

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

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: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	\$	\$	\$
Child Support: Including Court Ordered support you <u>receive</u>	\$	\$	\$
Alimony Show only amounts <u>received</u>	\$	\$	\$
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:

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 all 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 through Bluestem Health.
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.

Mail 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
