MUSCATINE COUNTY COMMUNITY SERVICES
GENERAL ASSISTANCE APPLICATION

(Allow up to 7 business days for application review & decision)

Emma
General Assistance Manager
P: (563) 263-7512
F: (563) 272-0959
E:cs-ga@muscatinecountyiowa.gov
www.muscatinecountyiowa.gov

Dear Applicant;

General Assistance is a County funded program that can help people with emergency financial needs if you currently reside in Muscatine County and have so for at least 30 days. Along with this letter, you will find the enclosed application and supplemental forms. In order to process your application, you will need to complete all the enclosed forms entirely.

In addition to the forms, you will need to submit the following:

- A copy of your bill you are requesting assistance with such as rent, electric, gas.
- Proof of income for all household members (last 30 days)
- ID Card or driver's license for each adult residing in the home
- Contact Information for your landlord if you rent (see landlord tenant form)
- Any other forms as requested by General Assistance staff

Eligibility and need shall be determined within approximately ten days after the application is properly completed and presented to the Director and all necessary members of the household sign the application form. Any resulting disbursements will be made as soon as possible after. Disbursement of general assistances funds will be made directly to the vendor.

The amount you request may not be the amount you receive for rent and/or utilities. Many requests are forwarded to the housing committee for review and funding. If you are awaiting SSI or SSDI and you receive funding through general assistance, you may be required to sign a repayment agreement and to reimburse the county for benefits received.

If you have any questions while completing this application, please do not hesitate to contact me at 563-263-7512 or cs-ga@.muscatinecountyiowa.gov

Thank You;

Emma
Emma
General Assistance Manager

MUSCATINE COUNTY COMMUNITY SERVICES
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Services Requested: ☐ **Food Assistance** ☐ **Non-Food Assistance** ☐ **Rent Assistance** ☐ **Utility Assistance** ☐ **Travel Assistance** ☐ **Other Services-Please list:**

Amount Requesting:_____Total Owed_____

*All assistance mailed directly to your provider.

Are you currently receiving a Housing Subsidy? ☐Yes ☐No **Monthly Rent $_____**

Do you have an eviction notice? ☐Yes ☐No **If yes, please provide a copy

Do you have a utility disconnect notice? ☐Yes ☐No **If yes, please provide a copy

Landlord Name_____ Phone Number:_____

Are you related to your landlord? ☐Yes ☐No

Have you ever received General Assistance from Muscatine or any other County? **☐Yes ☐No**

For: _____

REFERRAL SOURCE	
☐Social Security	☐ Social Service Agency
☐Family and/or Friends	☐ Self
☐Church	☐Other:

DEMOGRAPHICS					
Application Date:			Received Date:		
Social Security #:		**Birth Date:**	____/_____/_____	**Gender:**	Choose an item.
Last & First Name:					
	Last *(Please Print)*	First	MI		
Maiden Name: (If applicable)					
Current Address:			**How long at this address:**		
	Street/Avenue *(Please Print)*		(Years or months)		
City, State, Zip:			**County:**		
Mailing Address:	Street, City, State ,Zip:				
Phone Number:			**Email:**		
Previous Address: (If less than one year)					
City, State, Zip:			**County:**		

DETAILS				
Marital Status	☐ Single (never married)	☐ Divorced	☐ Widowed	☐ Married or Common Law
Race:	☐ White	☐ Asian or Pacific Islander	☐ Other (biracial; Sudanese; etc.)	
	☐ Native American	☐ Black or African American	☐ Unknown	
Ethnicity:	☐ Hispanic or Latino	☐ Non-Hispanic or Latino	**US Citizen?**	☐ Yes ☐ No
Primary Language:	☐ English	☐ Other- please list:		
Legal Status:	☐ Voluntary	☐ Involuntary, Civil Commitment	☐ Involuntary, Criminal Commitment	
Veteran Status:	Military Branch:	Type of Discharge:	Discharge Date:	

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OTHERS IN HOUSEHOLD		
First and Last Name:	**Relationship:**	**Date of Birth:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

EDUCATION LEVEL

☐ None Years of Education: _____

☐High School Diploma ☐ GED ☐ Trade School Certificate

☐Associate's Degree ☐ Bachelor's Degree or Higher

CURRENT EMPLOYMENT STATUS

☐ Employed, Full Time	☐Retired	☐ Unemployed, available for work
☐ Employed, Part Time	☐ Seasonally employed	☐ Unemployed, unavailable for work
☐ Homemaker/ Self-employed	☐ Sheltered work employment	☐ Vocational Rehabilitation
☐ In the Armed Forces	☐ Student	☐ Volunteer
☐Other, Not applicable	☐ Supported employment	☐ Work Activity Employment

