SOUTHEAST IOWA LINK (SEIL)

MENTAL HEALTH AND DISABILITY SERVICES REGION

DES MOINES, HENRY, JEFFERSON,
KEOKUK, LEE, LOUISA, VAN BUREN
& WASHINGTON COUNTIES

Wrap-Around Funding Request for Children Ages 3-17 Residing in Des Moines, Henry, Jefferson, Keokuk, Lee, Louisa, Van Buren, and Washington Counties July 1, 2022 through June 30, 2023

Application Date: _____ **Date Received by local MHDS Office:** _____

Agency/contact person completing this form, including contact information: _____

_____

First Name: _____ **Middle Name:** _____ **Last Name:** _____

SSN#: _____ **US Citizen:** ☐Yes ☐No **Date of Birth**: _____ **Gender:** ☐Female ☐Male

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

Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino

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

Childs:
Current Address: _____
Street City State Zip County

Mailing Address: ☐ Same ☐ Other: _____
Street City State Zip County

Home Phone:_____ **Cell Phone:** _____ **Email:** _____

Parent/Guardian:
Current Address: _____
Street City State Zip County

Home Phone:_____ **Cell Phone:** _____ **Email:** _____

Parent/Guardian:
Current Address: _____
Street City State Zip County

Home Phone:_____ **Cell Phone:** _____ **Email:** _____

Child currently resides with:

- ☐ **Both Parents**
- ☐ **Mother**
- ☐ **Father**
- ☐ **Guardian**
- ☐ **Other: Explain**_____

Current School District: _____ **Grade:** _____

Do you have an IEP or 504 Plan in place: ☐Yes ☐No **Would you like support/assistance working with the school:** ☐Yes ☐No

Has there been an out of home placement: ☐Yes ☐No **If yes, please provide dates and a brief explanation:** _____

_____

_____

Interested Persons/Emergency Contact:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Others in Household:

First Name and Last Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		
6.		

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐Hawk-I ☐Medicaid

☐Private Insurance ☐Marketplace Choice

☐No Insurance

Company Name: _____
Address: _____
Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays 2nd)

☐Hawk-I ☐Medicaid

☐Private Insurance ☐Marketplace Choice

☐No Insurance

Company Name: _____
Address: _____
Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)

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):

_____

_____

_____

Have all other funding sources been explored: ☐Yes ☐No **If no, please explain:**_____

Funding Requested (Required: Supporting documentation of need for service(s) requested must be included):

Mental Health Assessment/Evaluation

Service Requested | Provider | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

Prescription Medications

Service Requested | Provider (if known) | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

Counseling/Therapy

Service Requested | Provider (if known) | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

BHIS

Service Requested | Provider (if known) | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

Therapeutic Programming

Service Requested | Provider (if known) | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

Respite

Service Requested | Provider (if known) | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

Other (Please Describe)

Service Requested | Provider (if known) | Rate/Unit | Effective Date

☐No Insurance Coverage ☐Copayment ☐Deductible ☐Lapse in Coverage

Do you have any unmet needs: ☐Yes ☐No **If yes, please describe:** _____

Referral Source:

Name: _____ Agency: _____

Address: _____

Phone Number: _____ Email: _____

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.

I understand that if approved, the Wrap Around program may provide funding for services for my child for as long as funding is available. During the approval period, I agree to participate in the Wrap Around process. Participation will include face to face and/or electronic meetings and completing surveys about my child's progress, this program and the overall mental health system of care. I can contact the Children's Behavioral Health Service Coordinator at any time with questions or concerns.

_____

Parent/ Legal Guardian Signature **Date**

RELEASE OF INFORMATION STATEMENT:
I understand that protected mental health information is being released to the Jefferson/Keokuk/Van Buren/Washington Decategorization Project and to the Southeast Iowa Link Region for billing and care coordination services. The purpose of this disclosure is to facilitate effective treatment service coordination. I authorize the release or exchange of relevant information among agencies for the purposes of coordinating community services. I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to mental health information. I understand that Federal Law prohibits any further disclosure of this information. The undersigned understands that he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Southeast Iowa Link Region. I hereby authorize by my signature, disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____

Parent/ Legal Guardian Signature **Date**

Please submit completed application and supporting documents to:
Tami Gilliland, Coordinator of Disability Services
Keokuk County Community Services
615 S Jefferson St, Sigourney, IA 52591
641-622-2383 Office Phone
641-622-2166 Fax
tgilliland@southeastiowalink.com