

**SCOTT COUNTY COMMUNITY SERVICES
BENEFITS PROGRAM APPLICATION**

Applicant Information:

Name: _____ (Guardian-if child) _____
Date of Birth: _____ SSN#: _____ Phone: _____
Current Address: _____
City: _____ State: _____ Zip Code: _____
Time Living in Scott County: _____ Place of Birth: _____

Income Information:

Current Benefit (Examples: SSI, SSA, SSDI, VA, Pension) _____ Amount: \$ _____
Employer Address: _____
Employer Phone: _____ Employer FAX #: _____
City: _____ State: _____ Zip Code: _____
Position: _____ Hourly Wage: \$ _____ Annual (Yearly) Income: _____

Emergency Contact/Guardian:

Name of person NOT residing with you: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____
Relationship: _____

Landlord Information:

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Rent/ Mortgage Amount: \$ _____
Utilities you Pay: (Mark all that apply) Electric _____ Gas _____ Water _____ Trash/Sewer _____

Service Information:

Current Payee: _____
Please state all services received last 30 days: _____

Mental Health Services: Yes _____ No _____ Provider/ Doctor: _____
Care Coordinator: _____ Mother's Maiden Name: _____
HCBS Waiver Services: Yes _____ No _____ Provider _____
HCBS Provider Contact Name: _____ Substance Provider: _____
Food Assistance: Yes _____ No _____ Amount: \$ _____ Medicaid/ Title 19: _Yes _____ No _____

Assets:

Please mark all that apply: Checking _____ Savings _____ CD/ Mutual Fund/ Money Market _____

Vehicle: Yes _____ No _____ (if yes) Year _____ Make _____ Model _____

Other: (Specify) _____ Other: (Specify) _____

Current Bills:

Company Name: _____ Amount Owed: _____ Account # _____

Company Name: _____ Amount Owed: _____ Account # _____

Company Name: _____ Amount Owed: _____ Account # _____

Company Name: _____ Amount Owed: _____ Account # _____

Signatures:

I UNDERSTAND THAT I ASSUME FULL RESPONSIBILITY FOR THE ACCURACY OF STATEMENTS ON THIS APPLICATION. I UNDERSTAND THE COMMUNITY SERVICES DEPARTMENT WILL USE THESE STATEMENTS TO DETERMINE MY ELIGIBILITY FOR BENEFIT PROGRAM SERVICES.

I AM AWARE THAT THE INFORMATION THAT I HAVE GIVEN, MAY BE VERIFIED BY SCOTT COUNTY COMMUNITY SERVICES.

Signature of Applicant/ Parent / Guardian

Date

Signature of Case Aide

Date

For Payee at interview:

Documents Needed:

Picture ID _____

Proof of Address: _____

Legal Documents (Guardianship) _____

Social Security Card: _____

Lease: _____