Community Support Services Application

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MEDICAL CENTER

Please indicate which service you are applying for:

☐Intensive Psychiatric Rehabilitation (IPR) ☐ Peer Support Services ☐Community Support Services (CSS)

☐Intensive Service Navigation (ISN) ☐Home Based Habilitation/Supported Community Living

Referral Source Information

Date referral was made:

Name/Agency:

Phone:

Email:

Applicant Information

Name:

Date of Birth:

Phone:

Address:

City:

State:

Zip Code:

Preferred Language:

Are translation services needed?

Housing Environment (check all applicable):

☐ Alone	☐ With Immediate Family	☐ With Relatives
☐ With Friends	☐ With Roommates	
☐ Own home	☐ Apartment	☐ Family/Friend Home
☐ Shelter	☐ Homeless	☐ Residential Care Facility (RCF)
☐ HAB home	☐ Other, describe	

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Legal Guardian Information if applicable

Guardian Name:

Guardian Address:

City:

State:

Zip Code:

Guardian Phone:

Does the patient have an active court order?

Managed Care Organization

Iowa Total Care ☐

Wellpoint ☐

Molina ☐

Iowa Medicaid Enterprise (IME) ☐

Other Insurance ☐

Medicaid State ID #:

MCO #:

Diagnosis Information

Physical Health Diagnoses:

Primary Care Physician Name and Address:

Mental Health Diagnoses. Please list ICD-10 codes.

Psychiatrist Name and Address:

Therapist Name and Address:

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Has Individual been hospitalized in the past 2 years for Mental Health? ☐ Yes ☐ No

If yes, how many times:

Has Individual been incarcerated in the past 2 years? ☐ Yes ☐ No

If yes, how many times:

Other Information

Other services the applicant is currently receiving:

☐Home Based Habilitation ☐Supported Employment ☐Voc Rehab ☐Day Habilitation

☐Waiver services ☐Section 8 or other rent assistance programs ☐Payee Services

In the last 30 days has the applicant had any of the following: (check all applicable)

☐ Aggression ☐ Self-Harm ☐ Homelessness ☐ Illegal Substance Use

☐ Financial Instability ☐ Suicidal ideation or attempts

Financial Information: (check all applicable and indicate amount)

☐ SSI	☐ SSDI	☐ Employment
Monthly Amount:	Monthly Amount:	Monthly Amount:

Future Goals and Aspirations:

Reason for Referral:

****** Please include the following with the referral form:**

- A current psychiatric consult with the applicant's behavioral health diagnosis.
- A current release of information.

****** Please email referral to CBServices@broadlawns.org**