Community Support Advocates

1516 Valley West Dr.
West Des Moines, IA 50266
Attn: Referral Coordinator
nataliem@teamcsa.org 515-883-1776 Phone
515-883-2171 Fax

Application for Services **Date :_______________**

Program(s) for referral—Please mark any/all that apply:

______ Integrated Health Program ______ Knowledge Empowers Youth (KEY)

______ Targeted Case Management/Service Coordination ____ ISA

Client : ____ DOB: _________________________________

Address: ____ Phone: ________________________________

____ SSN #: ________________________________

Gender & Preferred Pronouns: ____

Diagnoses:____

Medicaid Eligible: ☐ Yes ☐ No Applied for Medicaid: ☐ Yes ☐ No

Medicaid Number: ______________________ Managed Care Provider (MCO): _____________________

Monthly Income amount:$_________________ Income Source: ________________

Payee: ☐ Yes ☐ No If Yes, who: ______________________________

Primary Care Physician/Clinic/Location: ____

Currently in School: ☐ Yes ☐ No Where:______________________ Graduation Date:________________

Preferred method of contact? ________________________________

Primary Contact Person:_____________________________________ Phone:_________________________

Email? ____

Referral Source: ______________________________________ Phone: ________________________________

Address: ____

Relationship to Applicant: ____

(If applicable)
Guardian Name: ______________________________________ Phone: _______________________________

Address: ____

If Child:

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Who is Legally able to sign: __________________________ Who has Custody:________________________

History of Previous Services (include substance abuse history—**include agency/location of service**):

____

____

____

History of Previous Psychiatric Services (include hospitalizations, BHIS, therapy, psychiatrist—**include agency/location of service**): ____

____

____

Services **currently** being received: ____

____

____

History of Previous Arrests/Legal Concerns: ____

____

____

Open Case with Vocational Rehabilitation? Y or N If Y, name of counselor _________________________

Currently on HCBS waiver services? If so, which waiver ____

Services being requested (**BE SPECIFIC**): ____

____

Referrals for other services already made to: ____

Date/Time/Location for YTDM:_________________________

Advanced Directives? ________________________________

DHS & other referring providers: Please send copies of DHS case plan, Court orders, Guardianship papers (court orders & letters of appointment), person centered plan/case plan, psychiatric/psychological records, social history, & assessments