GENERAL ASSISTANCE APPLICATION

I AGREE TO GIVE ALL INFORMATION AND VERIFICATION NEEDED TO DETERMINE MY ELIGIBILITY.

I am requesting: _____ Date: _____
(Type of Assistance)

Name: _____ Birth date: _____
(Last) (First) (M.I./Maiden)

Spouse: _____ Birth date: _____
(Last) (First) (M.I./Maiden)

Phone Number: _____ Your Social Security Number: _____

Are you a U.S. Citizen? ☐ Yes ☐ No Spouse's Social Security Number: _____

Current Address: _____
(Street) (PO Box) (County)

_____
(City) (State) (Zip)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If divorced or separated, give date: _____ Number of Children: _____

OTHER PERSONS IN HOUSEHOLD:

Name	Birth Date	Relationship

I HAVE LIVED AT THE ADDRESSES LISTED BELOW DURING THE PAST YEAR:

Street	City	County	State	Zip	Dates

LIST EMPLOYMENT HISTORY, STARTING WITH THE CURRENT OR LAST JOB:

Employer	Address	Start Date	End Date	Reason for Leaving

Are you registered with Nebraska Workforce Development? ☐ Yes ☐ No Date: _____

Is your spouse registered? ☐ Yes ☐ No Date: _____

Are you or your spouse a Veteran? ☐ Yes ☐ No During war time? ☐ Yes ☐ No

If yes, has the Veterans Administration helped you in the past year? ☐ Yes ☐ No

LIST CONTACTS FOR FIVE (5) PLACES WHERE YOU OR YOUR SPOUSE HAVE SOUGHT EMPLOYMENT:

Employment Contact	Address	City	State	Date Applied

INCOME: LIST THE MONTHLY AMOUNT OF INCOME YOU OR OTHERS IN YOUR HOUSEHOLD RECEIVE:

Source	Self	Spouse	Others
Salary / Employment	$	$	$
Child Support	$	$	$
Alimony	$	$	$
Social Security	$	$	$
Supplemental Security Income (SSI)	$	$	$
Retirement Income	$	$	$
Veteran's Pension	$	$	$
Union Payments	$	$	$
Unemployment Compensation	$	$	$
Worker's Compensation	$	$	$
Charitable Organizations	$	$	$
Supp. Nutrition Assistance Program (SNAP)	$	$	$
Friends	$	$	$
Assistance from Veterans	$	$	$
Self-Employment	$	$	$
Vocational Rehabilitation	$	$	$
Rentals	$	$	$
Boarders	$	$	$
Relatives	$	$	$
Other (Specify):	$	$	$

Your last paycheck: _____
(Date) (Amount) (Source)

How was it spent? List items and amounts:

_____

_____

_____

RESOURCES:

I own my own home: ☐ Yes ☐ No I own other property: ☐ Yes ☐ No

I have previously owned a house, farmland, or other property: ☐ Yes ☐ No

What happened to it? _____

CHECK "YES" OR "NO" FOR EACH ITEM AND LIST ACCOUNT NUMBERS AND AMOUNTS IF APPLICABLE:

Source	Yes	No	Amount
Checking Account #:			$
Savings Account #:			$
Other Accounts (Specify):			$
Cash On-Hand			$
Safety Deposit Box			$
Certificate of Deposit			$
Stocks or Bonds			$
Retirement Account			$
Farm Crops			$
Life Insurance Policy #: Does it have a cash value? Does it have a loan value?			$
Health Insurance Policy #: Name of company:			$

LIST ALL VEHICLES YOU OWN:

Make	Model	Year	Value
			$
			$
			$
			$

Do you own a mobile home? ☐ Yes ☐ No Value: $_____

LIST ALL VEHICLES (INCLUDING BOATS, RVs, ETC.) OWNED BY ANY MEMBERS OF YOUR HOUSEHOLD:

Make	Model	Year	Value
			$
			$
			$
			$

Have you ever applied for Supplemental Security Income (SSI)? ☐ Yes ☐ No

Have you ever applied for Medicaid? ☐ Yes ☐ No

State: _____ Caseworker's Name: _____

County: _____ Phone Number: _____

Do you have any special medical problems that you feel are related to your financial need? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

In case of emergency, notify: _____
(Name) (Address) (Phone Number)

If requesting rental assistance, advise: _____
(Landlord's Name) (Address) (Phone Number)

Monthly rental amount: $_____

AMOUNT OF FINANCIAL ASSISTANCE YOU ARE REQUESTING AND FOR WHAT SPECIFIC PURPOSES:

Eg. Water bill: $45; and rent: $250. Total: $295.

ANY ADDITIONAL INFORMATION THAT YOU FEEL MAY BE RELEVANT:

CLIENT'S RIGHTS

You have the right to:

- Expect your application to be received and acted upon promptly – within thirty (30) days for applications requesting continuing assistance, and within seven (7) days for applications requesting short-term assistance.
- Appeal and ask for a fair hearing if you are not satisfied with any action taken on your application.
- Be assisted in various aspects of application or determination of eligibility by the person of your choice.
- Have confidential treatment of private information.
- Have the program requirements and benefits fully explained.
- Know that you can be required to reimburse: (1) any assistance obtained through misrepresentation or fraud; (2) any interim assistance issued pending a determination of eligibility for any supplemental security income program or other categorical assistance program that provided retroactive benefits; and (3) any assistance obtained through receipt of a check that had been lost or stolen and subsequently reissued.
- Know that the County may request reimbursement for County Medical Assistance from legally responsible parties if they are of sufficient ability to repay.

SIGNATURES

Under penalties of law, I declare that I have read this form, including accompanying statement, and to the best of my knowledge, it is true, correct, and complete. I understand my responsibilities and agree to fulfill them. I agree to provide proof of need if requested, and I give consent for the agency to make whatever contacts are necessary to determine my eligibility, and I hereby authorize release of financial or medical information and understand that my signature below constitutes such a release.

I have had the assistance programs and program requirements explained to me, and I do ☐ / do not ☐ wish to receive assistance based on these requirements.

NOTE: If someone helped you fill out this form, be sure that the person signs below.

_____	_____
SIGNATURE OF APPLICANT	DATE
_____	_____
SIGNATURE OF SPOUSE	DATE
_____	_____
SIGNATURE OF PERSON WHO HELPED	DATE
_____	_____
SIGNATURE OF ELIGIBILITY WORKER	DATE