Lancaster County General Assistance Application

You must complete the entire application

Name _____.
(Last) (First) (Middle Initial)

Alias, Maiden Name, or Other Names used: _____.

Address _____.
(Street) (Town) (County) (State) (Zip)

Phone Number _____ Cell Phone _____ Message Phone _____.

1. Reason for Request: ☐ Rent - Amount _____ ☐ Deposit - Amount _____ ☐ Bus Pass

☐ Hospital/ER ☐ General Medical/Primary Care and Prescriptions ☐ Other _____.

2. I am: ☐ Single ☐ Married ☐ Legal Separation ☐ Divorced ☐ Widowed

Ex-spouse's name _____ If legally separated/divorced/widowed give date _____.

3. I (or my spouse) is/am a veteran. ☐ Yes ☐ No Branch of Service _____ Dates of Service: _____.

4. Are you/spouse currently a student? ☐ Yes ☐ No I/Spouse am ☐ Full Time ☐ Part Time Name of School? _____.

How many hours are you enrolled? _____ Hours Who Pays the Tuition? _____.

5. I am a: ☐ Citizen of the US. ☐ Immigrant ☐ Refugee My current status is _____.

My Sponsor is: _____.
Name Address City/State/Zip Phone

6. List **all** Household Members below **including yourself**:

Name First	MI	Last	Date of Birth Month	Day	Yr.	Age	Sex M/F	Social Security Number	Relationship

7. During the past **two (2) years** I have lived at the following locations, starting with the most current residence:

1) _____ / _____ / _____ / _____ / _____.
Street Address City/State/Zip How Long? From To

2) _____ / _____ / _____ / _____ / _____.
Street Address City/State/Zip How Long? From To

3) _____ / _____ / _____ / _____ / _____.
Street Address City/State/Zip How Long? From To

4) _____ / _____ / _____ / _____ / _____.
Street Address City/State/Zip How Long? From To

8. Do you have any specific medical problems which relate to your financial inability to pay for your basic needs? _____.

_____.

9. Are you currently enrolled in a treatment program? ☐ Yes ☐ No What Program? _____.

Date Started: _____ Assigned Caseworker: _____.

10. Are you eligible for medication assistance through the LB 95 program? ☐ Yes ☐ No ☐ Not Sure

11. In case of emergency, please notify:

Name: _____ Relationship _____ Telephone No. _____.

Address: _____ City _____ State _____ Zip _____.

12. Employment for the last **24 months** of places you and your spouse have worked:

Name of Employer	Monthly Gross	Hours per wk	Hourly Rate	Begin Date	End Date	Reason for Termination

13. Are you registered at Workforce? ☐ Yes ☐ No Date _____ Is your spouse registered? ☐ Yes ☐ No Date _____.

14. List five (5) places where you (or your spouse) have applied for employment within the past 30 days:

Name of business	Address	City, State	Date Applied

15. **INCOME, ASSETS and RESOURCES**

SOURCE	SELF	SPOUSE	FAMILY & OTHER
Earned Income: (Show your total monthly gross income)	$	$	$
I am paid: ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly	$	$	$
Child Support: Including Court Ordered support you receive	$	$	$
Alimony Show only amounts received	$	$	$
Social Security (RSDI) and/or Supplemental Security Income (SSI)	$	$	$
ADC – Aid to Dependent Children	$	$	$
Retirement Income - (type)	$	$	$
Veterans Pension and/or Assistance from Veterans Aid	$	$	$
Union Payments	$	$	$
Unemployment Compensation Date Started: Date Ended:	$	$	$
Worker's Compensation Date Started: Date Ended:	$	$	$
Gifts or Grants from other Assistance Programs or Charitable Organizations From Whom:	$	$	$
Loans or Gifts from Family, Relatives or Friends From Whom:	$	$	$
Self-employment Income including Business Ownership	$	$	$
Total Value of Business Assets (Include an Itemized listing on separate sheet)	$	$	$
Vocational Rehabilitation Stipends	$	$	$
Food Stamps Date Applied:	$	$	$
Other (includes Trust Accounts, Annuities, Student Loans, Housing Assistance and Public Assistance/grants)	$	$	$

16. Date - Amount and Source of last check received: _____.

List how this month's income was spent: (include rent, house payment, utilities, food, transportation, child support, medical expenses, etc.)

_____.

_____.

RESOURCES and POTENTIAL RESOURCES

17. Do you currently own your home? ☐ Yes ☐ No Do you own any other property? ☐ Yes ☐ No

Current Value_____ Loan Company_____Mortgage Amt _____.

Have you ever owned a house, farmland, or other property? ☐ Yes ☐ No Where was it, What was it, and what happened to it?
(Failure to disclose any property ever owned may be cause for denial or immediate termination of any/all General Assistance.)

_____

_____

_____.

18. Check either "yes" or "no" to the following. Give amounts and additional information if marked "yes".

Yes	No		
☐	☐	Checking account # _____ Bank _____	Balance $ _____.
☐	☐	Savings account # _____ Bank _____	Balance $ _____.
☐	☐	Cash on Hand	$ _____.
☐	☐	Safety Deposit Box	$ _____.
☐	☐	Certificate of deposit	$ _____.
☐	☐	Stocks or Bonds or Trust Accounts	$ _____.
☐	☐	Farm Crops	$_____.
☐	☐	Livestock	$_____.
☐	☐	Farm Machinery	$_____.
☐	☐	Car, Truck, Motorcycle, Make/Model _____ Year _____	Value $ _____
☐	☐	Second Vehicle Make/Model _____ Year _____	Value $ _____.
☐	☐	Mobile Home / RV Model _____ Year_____	Value $ _____
☐	☐	Burial Space(s), Burial Trust, Pre-Arrangement: Number of Plots Owned: _____	Value $ _____
		Where Located: _____.	
☐	☐	Life Insurance Name of Company _____Policy Owner _____.	
		Policy # _____ Cash Value $ _____ Loan Value $ _____.	
☐	☐	Health Insurance (including VA), Name of Company _____	
		Policy #_____Is this Insurance through an employer?	

