Lee County General Relief Application

HIPPA Yes______ NO______

Date of Application: _____/_____/______**Phone:** #(______)-______-________

Name of Applicant:____

Last First M.I.

Current Address:____

________________________ ___________ ____________ ___________

City State Zip County

Social Security #__ __ __/ __ __ / __ __ __ __ **Birth Date:** __ __ / __ __ / __ __ __ __

Sex: Male _____ Female _____

Parent Name (If applicant is under 18)

_____________________________ _______________________________________

Name Address

Ethnicity:
1) White, not Hispanic _____ 2) African American _____ 3) Native American _____
4) Asian or Pacific Islander _____ 5) Hispanic _____ 6) Other (Biracial, Indochinese etc.) _____

Guardian:(name)____________________ **Conservator:(name)**___________________

Payee:(name)____

Veterans of US Armed Forces:
Yes _____ No _____

Marital Status:
1) Single, never married ____2) Married ____3) Divorced ____4) Separated ____
5)Widowed ____

Legal Status:
Voluntary:________ Involuntary, Civil Commit:_________
Involuntary, Criminal Commit: _________

Applicant's Living Arrangement:
1) Lives alone _____ 2) Lives with relatives _____
3) Lives with persons unrelated to applicant _____

Referred By:
1)Self _____ 2) Family Member _____ 3) Case Management _____
4) Community Corrections _____5) Social Services other than Case Management _____
6) Other_____

Years of Education: (High School or GED) ______ College Years Completed: _____

Health Insurance: (Indicate all that apply)
1) Insured by Employer __________ 2) Other Private Insurance __________________
Name of Insurance Provider ____
3) Medicare _________
4) Medicaid __________________Medicaid (Title XIX)#________________________
5) No Insurance _________ 6) Other (explain)______________________

Current Employment Status:

Unemployed, available for work	_______	Student	______
Unemployed, unavailable for work	_______	Work Activity Employment	______
Employed, full time	_______	Sheltered Work Employment	______
Employed, part time	_______	Vocational Rehabilitation	______
Retired	_______	Armed Forces	______
Homemaker	_______		

Do You Rent Your Home: Yes ______ No_______

Do You Own Your Home: Yes_______ No_______

Do you have a Case Manager: No _________ Yes_______ Name _________________

Do you have an Income Maintenance Worker: No_____ Yes ____ Name __________

Who is your Beneficiary:____

Address:_______________________________________ Phone:___________________

Do you have life insurance or pre-burial arrangements paid: Yes______ No______

Have you applied for Social Security Disability: Yes _________ No _____________

Have you registered at the Workforce Development Office: Yes______ NO_______

Have you received General Relief in the past: No ______Yes_____ Where________

Primary Income Source:
Family and Friends ______
Private Relief Agency ______
SSDI ______
SSI ______
SS ______
Pension ______
Food Stamps ______
Veterans Benefits ______
Workers Comp. ______
General Assistance ______
FIP ______

Number of Persons Residing In Your Household:

Adults:_________ Persons Under 18:__________ Household Total:____________

Names of Persons Residing In Your Household, Including Yourself:

Name:________________________________ Relationship:________________

Name:________________________________ Relationship:________________

Name:________________________________ Relationship:________________

Name:________________________________ Relationship:________________

Name:________________________________ Relationship:________________

Monthly Gross Income for the Household:
Public Assistance $________ Social Security $_________ V.A. Benefits $________
S.S.I. $________ Employment Wages Per Hour $ ______________
Number of Hours Worked Each Week _________
Total Monthly Wage $__________________
Child Support $_______
S.S. D. I. $________ Dividend Interest $_____________
Other Income $________ Income Description_______________________________
Total Monthly Income $___________________

Resources:
Cash on Hand $___________ Checking $__________ Savings $_______
Time Certificates $___________ Trust Funds $__________ Stocks/Bonds $_______
Other Resources $___________ Resource Description ______________________
Other Resources $___________ Resource Description ______________________
Total Resources $___________

Resources Continued:

Item	Yes	No	Make, Year	Market	Amount
				Value	Owed
Automobile/Truck					
Automobile/Truck					
Snowmobiles/Boats					
Mobile Home/Camper					
Machinery, Tools					
Livestock, Other					

Employment History:

Employer	**Employer's**	**Job**	**From**		**To**	
	City	**Duties**	**Month**	**Year**	**Month**	**Year**

Legal Settlement:
Note: List all previous addresses up to the point where you lived at an address for three hundred and sixty five days consecutively without receiving any services for mental illness, mental retardation and/or developmental disabilities. Use addition paper if needed.

Please list where you have lived in the past, **begin with your current address**.

Current Address: ____________________ City ______________ State ___________
What dates have you lived at this address? From:_______ To:__________
Did you receive treatment or support services for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes ____ No____
(If yes) What were the dates? From: _____________ To: _____________
Who provided your service(s):______________________________________

Previous Address: ___________________________City _______________ State ____
What dates did you live at this address? From: ________________To: ______________
Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes _____ No____
(If yes) What were the dates? From: ______________ To: _______________
Who provided your service(s):____

Previous Address: ____________________________City _______________ State ____
What dates did you live at this address? From: ________________To: ______________
Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes _____ No____
(If yes) What were the dates? From: ______________ To: _______________
Who provided your service(s):____

Previous Address: ____________________________City _______________ State ____
What dates did you live at this address? From: ________________To: ______________
Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes _____ No____
(If yes) What were the dates? From: ______________ To: _______________
Who provided your service(s):____

Previous Address: ____________________________City _______________ State ____
What dates did you live at this address? From: ________________To: ______________
Did you receive treatment or support service for Mental Illness, Mental Retardation or Developmental Disabilities while at this address? Yes _____ No____
(If yes) What were the dates? From: ______________ To: _______________
Who provided your service(s):____

Signature: I hereby state that the above information is accurate to the best of my knowledge. I understand that I may be liable for the full cost of services provided to me, which were paid based on inaccurate information, which I may have supplied.

Release: I hereby authorize the Lee County General Assistance Office designee to request any and all information to verify the application data. The applicant has a right to appeal the decision of the General Assistance Director by writing a letter requesting an appeal within 30 days of the issuance of the notice of decision concerning that action. The appeal form may be obtained from the Central Point of Coordination Office, P.O. Box 190, Fort Madison, IA 52632. We will consider this application without regard to race, color, sex, age, handicap, religion, national origin or political belief.

Consumer/Guardian Signature:___________________________ Date:_____________

Date:________________ **Consumer's Name:**______________________________

Narative:____

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Approved: ___________ **Denied:**___________ **Pending:**___________

Approved for:

Rent: _________ **$**______________

Utilities: _________ **$**______________

Medical: _________ **$**______________ **or** _____________

Burial: _________ **$**______________

If denied, reason for this denial is:
Over Income Guidelines __________ Fraudulent Information_________

Explanation: ____

Signature of Person Issuing Decision:_______________________ **Date:**___________

State Case: Yes______ No______ **G.R. #**________________

Disability Group (primary diagnosis): Mental Illness (40) ________
Chronic Mental Illness (41)______ Mental Retardation (42) ________
Developmental Disabilities (43) _________ No Disability (44) ________