

APPLICATION FOR COUNTY ASSISTANCE CASE #  
(please answer all questions)

Date \_\_\_\_\_ Phone Number \_\_\_\_\_

FULL NAME: \_\_\_\_\_

MAIDEN NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOW LONG HAVE YOU LIVED IN TURNER COUNTY? \_\_\_\_\_

PREVIOUS ADDRESS: \_\_\_\_\_

MARITAL STATUS(circle) single married divorced separated widow widower

SPOUSE/SIGNIFICANT OTHER FULL NAME: \_\_\_\_\_

MAIDEN NAME: \_\_\_\_\_

SPOUSE/SIGNIFICANT OTHER SOCIAL SECURITY #: \_\_\_\_\_

SPOUSE/SIGNIFICANT OTHER BIRTH DATE: \_\_\_\_\_

LIST ALL DEPENDENTS:(not including you & your spouse/significant other)

	name	relationship	SS#	date of birth	place of birth
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

LIST ANY OTHER PERSONS LIVING IN HOUSEHOLD:

	NAME	SS#	AGE
1.	_____	_____	_____
2.	_____	_____	_____

EDUCATION(indicate) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

DEGREE/COURSE: \_\_\_\_\_ OTHER TRAINING: \_\_\_\_\_

EMPLOYER INFORMATION:

APPLICANTS EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOURLY RATE: \_\_\_\_\_ HOURS PER WEEK: \_\_\_\_\_

WHEN DID YOU START WORKING HERE: \_\_\_\_\_

PREVIOUS EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOURLY RATE: \_\_\_\_\_ HOURS PER WEEK: \_\_\_\_\_

START AND END DATE: \_\_\_\_\_

IF NOT EMPLOYED OTHER SOURCES OF INCOME AND AMOUNTS: \_\_\_\_\_

SPOUSE/SIGNIFICANT OTHER EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOURLY RATE: \_\_\_\_\_ HOURS PER WEEK: \_\_\_\_\_

DATE STARTED WORKING HERE: \_\_\_\_\_

PREVIOUS EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

IF NOT EMPLOYED OTHER SOURCES OF INCOME AND AMOUNTS: \_\_\_\_\_

TYPE OF REQUEST(INDICATE): MEDICAL FOOD UTILITIES OTHER: \_\_\_\_\_

IF MEDICAL WAS THIS ILLNESS AN EMERGENCY? YES NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

ARE YOU ELIGIBLE FOR EITHER INDIAN HEALTH SERVICES OR MEDICAL SERVICES THROUGH THE VETERAN'S HOSPITALS? YES NO

WHAT IS YOUR TOTAL HOSPITAL BILL? \_\_\_\_\_

IS HEALTH INSURANCE AVAILABLE AT JOB? YES NO

HAVE YOU TRIED TO ARRANGE PAYMENTS? YES NO

HAVE YOU ATTEMPTED TO OBTAIN A LOAN FOR THIS EXPENSE? YES NO

ARE YOUR FAMILY MEMBERS ABLE TO HELP WITH THIS EXPENSE? YES NO

**ASSETS:**

Equity value of primary residence plus entire equity value of other real property \$ \_\_\_\_\_

Equity value of recreational and leisure equipment \$ \_\_\_\_\_

Equity value of motor vehicles \$ \_\_\_\_\_

Cash on hand \$ \_\_\_\_\_

Personal assets, savings, CDs, stocks, securities, notes due, cash value of life insurance, judgments receivable, and monetary gifts \$ \_\_\_\_\_

Equity value of business property, including real estate, equipment, and inventory \$ \_\_\_\_\_

Household goods and personal property beyond that which can reasonably be considered to be essential for everyday living and self support \$ \_\_\_\_\_

