



County Social Services

Application Form

For individuals living in: Allamakee, Black Hawk, Butler, Cerro Gordo,
Chickasaw, Clayton, Emmet, Fayette, Floyd, Grundy, Hancock, Howard, Humboldt, Kossuth,
Mitchell, Pocahontas, Tama, Webster, Winnebago, Winneshiek, Worth, & Wright Counties

Application Date: _____ Date Received by Office: _____

First Name: _____ Last Name: _____ MI: _____

Nickname: _____ Maiden Name: _____

Birth Date: _____ Ethnic Background: White African American Native American Asian Hispanic Other _____

Sex: Male Female US Citizen: Yes No If you are not a citizen, are you in the country legally? Yes No

SSN# _____

Marital Status: Never married Married Divorced Separated Widowed

Legal Status: Voluntary Involuntary-Civil Involuntary-Criminal Probation Parole Jail/Prison

Are you considered legally blind? Yes No If yes, when was this determined? _____

Primary Phone #: _____ May we leave a message? Yes No

Current Residence:

Address	City	State	County
Date you moved here: _____			Reside: <input type="checkbox"/> Alone <input type="checkbox"/> With Relatives <input type="checkbox"/> Unrelated persons
Current Service Providers:			
Name	Location		
1. _____	_____		
2. _____	_____		
3. _____	_____		

Use as current Mailing Address: Yes No If not, _____

Address	City	State	County
Current Residential Arrangement: (Check applicable arrangement)			
<input type="checkbox"/> Private Residence <input type="checkbox"/> Foster Care/Family Life Home <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Homeless/Shelter/Street <input type="checkbox"/> Other _____			

Veteran Status: Yes No Branch & Type of Discharge: _____ Dates of Service: _____

Current Employment: (Check applicable employment)

<input type="checkbox"/> Unemployed, available for work	<input type="checkbox"/> Unemployed, unavailable for work	<input type="checkbox"/> Employed, Full time
<input type="checkbox"/> Employed, Part time	<input type="checkbox"/> Retired	<input type="checkbox"/> Student
<input type="checkbox"/> Work Activity	<input type="checkbox"/> Sheltered Work Employment	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Seasonally Employed	<input type="checkbox"/> Armed Forces
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Other _____

Current Employer: _____ Position: _____

Dates of employment: _____ Hourly Wage: _____ Hours worked weekly: _____

Employment History: (list starting with most recent to previous.)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				

Education: What is the highest level of education you achieved? _____ # of years _____ Degree

Emergency Contact Person:

Name: _____

Relationship: _____

Address: _____

Phone: _____

Guardian/Conservator appointed by the Court? Yes No

Protective Payee Appointed by Social Security? Yes No

<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Protective Payee (Please check those that apply & write in name, address etc.) Name: _____ Address: _____ Phone: _____
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<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Protective Payee (Please check those that apply & write in name, address etc.) Name: _____ Address: _____ Phone: _____
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List All People In Household:

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			

INCOME: Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.

If you have reported no income above, how do you pay your bills? (Do not leave blank if no income is reported!)

Gross Monthly Income (before taxes):
(Check Type & fill in amount)

Applicant
Amount:

Others in Household
Amount:

- Social Security
- SSDI
- SSI
- Veteran's Benefits
- Employment Wages
- FIP
- Child Support
- Rental Income
- Dividends, Interest, Etc
- Pension
- Other

Total Monthly Income: _____

Household Resources: (Check and fill in amount and location):

Type	Amount	Bank, Trustee, or Company
<input type="checkbox"/> Cash	_____	_____
<input type="checkbox"/> Checking Account	_____	_____
<input type="checkbox"/> Savings Account	_____	_____
<input type="checkbox"/> Certificates of Deposit	_____	_____
<input type="checkbox"/> Trust Funds	_____	_____
<input type="checkbox"/> Stocks and Bonds (cash value?)	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins (cash value?)	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Total Resources: _____

Motor Vehicles: Yes No
 (include car, truck, motorcycle, boat, recreational vehicle, etc.)

Make & Year: _____	Estimated value: _____
Make & Year: _____	Estimated value: _____
Make & Year: _____	Estimated value: _____
Make & Year: _____	Estimated value: _____

Do you, your spouse or dependent children own or have interest in the following:

Yes No - House including the one you live in? Yes No Any other real estate or land? Yes No Other? _____
 If yes to any of the above, please explain: _____

Have you sold or given away any property in the last five (5) years? Yes No If yes, what did you sell or give away?

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

Secondary Carrier (pays 2nd)

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A, B, D	<input type="checkbox"/> Medically Necessary	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number: _____		
(or Medicaid/Title 19 or Medicare Claim Number)		
Start Date: _____ Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spend down: _____ Deductible: _____		

<input type="checkbox"/> Applicant Pays	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Family Planning only
<input type="checkbox"/> Medicare A, B, D	<input type="checkbox"/> Medically Necessary	<input type="checkbox"/> MEPD
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> HAWK-I
Company Name _____		
Address _____		
Policy Number _____		
(or Medicaid/Title 19 or Medicare Claim Number)		
Start Date: _____ Any limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spend down: _____ Deductible: _____		

Referral Source:

<input type="checkbox"/> Self	<input type="checkbox"/> Community Corrections	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Social Service Agency
<input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other Case Management	

Have you applied for any of the public programs listed below?

(Please check those you have applied for and the status of your referral) Please advise if your application has been Approved or Denied. If you appealed the denial, please advise of the date of appeal _____ Please advise if you have applied for reconsideration. Please advise if you have had a hearing with an Administrative Law Judge and the date of the scheduled hearing: _____

<input type="checkbox"/> Social Security _____	<input type="checkbox"/> SSDI _____	<input type="checkbox"/> Medicare _____
<input type="checkbox"/> SSI _____	<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> DHS Food Assistance: _____
<input type="checkbox"/> Veterans _____	<input type="checkbox"/> Unemployment _____	
<input type="checkbox"/> FIP _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

