

# GENERAL ASSISTANCE APPLICATION

## WARREN COUNTY

The program for which you are applying is a County funded program. The information on this form will be used in determining your eligibility for assistance. If you need help in completing any of the questions or certain items are unclear, please request assistance from local office personal. Your answers must be clear, complete and correct. You may attach a separate sheet for further detailed statements for answers to the questions.

YOUR SIGNATURE IS ALSO AN AUTHORIZATION FOR THIS OFFICE TO OBTAIN VERIFICATION OF FACTS GIVEN ON THIS FORM. You may be required to sign additional Authorization for Release of Information forms in order that further verification of information may be made.

First Name	Middle	Last	Social Security No.
Street Address	City	State	Zip Code
Mailing Address (if different from above)		Telephone Number (where you can be reached)	
Directions to your home:			

Marital Status: Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Single \_\_\_\_\_

Date of Marriage: \_\_\_\_\_ Place: \_\_\_\_\_

Marriage terminated, names, dates and places: \_\_\_\_\_

List EVERYONE for whom you are applying, including yourself.

Name First                      Last	Date of Birth	Place of Birth	Schooling Completed	Social Security #	Occupation

Is anyone else living in your home? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list name and relationship to you: \_\_\_\_\_

LEGAL SETTLEMENT (last County where you resided for a 12 month continuous period)

VETERANS STATUS (Are you a veteran?) Yes \_\_\_\_\_ No \_\_\_\_\_

Military Service

Branch	Date Enlisted	Place	Date Discharged	Type of Discharge (Honorable, Dishonorable, etc.)

List where you have lived for the last 4 years. Begin with your present address.

City	County	State	From	To	City	County	State	From	To
Relatives out of the home (parents, brothers, sisters, etc.)			Relationship to Head of Household		Address				

**RESOURCES:**

Does anyone in your home expect to receive an inheritance within the next six months? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If you are buying, monthly payment \_\_\_\_\_. If you rent, how much rent are you paying: \_\_\_\_\_ monthly  
 Landlord: \_\_\_\_\_ Are utilities included in rent? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Landlord's Address: \_\_\_\_\_  
 Does anyone in your home own or are they buying real estate other than your homestead? Yes \_\_\_\_\_ No \_\_\_\_\_

Does anyone in your home have any of the following resources? Check yes or no for each item. Complete the information line for items checked yes.

	Yes	No	Amount	Location	Name/Names of Person
Checking Account					
Savings Account					
Stocks or Bonds					
Time Certificates					
Burial Contract					
Trust Fund					
Safety Deposit Box					
Item	Yes	No	Make, Yr.	Market Value	Amount Owed
Automobile(s)					
Truck(s), motorcycle					
Snowmobiles, Boats					
Mobil Home/Camper					
Machinery, Tools					
Airplanes					
Livestock, Other					

Does anyone in your home have any of the following:

Life Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Health Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_  
 Hospital Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Burial and other insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Premiums, amounts and paid by whom: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all sources of income available to you, your spouse and/or dependent(s). Please check yes or no.

Source of Income	YOU AND/OR YOUR SPOUSE			DEPENDENT(S)				
	Yes	No	Amount	How Often Is Income Received	Yes	No	Amount	How Often Is Income Received
Social Security	Yes	No			Yes	No		
Supplemental Security Income (Gold Check)	Yes	No			Yes	No		
Veteran's Benefits	Yes	No			Yes	No		
IPERS or Civil Service	Yes	No			Yes	No		
Railroad Retirement	Yes	No			Yes	No		
Insurance Payments	Yes	No			Yes	No		
Other Pension or Compensation	Yes	No			Yes	No		
Earnings (Wages)	Yes	No			Yes	No		
Unemployment Benefits	Yes	No			Yes	No		
Workman's Compensation	Yes	No			Yes	No		
Military Allotment or Dependency Allowance	Yes	No			Yes	No		
Cash from relatives	Yes	No			Yes	No		
Money from Interest	Yes	No			Yes	No		
Other (list)	Yes	No			Yes	No		

ARE YOU CURRENTLY RECEIVING OR HAVE YOU EVER RECEIVED PUBLIC ASSISTANCE: Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please list including dates of receipt: \_\_\_\_\_

EMPLOYMENT HISTORY: (start with most recent or current employment)

MAN	WOMAN	EMPLOYER	ADDRESS	KIND OF WORK	DATE BEGAN	DATE ENDED	MONTHLY WAGES	REASON FOR DISCONTINUING

MISCELLANEOUS INFORMATION:

A. Type and amount of assistance requested (please state:)

\_\_\_\_\_  
\_\_\_\_\_

B. Do you feel that you, your spouse or dependents have applied for all the benefits for which you might be eligible: Yes \_\_\_\_\_ No \_\_\_\_\_

C. Have you, your spouse (including deceased or ex-spouse) ever worked for a railroad? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, enter Railroad Retirement Claim No. \_\_\_\_\_.

D. Do you, your spouse or dependent children have a serious disability? \_\_\_\_\_  
\_\_\_\_\_

E. Have you, your spouse or dependent children ever worked for the Federal or State Government? Yes \_\_\_\_\_ No \_\_\_\_\_

F. Are you an American citizen? Yes \_\_\_\_\_ No \_\_\_\_\_

G. Name of primary physician \_\_\_\_\_

H. Name of Primary pharmacy \_\_\_\_\_

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I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHER UNDERSTAND THAT I MAY BE LEGALLY PROSECUTED FOR INTENTIONALLY MAKING FALSE STATEMENTS IN ORDER TO RECEIVE ASSISTANCE.

\_\_\_\_\_  
Signature of Applicant (or legal guardian)

\_\_\_\_\_  
Date

If you are dissatisfied with the action of this office, you may appeal to the Warren County Board of Supervisors, Court House, Indianola, Iowa.

PROHIBITION AGAINST DISCRIMINATION

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

If you feel you have been the object of such discrimination, you may file a complaint in letter form with the Warren County Board of Supervisors, County House, Indianola, Iowa.

CONFIDENTIALITY

All applicants and/or recipients have the right to confidential treatment of information concerning their situation; however, it should be understood that such information may be shared with other employees of the Department of Human Services, when appropriate, and with the Board of Human Services and Board of Supervisors. A certain amount of information may need to be released to direct providers of service, such as grocery stores, pharmacies, hospitals, doctors, clothing stores, etc., in order to authorize release of goods to the client. In certain instances when the General Relief employee is working cooperatively with other agencies, i.e., Veterans Affairs, Community Action Center, and/or County department, certain information may be released in order to complete transactions.