BREMER COUNTY
GENERAL ASSISTANCE
203 1st Avenue N.E.
Waverly, IA 50677

PHONE: (319) 352-2993
FAX: (319) 352-2997

COMPLETE APPLICATIONS ARE REQUIRED!
Gather all the required material and return with your photo identification.

THE FOLLOWING IS REQUIRED FOR ALL PROGRAMS:

- Identification (picture ID or driver's license) and social security card. We also may need birth dates and social security numbers for each person living in the immediate household.

- Written proof of income for all household members including:
  - *Social security/pension(s)
  - *Alimony
  - *College tuition/College loans
  - *Periodic income received quarterly, semi-annually (interest, income, grants, etc)
  - *FIP (Family Investment Plan)
  - *Child Support
  - *Babysitting
  - *Employment stubs
  - *Odd jobs for cash

- **For General Assistance** eligibility is based on 2 months of income from the date of your interview. Bring written proof of last month's and current month's income received by you and all other household members.

- Verification and documentation required for payments made during the last 2 months for child support, alimony and any medical expenses if you wish to use them as allowable expenses.

- You must list all vehicles registered to all members who are living in the household and their value.

- Previous year tax statement is required if self employed, as well as records of previous 2 months of income.

- Bank statement(s) for all checking and savings from previous 2 months. Written proof of all resources such as; Certificate of Deposits, Individual Retirement Accounts, Stocks & Bonds with their current value for all household members.

YOU ARE NOT ELIGIBLE FOR OUR SERVICES IF:

- You are under 18 years of age
- You do not live in Bremer County
- You are a veteran
- You or a household member is receiving FIP with DHS
- You are not a citizen of the United States of America
- You fail to comply with available services like FIP or Workforce Center or have exceeded your 5 year FIP benefits
- Your resources are greater than $500 for General Assistance or $2000 for MH/MD services
- You have already received General Assistance in the past 12 months or current fiscal year
- You are receiving other government or charitable funding that is expected to meet the need of the individual for the bill in question. (i.e. FIP and Section 8 Housing, etc)

GENERAL ASSISTANCE ALSO REQUIRES THE FOLLOWING:

Each Adult of the Household is required to register and cooperate with the Iowa Workforce Development Center

Exception to policy:

If you (in determination of the CPC Administrator):

- Are totally unable to work due to chronic illness or handicap. Documentation from a doctor will be required.
- Are caring for a dependent family member who requires home care and supervision.

Written Verification of having applied for (or proof that you are receiving) food stamps and the amount you receive. Your DHS worker can provide this verification. If you have children, you must also apply for FIP and Title 19. **Failure to do so** will result in denial of our services.

If you were denied services from DHS, we will need a copy of the denial letter and the reasons why services were denied.

Rental Assistance requires the landlord or property owner to fill out and sign a rental assistance form. This assistance does not cover deposits or first month rent. Only current month if no back rent is due.

Utility Assistance, please bring the entire bill with a due date falling within the current month. The bill must be in your name. If utilities are shut off, we are unable to pay the current bill unless proof is provided that the remainder of the bill will be covered and the utilities can be restored. We are unable to pay on any back due amounts, all must be paid prior to authorization of County funds. We do not pay utility deposits or bills from a previous addresses.

BREMER COUNTY NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice of Privacy Practices contact Bremer County's Privacy Officer.

Jan Heidemann, Privacy Officer,
Bremer County Annex,
203 1st Ave. NE, Waverly IA 50677
(319) 352-2993 ext 104

This Notice of Privacy Practices describes how Bremer County may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Bremer County is required to abide by the terms of this Notice of Privacy Practices. Bremer County may change the terms of this notice, at any time. The new notice will be effective for all protected health information that Bremer County maintains at that time. Upon request, Bremer County will provide you with any revised Notice of Privacy Practices

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by Bremer County for the purpose of providing or accessing health care services for you. Your protected health information may also be used and disclosed to pay your health care bills and to support the business operation of Bremer County.

The following categories describe ways that Bremer County is permitted to use and disclose health care information. Examples of types of uses and disclosures are listed in each category. Not every use or disclosure for each category is listed; however, all of the ways Bremer County is permitted to use and disclose information falls into one of these categories:

1) **Treatment:**
Bremer County may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, Bremer County would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example is that protected health information may be provided to a facility to which you have been referred to ensure that the facility has the necessary information to treat you.

2) **Payment**
Bremer County may use and disclose health care information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. Bremer County may also discuss your protected health information about a service you are going to receive to determine whether you are eligible for the service, and for undertaking utilization review activities. For example, authorizing a service may require that your relevant protected health information be discussed with a provider to determine your need and eligibility for the service.

3) **Healthcare Operations**
Bremer County may use or disclose, as-needed, your protected health information in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, Bremer County may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.

Bremer County may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for Bremer County. Whenever an arrangement between Bremer County and a business associate involves the use or disclosure of your protected health information, Bremer County will have a written contract that contains terms that will protect the privacy of your protected health information

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Bremer County has taken an action in reliance on the use or disclosure indicated in the authorization.