Employer Name and Address: **# of Months/Years:**

HEALTH INSURANCE TYPE

☐ **No Insurance**	☐ **Medicare**	☐ **MEPD**-Medicaid for Employed Persons w/Disabilities	☐ **Other**

☐ **Private Third Party Health Insurance**	☐ **Iowa Medicaid (Iowa DHS)**
Policy #:	**Medicaid State ID #:**
Name of Health Insurance Plan:	**MCOs** (*circle one if applicable*): 1. Amerigroup 2. Iowa Total Care

APPLICATION FOR BENEFITS

If you are NOT already receiving any benefits, have you applied for any of the following?

☐ FIP	☐ Health Insurance Care Coverage	☐ RR-Railroad Retirement Benefits	☐ Food Assistance
☐ SSDI (Social Security Disability)	☐ SSI (Supplemental Security Income)	☐ SS (Social Security Retirement)	
☐ Unemployment Compensation	☐ Veteran's Benefits	☐ Workers compensation	

What is the status of your benefit application(s)

☐ Approved, but not started	☐ Denied	☐ Pending	☐ Other

Explain:

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ASSETS			
☐ Vehicle(s) # of Vehicles: _____			☐ Property
Make: Model:	Make: Model:	Make: Model:	Type:
Year:	Year:	Year:	Address:
Value:	Value:	Value:	Value:

FINANCIAL DISCLOSURE OF INCOME AND RESOURCES		
Monthly Income Source: NET (Check type and fill in amount)	Applicant Monthly Amount	Others in Household Monthly $ Amounts
☐ Employment Wages		
☐ Child Support Received		
☐ Energy Assistance		
☐ Friends & Family		
☐ DHS Cash Assistance (FIP)		
☐ Food Assistance		
☐ Social Security Retirement- SS		
☐ Supplemental Social Security - SSI		
☐ Social Security Disability - SSDI		
☐ Unemployment Compensation		
☐ Veteran's Benefits		
☐ Worker's Compensation		
☐ Pensions		
☐ Income Tax Return Amount		
☐ Other federal cash assistance		
☐ Self-Employment		
☐ Other (specify)		

HOUSEHOLD RESOURCES			
Resource Type (Check all that apply)	Applicant Monthly Amount $	Others in the Household Monthly Amount $	Location
☐Cash on Hand			
☐ Checking Account			
☐ Savings Account			
☐ Annuity			
☐ Certificate of Deposit (CD)			
☐ Individual Retirement Account (IRA)			
☐ Trust Funds			
☐ Stocks & Bonds			
☐ Whole Life Insurance (cash value)			
☐ Other Resources (List)			
☐ Other Resources (List)			

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EXPENSES	AMOUNT	PAST DUE (yes/no)	PAST DUE AMOUNT
Rent/Mortgage Payment			
Lot Rent			
Gas			
Electric			
Water/Sewer			
Taxes/Home Insurance			
Telephone/Cell Phone			
Groceries			
Dining Out			
Daycare/Sitters			
Child Support			
Student Loan			
Tuition			
Lessons			
Car Payment			
Insurance			
Gas			
Public Transportation			
Repairs			
Clothing/Shoes			
Laundry			
Dr./Dental/Insurance			
Prescriptions			
Cable/Internet			
Movies			
Sports			
Credit Card			
Life Insurance			
Church			
Pets			
Loans			
Cigarettes			
Other			
TOTAL EXPENSES			

EMERGENCY CONTACT	
Name:	
Address:	
Phone #:	Email:

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PLEASE READ BEFORE SIGNING

- Your application must be complete or there may be a delay in the funding decision. If you need assistance to complete this application, please contact your local county office.
- You must provide documentation of financial resources and expenses as part of this process to avoid delays in the review of your application.
- I agree to inform the local county office of any changes provided in this application within 10 days of the change.
- I understand I may be expected to contribute toward the cost of my services after receiving a Notice of Decision.

I hereby attest that the information I have provided is true and correct to the best of my knowledge. I also give permission to release this information to verify and/or communicate eligibility for the assistance requested. I also understand that this is a government document and if I knowingly provide false information, the Region has the right to pursue collection of funds.