One Time gains(lump sum payments, inheritance, winnings, etc. \$ \_\_\_\_\_

NAME OF BANK & ADDRESS: \_\_\_\_\_

NAME AND ADDRESS OF LANDLORD/MORTGAGOR: \_\_\_\_\_

HAVE YOU/SPOUSE/SIGNIFICANT OTHER SOLD OR TRANSFERRED REAL PROPERTY IN THE PAST 3 YEARS? Y N

ARE YOU/SPOUSE/SIGNIFICANT OTHER CURRENTLY A PARTNER/SILENT PARTNER IN A BUSINESS? YES NO IF YES, NAME, LOCATION, DATE: \_\_\_\_\_

ARE YOU/SPOUSE/SIGNIFICANT OTHER INVOLVED IN A CONTRACT FOR DEED OR LEASE SITUATION EITHER AS A SELLER OR BUYER? \_\_\_\_\_

**MONTHLY HOUSEHOLD INCOME: (attach income tax form)**

Gross salary, wages, commissions, and bonuses \$ \_\_\_\_\_

Self-employment income \$ \_\_\_\_\_

Pension, social security, and VA disability insurance payments \$ \_\_\_\_\_

Annuities and/or trust income \$ \_\_\_\_\_

Interest, dividends, rents, royalties, and investment gains \$ \_\_\_\_\_

Unemployment compensation and/or strike benefits \$ \_\_\_\_\_

Workers compensation benefits \$ \_\_\_\_\_

Alimony and child support \$ \_\_\_\_\_

School grants and stipends(excluding grants for books & tuition) \$ \_\_\_\_\_

**DEDUCTIONS FROM MONTHLY INCOME:**

Income taxes and contributions to social security & medicare, etc. \$ \_\_\_\_\_

Contributions to standard retirement programs \$ \_\_\_\_\_

**MONTHLY EXPENSES:**

Actual rent paid or scheduled principle and interest payments for a personal residence plus property taxes and homeowners insurance costs \$ \_\_\_\_\_

All utilities \$ \_\_\_\_\_

Child care expenses related to work schedules \$ \_\_\_\_\_

Grocery expenses plus household supplies & toiletries \$ \_\_\_\_\_

Basic auto expenses, gasoline, and upkeep \$ \_\_\_\_\_

Insurance Health \$ \_\_\_\_\_, Life \$ \_\_\_\_\_, Auto \$ \_\_\_\_\_

Monthly health or medical installment payments \$ \_\_\_\_\_

Customary monthly expenses for medicine and medical care \$ \_\_\_\_\_

Court-ordered child support and alimony payments \$ \_\_\_\_\_

Automobile installment payments pertaining to one vehicle \$ \_\_\_\_\_

Other expenses(including clothing & installment debt for necessary household items) \$ \_\_\_\_\_

DO YOU RECEIVE FOOD STAMPS? YES NO

DO YOU RECEIVE AFDC? YES NO

DO YOU RECEIVE WIC? YES NO

FOR OFFICE USE:

**AUTHORIZATION TO FURNISH INFORMATION  
AND TO RELEASE INFORMATION**

TO WHOM IT MAY CONCERN:

I hereby authorize any person, agency or institution to supply information requested by Turner County, concerning me or my family, and to allow inspection and reproduction of records in his or their possession pertaining to me or my family by and duly authorized representation of Turner County.

I further authorize Turner County to release such information to providers or cooperating State or Federal Agencies.

I herewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

This authorization is given only in connection with its use by Turner County in its administration of its programs and for no other purpose. It shall continue in effect until such time as I state, in writing, to Turner County that it is no longer valid.

\_\_\_\_\_  
APPLICANT SIGNATURE DATE

\_\_\_\_\_  
SPOUSE SIGNATURE OR GUARDIAN (if applicable) DATE

\_\_\_\_\_  
ADDRESS(city/state/zip)

\_\_\_\_\_  
TELEPHONE NUMBER APPLICANT'S SS#

INFORMATION REQUESTED

<u>SOURCE</u>	<u>DATE</u>	<u>AMOUNT</u>
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\_\_\_\_\_  
SIGNATURE OF PERSON FURNISHING INFORMATION DATE