LOUISA COUNTY COMMUNITY SERVICES
503 Franklin St.
Wapello, Iowa 52653
General Assistance Application
Phone 319-523-5125

Name _____ **Date**_____

Address _____ **Phone** _____
(Street) (P.O. Box)
_____**Household Size**_____
(City) (State) (Zip)

How long have you lived in Louisa County?_____**Where did you live before?**_____**How long?** _____

Are you an U.S. citizen? _____**Yes** _____**No**
If No, do you have a resident alien card? Yes No Or a valid work permit? Yes No

Type of help needed:_____

HOUSEHOLD SIZE (List everyone in your household

First Name	Last Name	SS Number	Birth Date	Age	Relationship
1.					
2.					
3.					
4.					
5.					
6.					
7.					

MARITAL STATUS (Circle one of the following)
Married Single Separated Divorced Widowed

LIVING ARRANGEMENTS (Check the one that applies)
_____**Renting: Landlord's Name** _____
Address_____**Phone:**_____
Is Landlord a relative? Yes No Relationship:_____
_____**Living with friends or relatives: Name**_____
Phone_____
_____**Buying Home** _____**Own Home**

EMPLOYMENT **(List everyone in your household who is employed)**

Presently employed person(s) **Employer, town** **Date Started**

1. _____

2. _____

Unemployed person (s) **Last Place of Employment** **Start Date/End Date**

1. _____

2. _____

List reason for loss of employment: _____

Do you or anyone in your household have any mental or physical disabilities to keep you from employment? Yes No (explain) _____

RESOURCES **(List the amounts of resources that you and your household members have)**

Cash	**$**_____	**Checking Account**	**$**_____
Savings Acct	**$**_____	**Money Market Acct**	**$**_____
Stocks, Bonds, Etc.	**$**_____	**Time Certificates**	**$**_____
Real Estate	**$**_____	**Other (specify)**	**$**_____

Bank Loan on house or car $_____ **Do you still owe on this loan? $**_____

List Vehicles in your name and/or anyone else in your household:

Year_____ **Make**_____ **Model**_____ **Value $**_____

Year_____ **Make**_____ **Model**_____ **Value $**_____

MEDICAL INFORMATION

Does your employer offer you health insurance? Yes No Insurance Company_____

Are you signed up with your employer's health insurance? Yes No

If not, explain why:_____

Do you have Life Insurance? Yes No Company_____

Policy Holder_____ **Face Value $**_____

Do you have Burial Insurance? Yes No Company_____

Policy Holder_____ **Face Value $**_____

What members of your household are receiving Title 19? _____

_____

Do any of the household members receive Medicare or Serviceman's Dependent Yes No

Are you currently in a workman's compensation lawsuit or an accident/injury lawsuit? Yes No

MILITARY SERVICE

Dates of service: _____ Was this an honorable discharge? _____

INCOME **(Please list all sources of income for each household member)**

Source of Income	Weekly Net	Monthly Net	Person Receiving Income
Employment			
Self Employment			
Unemployment Comp.			
Workman's Comp.			
Social Security			
S.S.I.			
S.S.D.			
Disability Payment			
Pension/Retirement			
Veteran's Benefits			
Cash from Relative			
Child Support			
Alimony			
FIP			
Food Stamps			
Do you receive income from a rental property?			

Energy Assistance _____ **Date Received** _____

Emergency Assistance _____ **Date Received** _____

MONTHLY EXPENSES **(List what your household pays out per month for the following)**

Rent $_____

Lot Rent $_____

House Payment $_____

Heating $_____

Electric $_____

Water $_____

Phone $_____

Food $_____

Non-Food $_____

Car Payment $_____

Car Insurance $_____

House Insurance $_____

Loans (list name of bank)

_____ $_____

_____ $_____

_____ $_____

Charge Accounts

_____ $_____

_____ $_____

Other Monthly Expenses

_____ $_____

_____ $_____

MEDICAL EXPENSES **(List only bills under 90 days old. List how much you owe and how much you pay toward the bill on a monthly basis, if any.)**

	Total Owed	Monthly Payment
Name of Doctor _____	$_____	$
_____	$_____	$_____
Name of Hospital_____	$_____	$_____
_____	$_____	$_____

List name of medication(s) any of your household members are presently taking:	Name of Pharmacy	How much you pay to Pharmacy each month
		$_____
		$_____

Health Insurance cost to you per month: $_____

Life Insurance cost to you per month: $_____

CERTIFICATION STATEMENT

I understand that I assume full responsibility for the statements on this form for all household members. I understand that the Louisa County General Assistance office will use these statements to determine my eligibility for General Assistance. If I provide false statements to the General Assistance Director or the Director's designee, this can be considered fraud and will be reported to the County Attorney. I am aware that the information on this form may be investigated and verified.

I understand that I shall provide two (2) new Job searches every week, if applicable, as so stated in the Louisa County Assistance Guidelines. A refusal or failure to actively seek employment or to accept a reasonable employment offer shall disqualify me from receiving General Assistance.

I have received a copy of Louisa County's Notice of Privacy Practices.

Signature of Applicant (Legal Name)_____

Date_____Expires_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Louisa County General Assistance Director or Director's designee to release to or receive from any banking or savings institution, the Board of Supervisors, employer, firm, corporation, Department of Human Services, or any persons any information which they desire to document or verify the confidential information given. My signature below represents all household members.

Signature of Applicant (Legal Name)_____

Date_____Expires_____

FOR OFFICE USE ONLY

DATE: _____

HOUSEHOLD SIZE:_____

MAXIMUM ALLOWABLE: _____

TOTAL INCOME FOR MONTH: $_____

TOTAL MEDICAL EXPENSES: $_____

AVAILABLE NET WORTH: $_____

THIS HOUSEHOLD IS OVER INCOME GUIDELINES: YES NO