Bremer County may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Bremer County may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed

1) Others Involved in Your Healthcare
Unless you object, Bremer County may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, Bremer County may disclose such information as necessary if Bremer County, based on its professional judgment, determines that it is in your best interest. Bremer County may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, Bremer County may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2) Emergencies
Bremer County may use or disclose your protected health information in an emergency treatment situation. If this happens, Bremer County shall try to obtain your acknowledgment of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Bremer County may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

1) Required By Law
Bremer County may use or disclose your protected health information to the extent that the use or disclosure is required by law. You will be notified, as required by law, of any such uses or disclosures.

2) Public Health
Bremer County may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Bremer County may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3) Communicable Diseases
Bremer County may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease.

4) Health Oversight
Bremer County may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

5) Abuse or Neglect
Bremer County may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, Bremer County may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6) Food and Drug Administration
Bremer County may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

7) Legal Proceedings
Bremer County may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

8) Law Enforcement
Bremer County may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on county premises, and (6) medical emergency (not on Bremer County's premises) and it is likely that a crime has occurred.

9) Coroners, Funeral Directors, and Organ Donation
Bremer County may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

10) Research
Bremer County may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

11) Criminal Activity
Consistent with applicable federal and state laws, Bremer County may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Bremer County may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual

12) Military Activity and National Security
When the appropriate conditions apply, Bremer County may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. Bremer County may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

13) Workers' Compensation
Your protected health information may be disclosed by Bremer County as authorized to comply with workers' compensation laws and other similar legally-established programs

14) Inmates
Bremer County may use or disclose your protected health information if you are an inmate of a correctional facility and Bremer County created or received your protected health information in the course of providing care to you.

15) Required Uses and Disclosures
Under the law, Bremer County must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine County compliance with the requirements of 45 C.F.R. section 164.500 et. seq.

YOUR RIGHTS

The following are a list of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as Bremer County maintains the protected health information. A "designated record set" contains medical and billing records and any other records that Bremer County uses in making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the Bremer County Privacy Contact if you have questions about access to your medical record

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means you may ask Bremer County not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Bremer County is not required to agree to a restriction that you may request. If Bremer County believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Bremer County does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Bremer County. You may request a restriction in writing to the Bremer County Privacy Officer.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM BREMER COUNTY BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

Bremer County will accommodate reasonable requests. Bremer County may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Bremer County will not request an explanation from you as to the basis for the request. Please make this request in writing to the Bremer County Privacy Contact.

RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION

This means you may request an amendment of protected health information about you in a designated record set for as long as Bremer County maintains this information. In certain cases, Bremer County may deny your request for an amendment. If Bremer County denies your request for amendment, you have the right to file a statement of disagreement with Bremer County and Bremer County may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures Bremer County may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS

You may file a complaint to Bremer County or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Bremer County. You may file a complaint against Bremer County by notifying the Bremer County Privacy Officer. Bremer County will not retaliate against you for filing a complaint.

You may contact Bremer County Privacy Officer, Jan Heidemann, Privacy Officer, Bremer County Annex, 203 1st Ave. NE, Waverly IA 50677 (319) 352-2990 for further information about the complaint process
This notice was published and becomes effective on **April 14, 2003**.

BREMER COUNTY
GENERAL ASSISTANCE
Application

Application Date: ____________________ **Date Received by CPC Office:** ____________________

Last Name: ____________________ **First Name:** ____________________ **MI:** ________

Phone #:____________ **Birth Date:**__________ **SSN#**______________ **State ID#**______________

Current Address: ____
Street City State Zip County

Date Moved in to this address:______________

Previous Address: ____
Street City State Zip County

Email Address: ____

Sex: ☐Male ☐Female **Ethnic Background:** ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other ______

Guardian/Conservator appointed by the Court? ☐Yes ☐No

☐Legal Guardian ☐Conservator ☐Protective Payee
(Please check those that apply & write in name, address etc.)
Name: ______________________
Address: ______________________
Phone: ______________________

Protective Payee Appointed by Social Security? ☐Yes ☐No

☐Legal Guardian ☐Protective Payee ☐Conservator
(Please check that apply & write in name, address etc.)
Name: ______________________
Address: ______________________
Phone: ______________________

Veteran Status: ☐Yes ☐No **Branch & Type of Discharge:** ______________ **Dates of Service:** __________

Marital Status: ☐Never married ☐Married ☐Divorced ☐Separated ☐Widowed

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

Are you here in the U.S. legally? ☐Yes ☐No **Living Arrangement:** ☐Alone ☐With relatives ☐With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

☐Private Residence
☐Foster Care/Family Life Home
☐ICF
☐Homeless/Shelter/Street
☐State Resource Center
☐RCF/MR
☐ICF/PMI
☐ICF/ MR
☐Supported Comm. Living
☐RCF/PMI
☐Correctional Facility
☐Other______________________
☐State MHI
☐RCF

