

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



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:** _____

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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:** _____

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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:** _____



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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 (42 C.F.R. 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.