X _____ _____

Signature of Applicant **Date**

RIGHT OF APPEAL

If you do not agree with the action of the local County office you may request a reconsideration of the decision. You will receive a Notice of Decision that will explain the appeal process.

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General Assistance Release of Information

I,_____, hereby certify that the facts set forth in the completed General Assistance application dated_____ _____are true and complete to the best of my knowledge. A false statement or incorrect statement an application for assistance may be cause for denial of benefits.

AUTHORIZATION TO OBTAIN INFORMATION:

"I hereby authorize the following Muscatine County offices, General Assistance, Veterans Affairs, Public Health, Auditor, Treasurer, Attorney, Sheriff, and the Iowa Department of Human Services, Social Security Administration, UIHC, Iowa Workforce Development, Crisis Center, Child Support Recovery Unit, other medical providers, landlords, utility providers, and Community Service providers including MCSA, Salvation Army, Ministerial Alliance (including area churches), United Way, Community Foundation Funds and others as deemed necessary to coordinate funding, as well as current or previous employers, probation, parole officers, financial institutions, or law enforcement officials to release confidential information concerning my personal situation to the Muscatine County General Assistance office and/or Director if such information is deemed necessary. I understand that in order for information to be disclosed from the Muscatine County General Assistance office and/or Director, a separate Authorization to disclose information will be completed except for payment, treatment, or operations purposes where an authorization is not required. If any other persons not listed above have information that the General Assistance Director needs to process my request, a separate authorization to obtain information will also be completed."

Expires When: This authorization is good for 12 months from the date signed. I may write to General Assistance and my sources to revoke this authorization at any time. GA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

I have read this form and agree to the disclosures above from the types of sources listed.

_____

(Signature of Applicant) (Date)

NOTICE OF PRIVACY PRACTICES FOR HEALTH CARE PROVIDERS
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 the Covered Entity's Privacy Officer:
Jessica Bopes, Muscatine County Community Services 315 Iowa Avenue, Suite 1 Muscatine, Iowa 52761
Phone: 563-263-7512

This Notice of Privacy Practices describes how the Covered Entity 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 ("PHI"). "PHI" 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.

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

PERMITTED USES AND DISCLOSURES OF PHI
Your PHI may be used and disclosed by the Covered Entity for the purpose of providing or accessing health care services for you. Your PHI may also be used and disclosed to pay your health care bills and to support the business operation of the Covered Entity.

The following categories describe ways that the Covered Entity 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 the Covered Entity is permitted to use and disclose information falls into one of these categories:

1) Treatment:
The Covered Entity may use and disclose your PHI 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 PHI. For example, the Covered Entity would disclose your PHI, as necessary, to a home health agency that provides care to you. Another example is that PHI 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
The Covered Entity 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. The Covered Entity may also discuss your PHI 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 PHI be discussed with a provider to determine your need and eligibility for the service.

3) Healthcare Operations
The Covered Entity may use or disclose, as-needed, your PHI 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, the Covered Entity may use or disclose your PHI, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.

The Covered Entity may share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the Covered Entity. Whenever an arrangement between the Covered Entity and a

business associate involves the use or disclosure of your PHI, the Covered Entity will have a written contract that contains terms that will protect the privacy of your PHI.

USES AND DISCLOSURES OF PHI REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI 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 the Covered Entity has taken an action in reliance on the use or disclosure indicated in the authorization.

The Covered Entity also may keep psychotherapy notes. These are given a higher degree of protection and cannot be disclosed without your express permission except to carry out certain treatment, payment, or health care operations including allowing the note taker to use them for treatment, using the notes for training programs, or using the notes in defense of a legal proceeding. You have the opportunity to specifically authorize disclosure of psychotherapy notes on the *Authorization for Release of PHI* form.

We will not use or disclose your PHI for marketing purposes without your written authorization unless the marketing is conducted through a face-to-face communication or involves a gift of nominal value.

We will not accept payment of any kind for your PHI without your written authorization. Sale of PHI is prohibited only as it is defined by law and does not include accepting payment for your treatment.

You may revoke an authorization at any time by notifying us in writing. If this should ever be the case, please be aware that revocation will not impact any uses or disclosures that occurred while the authorization was in effect.