List **All** Personal Assets not listed above:_____.

19. Have you applied for?

Yes	No	
☐	☐	SSI or SSD (Social Security Supplement Income - Disability)When _____ Status_____
☐	☐	Medicaid When _____ Status_____ Caseworker_____.
☐	☐	Workman's Compensation? When _____ Status_____
☐	☐	Any claim with an Insurance Company or potential Third Party Payee? When _____ Status_____
☐	☐	Are you represented by an Attorney or Law Firm for any of these claims? Who?_____.

20. Did you file **Federal Tax Returns** last year? ☐ Yes ☐ No **State Returns** ☐ Yes ☐ No Did you receive a **refund**? ☐ Yes ☐ No

Amount of Refund_____ When was the refund received?_____.

21. Please provide any other information you feel is pertinent to your determination of eligibility for General Assistance:

_____.

_____.

_____.

SIGNATURES

I understand that the provision of certain confidential information as indicated within the provisions of the Lancaster County General Assistance Policy is needed to make a determination of my eligibility for General Assistance. This information may be in the form of written statements of verification as well as agency contact. This may include, but is not limited to, information from an employer, attorney, health care provider, relative, Social Security, etc. In my case, however, I specifically do not authorize contacting

_____.

I otherwise authorize the release of that confidential information to the General Assistance Worker and agree to provide necessary written statements of verification which are needed to determine my eligibility for General Assistance as indicated within the provisions of Lancaster County General Assistance Policy Guidelines.

I declare that I have read this application 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 information and give consent for this agency to make whatever contacts are necessary within the terms of the release of confidential information as cited above in order to determine my eligibility.

I have received an information sheet about my rights and responsibilities. I have had the assistance programs and program requirements explained to me. When signed, the submission of this application indicates my intent 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 person who helped

_____ _____.
Signature of Spouse Date Address of person who helped

_____.
Signature of Eligibility Worker Date

RIGHT OF SUBROGATION

I understand that receiving general assistance or health services pursuant to this application gives Lancaster County an automatic right of subrogation against any claim or right which I may have against a third party relating to this assistance. I agree that any funds or payments, which I receive under such a claim or right, up to the amount of assistance I received from the County, will be immediately, reimbursed to the Lancaster County General Assistance Fund.

_____ _____
Signature of applicant Date

_____ _____
Signature of Eligibility Worker as Witness Date

Although you aren't required to provide this information, your cooperation will help determine compliance with Federal Civil Rights Law. In no instance will this information be used in considering your application. If you decline to provide this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964. The worker will complete this information if it is left unanswered.

☐ Black -not of Hispanic Origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ White -not of Hispanic Origin ☐ Other

INFORMATION ABOUT LANCASTER COUNTY GENERAL ASSISTANCE PROGRAM
KEEP THIS PAGE FOR YOUR RECORDS

CLIENT RESPONSIBILITIES

1. **Provide complete and accurate information, sign all required documents and provide documented verification of information used to determine eligibility;**
2. **Report <u>all</u> changes in your situation promptly (within 3 days for initial determination and short-term assistance and with 10 days for continuing assistance). This includes information such as:**
    a. **An increase or decrease in monthly income and expenses;**
    b. **An increase or decrease in resources;**
    c. **A change in employment status;**
    d. **A change in the composition of the household regardless of whether the change involves a related or unrelated household member;**
    e. **A change in address and/or living arrangements;**
    f. **A change in incapacity or disability status;**
    g. **Proof of employment search as required.**
3. **Accept referral to any other public or private agency or organization which may be able to provide the requested assistance to the client.**
4. **You must apply for and be in compliance with all federal, state, and local programs to which you may be entitled in order to be favorably considered for eligibility under General Assistance.**

AGENCY RESPONSIBILITIES

1. **Give an explanation of program requirements;**
2. **Explain the eligibility factors that require verification;**
3. **Obtain the client's written consent for needed verification;**
4. **Explore current and potential available income and resources with the client;**
5. **Inform the client of his/her rights and responsibilities;**
6. **Act with promptness on the client's application for assistance as defined in section 2:501;**
7. **Inform the client of medical services available and program restriction on use of private medical providers (SEE "INFORMATION ABOUT MEDICAL SERVICES" BELOW);**
8. **Provide adequate notice to the client of approval, rejection, termination or any other case action which will affect the client's assistance payment.**

INFORMATION ABOUT MEDICAL SERVICES

1. **Primary medical care and related health care services are available through the Primary Health Care Clinic at the Health360 Clinic, 2301 "O" Street, Lincoln, (402) 441-6642.**
2. **All health services and non-emergent hospital outpatient or inpatient care must be prior authorized in order for payment to be considered. Your worker will need a written diagnosis and treatment plan from your physician in order to make a request for authorization. If you receive medical services that are not prior authorized, you will be financially responsible for charges incurred.**
3. **If you have a medical emergency and go to the emergency room and/or are hospitalized, we must be notified with seventy-two (72) hours of the event. This is required for payment to be considered, but is not a guarantee that payment will be made.**

    Contact General Assistance at (402) 441-3095.
    Return to: Lancaster County General Assistance, 3131 O St., Suite 2106,
    Lincoln, NE 68510

4. **All bills for approved medical services must be received and/or resubmitted with ninety (90) days of the date of the last services provided or payment will be denied.**

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States.

— OR —

☐ I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status is: _____; and my alien number is: _____. I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME _____

(first, middle, last)

SIGNATURE _____

DATE _____