MUSCATINE COUNTY COMMUNITY SERVICES
GENERAL ASSISTANCE APPLICATION

Services Requested: ☐ **Food Assistance** ☐ **Non-Food Assistance** ☐ **Rent Assistance** ☐ **Utility Assistance**
☐ **Travel Assistance** ☐ **Burial Assistance** ☐ **Other Services-Please list:**

REFERRAL SOURCE

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

DEMOGRAPHICS

Application Date:			Received Date:		
Social Security #:		**Birth Date:**	____/_____/_____	**Gender:**	[ ] Male [ ] Female
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 Address:**			
Previous Address: (If less than one year)					
City, State, Zip:		**County:**			

DETAILS

Marital Status	☐ Single (never married)	☐ Divorced	☐ Widowed	☐ Married or Common Law ☐ Living Together
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:	

OTHERS IN HOUSEHOLD

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

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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	☐ Sheltered work employment	☐ Vocational Rehabilitation
☐ In the Armed Forces	☐ Student	☐ Volunteer
☐ Other, Not applicable	☐ Supported employment	☐ Work Activity Employment

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

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

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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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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**

X _____ _____

Signature of Legal Representative **Date**

(Application must be signed or witnessed and dated to be considered for assistance.)

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.

EMERGENCY CONTACT			
Name		**Relationship:**	
Address:		**Phone #:**	
City, Zip Code			