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

1) Others Involved in Your Healthcare

Unless you object, the Covered Entity may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, the Covered Entity may disclose such information as necessary if the Covered Entity, based on its professional judgment, determines that it is in your best interest. The Covered Entity may use or disclose PHI 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, the Covered Entity may use or disclose your PHI 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

The Covered Entity may use or disclose your PHI in an emergency treatment situation. If this happens, the Covered Entity 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

The Covered Entity may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

1) Required By Law

The Covered Entity may use or disclose your PHI to the extent that the law requires the use or disclosure. You will be notified, as required by law, of any such uses or disclosures.

2) Public Health

The Covered Entity may disclose your PHI 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. The Covered Entity may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3) Communicable Diseases

The Covered Entity may disclose your PHI, 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

The Covered Entity may disclose your PHI 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

The Covered Entity may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, the Covered Entity may disclose your PHI 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

The Covered Entity may disclose your PHI 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

The Covered Entity may disclose PHI 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

The Covered Entity may also disclose PHI, 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 Covered Entity premises, and (6) medical emergency (not on the Covered Entity's premises) and it is likely that a crime has occurred.

9) Coroners, Funeral Directors, and Organ Donation

The Covered Entity may disclose PHI 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 PHI 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. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

10) Research

The Covered Entity may disclose your PHI 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 PHI.

11) Criminal Activity

Consistent with applicable federal and state laws, the Covered Entity may disclose your PHI, 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. The Covered Entity may also disclose PHI 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, the Covered Entity may use or disclose PHI 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 service. The Covered Entity may also disclose your PHI 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 PHI may be disclosed by the Covered Entity as authorized to comply with workers' compensation laws and other similar legally established programs.

14) Inmates

The Covered Entity may use or disclose your PHI if you are an inmate of a correctional facility and the Covered Entity created or received your PHI in the course of providing care to you.

15) Required Uses and Disclosures

Under the law, the Covered Entity shall make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the Covered Entity's 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 PHI and a brief description of how you may exercise these rights:

RIGHT TO INSPECT AND COPY YOUR PHI

This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as the Covered Entity maintains the PHI. A "designated record set" contains medical and billing records and any other records that the Covered Entity 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 PHI that is subject to law that prohibits access to PHI. 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 Covered Entity Privacy Officer if you have questions about access to your medical record.

RIGHT TO REQUEST A RESTRICTION OF YOUR PHI

This means you may ask the Covered Entity not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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.

The Covered Entity is not required to agree to a restriction that you may request, except in the case of a disclosure you have restricted under 45 C.F.R. §164.522(a)(1)(vi) related to restricted disclosures to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you have (or someone other than you but not the health plan has) paid out-of-pocket, in full. If the Covered Entity believes that it is in your best interest to permit use and disclosure of your PHI, your PHI

will not be restricted. If the Covered Entity does agree to the requested restriction, it may not use or disclose your PHI 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 the Covered Entity. You may request a restriction in writing to the Covered Entity Privacy Officer. To request a restriction, you must provide us, in writing 1) what information you want to limit;

2) Whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM THE COVERED ENTITY BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

The Covered Entity will accommodate reasonable requests. The Covered Entity 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. The Covered Entity will not request an explanation from you as to the basis for the request. Please make this request in writing to the Covered Entity Privacy Officer.

RIGHT TO REQUEST AN AMENDMENT TO YOUR PHI

This means you may request an amendment of PHI about you in a designated record set for as long as the Covered Entity maintains this information. In certain cases, the Covered Entity may deny your request for an amendment. If the Covered Entity denies your request for amendment, you have the right to file a statement of disagreement with the Covered Entity and the Covered Entity may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All requests for amendments must be in writing.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PHI

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 the Covered Entity 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.

THE COVERED ENTITY'S DUTIES AND OTHER INFORMATION

The Covered Entity is required by law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI, and abide by the terms of the notice currently in effect.

We must inform you of any breach of your PHI that compromises your PHI and that is held or transmitted in an unsecured manner, within 60 days after we discover, or by exercising reasonable diligence, should have discovered the breach.

We reserve the right to change our policies and practices regarding how we use or disclose PHI, or how we will implement Individual rights concerning PHI. We reserve the right to change this notice and to make the provisions in our new notice effective for all information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. The revised notice will be posted and available at our places of service.

COMPLAINTS

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

You may contact the Covered Entity Privacy Officer, Jessica Bopes, Muscatine County Community Services, Director, (563) 263-7512 for further information about the complaint process.