Disability Group/Primary Diagnosis:
☐Mental Illness ☐Chronic Mental Illness ☐Mental Retardation ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Specific Diagnosis determined by:______________________________ **Date:**________
Axis I: ______________________________ **Dx Code:** ______________
Axis II:______________________________ **Dx Code:** ______________

If agency referral, name of agency/contact person and contact information: ______________

Referral Source:

☐Self
☐Family/Friend
☐Targeted Case Management
☐Other Case Management
☐Community Corrections
☐Social Service Agency
☐Other ___________

Education:

Years of Education: ____________
GED: ☐Yes ☐No
H.S. Diploma: ☐Yes ☐No
College Degree: ____________

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

____

____

____

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	☐ Volunteer	☐ Other _______

Current Employer: ______________________ **Position:** ______________________

Dates of employment: ______________ **Hourly Wage:** ____________ **Hours worked weekly:** ______

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

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				
4.				
5.				

Have you applied for any of the public programs listed below?

(Please check those you have applied for and the status of your referral) Please advise if your application has been Approved or Denied. If you appealed the denial, please advise of the *date of appeal* ___________ Please advise if you have applied for reconsideration. Please advise if you have had a hearing with an Administrative Law Judge and the *date of the scheduled hearing*: _______________

☐ **Social Security** __________	☐ **SSDI** __________	☐ **Medicare** __________
☐ **SSI** __________	☐ **Medicaid** __________	☐ **DHS Food Assistance**
☐ **Veterans** __________	☐ **Unemployment** __________	__________
☐ **FIP** __________	☐ **Other** __________	☐ **Other** __________

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐ Applicant Pays ☐ Medicaid ☐ Family Planning only
☐ Medicare A,B D ☐ Medically Needy ☐ MEPD
☐ No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name ______________________

Address ______________________

____

Policy Number: ______________________

(or Medicaid/Title 19 or Medicare Claim Number)

Secondary Carrier (pays 2nd)

☐ Applicant Pays ☐ Medicaid- ☐ Family Planning only
☐ Medicare A,B, D ☐ Medically Needy ☐ MEPD
☐ No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name ______________________

Address ______________________

____

Policy Number ______________________

(or Medicaid/Title 19 or Medicare Claim Number)

Others in Household:

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		

NOTICE: Proof of income is 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!)

____
____
____

Gross Monthly Income (before taxes): (Check Type & fill in amount)	**Applicant Amount:**	**Others in Household Amount:**
☐ Social Security	________	________
☐ SSDI	________	________
☐ SSI	________	________
☐ Veteran's Benefits	________	________
☐ Employment Wages	________	________
☐ FIP	________	________
☐ Child Support	________	________
☐ Rental Income	________	________
☐ Dividends, Interest, Etc	________	________
☐ Pension	________	________
☐ Other	________	________
Total Monthly Income:	________	________

Household Resources: (Check and fill in amount and location):

Type	**Amount**	**Bank, Trustee, or Company**
☐ Cash	________	________
☐ Checking Account	________	________
☐ Savings Account	________	________
☐ Certificates of Deposit	________	________
☐ Trust Funds	________	________
☐ Stocks and Bonds (cash value?)	________	________
☐ Burial Fund/Life Ins (cash value?).	________	________
☐ Retirement Funds (cash value?)	________	________
☐ Other ________	________	________
☐ Other ________	________	________
Total Resources:	________	

Motor Vehicles: ☐ Yes ☐ No (include car, truck, motorcycle, boat, Recreational vehicle, etc.)

Make & Year: ________ Estimated value: ________
Make & Year: ________ Estimated value: ________
Make & Year: ________ Estimated 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: ________

Have you sold or given away any property in the last five (5) years? ☐ Yes ☐ No **If yes, what did you sell or give away?**

____
____

Contact Person: (including Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc, Relative)

Name: ________ Relationship: ________

Address: ________ Phone: ________

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 County CPC staff to check for verification of the information provided including verification with Iowa county government and the state Iowa Dept. of Human Services (DHS) staff.

I understand that the information gathered in this document is for the use of an Iowa County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal settlement. I understand that information in this document will remain confidential.

____

Applicant's Signature (or Legal Guardian) **Date**

____

Signature of other completing form if not Applicant or legal Guardian **Date**

Acknowledgment of Receipt of Notice of Privacy Practice located on reverse side of the face sheet

I, ____, do hereby acknowledge receipt of a copy of the Notice of Privacy, Policy and Procedure.

Signature of Individual: ______________________________________ **Date:** ______________

Individual's Personal Representative Signature: ______________________________ **Date:** ____________

Legal authority of personal representative ____

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

Unique ID#: ______________________ Date Contacted: ____________________

Disability Group-DX Type: ☐MI ☐CMI ☐MR ☐DD ☐SA ☐GA

Legal Residency: ____

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 guidelines
☐Does not meet diagnostic criteria
☐Does Not meet service plan criteria
☐Does not meet plan criteria
☐Other county of responsibility ____________________
☐Applicant desires to stop process
☐Other________________________________

Other referrals given (DHS, TCM, etc.): ____

County Co-payment amount/terms (if applicable): ______________________________________

Comments: ____

____

____

County staff making determination & Date: ____