DD population.

- ☐ 470-3439, *Legal Settlement Worksheet*, **IF** the *CPC Application* does not include it, or **IF** a *CPC Application* is not included in the materials sent to Central Office.

- ☐ A written statement, study, or report signed by a licensed professional establishing a diagnosis of mental illness, mental retardation, or developmental disability **OR** optional use of this form Part 3 by such licensed professional.

- ☐ RS-1120-0, *Services Reporting System,* completed except for item 41 and the last two digits of item 40. For MR-DD population only, include services to be provided soon in items 50-58.

- ☐ **If needed**, additional narrative including:
  - A statement explaining why you believe that the applicant does not have legal settlement in Iowa.
  - A history of the custody or guardianships of the applicant, if custody or guardianship has ever been with someone other than the natural parents, and a statement of the legal settlement of the custodian or guardian on the date that the applicant reached majority.
  - A description of the applicant's family and the applicant's relationship with family members and significant others and the attempts made to seek services for the applicant near these people or the reason for not doing so.
  - An explanation of the applicant's financial status, including Social Security and Veteran's status and other entitlements.