Tadan's Touch Foundation & Tadan's Touch of Hope Counseling
46 Spruce St. Suite 1 & 2
PH: 563-349-8038 *Tipton, Iowa 52772* *FAX: 563-886-8016*

APPLICATION FOR SERVICES

Adults considering applying to Tadan's Touch of Hope Counseling Service *IPR* programs must fulfill these basic requirements:

- ✔ Have a diagnosed mental illness
- ✔ Committed to change behaviors
- ✔ Committed to change their environment
- ✔ Committed to be fully engaged with these changes

Tadan's Touch Foundation and Tadan's Touch of Hope supports each individual with their commitment to change their lives. Tadan's Touch Foundation's mission is to use the Intensive Psychiatric Rehabilitation model to help make Memories into Movements through the use of a collaborative, person-centered program using compassion, passion, and strengths to change lives.

If you have questions please contact Todd A. Foss at todd@tadanstouch.org

Tadan's Touch Foundation & Tadan's Touch of Hope Counseling
46 Spruce St. Suite 1 & 2
PH: 563-349-8038 *Tipton, Iowa 52772* *FAX: 563-886-8016*

General Information:

Name of Client (first, MI, last): ______________________________**Date:** ____________________

Address: _______________________________ **Phone:** ___________________

_______________________________ **Email:** ___________________

What is the best way to contact you? ____

Date of Birth: ____________________**Age:** ______**Gender:** ______________________

Marital Status: M / S / D / W (please circle) (optional)

Race: (please check) (optional)
____American Indian or Alaska Native
____Asian
____Black or African American
____Native Hawaiian or Other Pacific Islander
____White

Medicaid #: ___________________ AG Member ID:____________
Social Security #: __________________
Services Requested:
Intensive Psychiatric Rehab. Y N

Emergency Contact: _______________________
Address: ____________________________
____
Phone: _____________________________
Relationship: ________________________

Income:
Do you have an income? _____Yes _____No **Are you employed?** _____Yes _____No
Are you receiving Food Assistance (SNAP)? _____Yes _____No
Are you a Veteran: _____Yes _____No?
Do you receive Veterans disability benefits? ____Yes ____No Monthly **Amount**: ________
SSI: _____Yes _____No **Monthly Amount:** ______________ **Have you applied?** Y N
SSDI: _____Yes _____No **Monthly Amount:** ______________**Have you applied**? Y N
Any other monthly income? _____________________Monthly Amount: _________

Who is Helping You Now? (Please list name/agency of all that apply)
Primary Care Doctor: ________________________ Psychiatrist: __________________________
Therapist: _______________________________ Case Manager: __________________
Substance Abuse Agency: ____________________ Attorney: _____________________________

Probation/Parole Officer: ____________________ Pharmacy: __________________________
Family/Friends: ____
Other: ____

Mental Health (Required):
Diagnosis: (Please list diagnosis, who made diagnosis and where and complete the release of information for Diagnosis Request) ____
____

Have you had any mental health hospitalizations in the past year? _____Yes _____No
How many? _______**Where?** ____
Have you been in any substance abuse or dual diagnosis programs in the past year?
_____Yes _____No **How many?** _____ **Where?** _______________________________

Are you under a committal? _____Yes _____No
If so, which court or county holds the committal? _________________________________

Are you currently taking any psychiatric medications? _____Yes _____No
Is there anything else about your current or past mental health that you think we should know? ____
____

Physical Health:
Current presenting problem/s: ____
____
Are you currently taking any physical health medications? _____Yes _____No

Allergies: ____

Is there anything else about your physical health that we may need to know? (for example: limited mobility, need oxygen, etc.) ____
____

Legal:
Are you currently on probation/parole? _____Yes _____No
If yes:
Charge(s): __________________________Time remaining on probation/parole: ____________
Fines: ____________________________Community Service: ___________________________
Do you have a probation/parole officer? _____Yes _____No If yes, name: ________________
Are you currently involved in any type of court proceeding or do you have any charges pending? _____Yes _____No If yes, please explain: _______________________________
____
Have you had any legal issues in the past? _____Yes _____No If yes, please explain:
____
____

Is there anything that hasn't been covered in this application that you would like us to know about you? ____
____
____
____

Is there anyone who could verify the information on this application? _____Yes _____No

May we contact them? _____Yes ____No

Name: ______________**Phone Number:** ______________**Relationship:** ______________

I have read and reviewed this application and to the best of my knowledge, the information in it is true and correct. By signing, I give Tadan's Touch Foundation the permission to contact the person or agency listed above, as well as any necessary people and/or agencies required to determine eligibility and funding for services.

Signature: ____________________________________ Date: ________________

Tadan's Touch Foundation & Tadan's Touch of Hope Counseling
46 Spruce St. Suite 1 & 2
PH: 563-349-8038 *Tipton, Iowa 52772* *FAX: 563-886-8016*

Client Full Name:	State ID:
Address:	Date of Birth:
Name/Agency being authorized to disclose/receive from Tadan's Touch:	Address/Phone Number:

The information released or shared may include:

☐Diagnosis Request ☐Psychosocial Evaluation ☐Social History ☐Assessment ☐Service Documentation ☐Discharge Summary ☐Treatment Plan/Diagnosis ☐Recommendations/Plans ☐Medication List
☐Other (also note exception or limits to this release): ________________________________
____

I specifically authorize the release of information relating to: Mental Health: YES NO
Substance Abuse: YES NO HIV & related information: YES NO

The purpose or need for such disclosure is for coordination of services, service planning and other: including but not limited to medication management, maintaining benefits, housing, dealing with emergencies

Signature of Client: _______________________ Date: ______ Signature of Guardian: ____________________ Date: ________

I understand the content and the nature of the material that I am releasing. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. I understand that I may revoke this authorization by providing a written revocation to Tadan's Touch. I also understand that the information which has been released prior to revocation may be used for the purposes listed above. Unless withdrawn, the consent will expire one year from the date of my signature, or by __________________________. This release is no longer valid if a client terminates or is discharged from services.

Client Signature: ____________________________________ Date: _______________________

Guardian Signature: _________________________________ Date: _______________________

Witness: ____ Copy given? ☐ YES ☐ Client Declined Copy

Prohibition on Redisclosure: This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law or by state law for mental health and HIV-related information federal requirements (42C.F.F. part 2) and state requirements (Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.