CLINTON COUNTY
INDIGENT CREMATION ASSISTANCE APPLICATION

DATE:_____

Name of Decedent:_____ D/O/B:_____

Date of Death: _____Social Security #:_____

Address at time of death:_____

_____

When did decedent move to this address? _____

Is the decedent a Veteran? _____Yes or _____NO If yes you will have to apply for burial assistance through the Veteran's Affairs Office or ask the funeral home director to assist you in applying.

Place of death: _____Home _____Hospital/Nursing Home ____Other:_____

Do you understand that Clinton County will only pay for a direct cremation with no service and agree to this type of service? _____Yes _____No

Funeral Home Information:

Name the Funeral Home: _____

_____/_____

Address /Phone Number

Applicant(s) Information:

_____

Last Name First Name Middle

_____

Street Address City State Zip

Relationship to the deceased:_____Phone Number:_____

Household Members Names : **Relationship to the deceased:**

_____

_____

_____

_____

_____

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FINANCIAL INFORMATION		
MONTHLY GROSS INCOME:	**DECEDENT**	**OTHERS IN HOUSEHOLD**
EMPLOYMENT WAGES	$	$
FIP	$	$
SOCIAL SECURITY	$	$
SSDI	$	$
SSI	$	$
VETERAN'S BENEFITS	$	$
CHILD SUPPORT RECEIVED	$	$
UNEMPLOYMENT, PENSIONS	$	$
OTHER INCOME	$	$

HOUSEHOLD RESOURCES:		CHECK YES OR NO				AMMOUNT
CHECKING ACCOUNT		YES		NO		$
SAVINGS ACCOUNT		YES		NO		$
CERTIFICATE OF DEPOSIT		YES		NO		$
TRUST FUNDS		YES		NO		$
WHOLE LIFE INSURANCE - CASH VALUE		YES		NO		$
TERM LIFE INSURANCE		YES		NO		$
STOCKS AND BONDS		YES		NO		$
BURIAL FUND OR TRUST		YES		NO		$
OTHER RESOURCES		YES		NO		$
VEHICLE 1		YES		NO	YEAR:	$ VALUE:
VEHICLE 2		YES		NO	YEAR:	$ VALUE:
REAL ESTATE		YES		NO	Location: Equity: $	

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PLEASE READ BEFORE SIGNING:

The General Assistance Worker shall investigate the facts of the application to determine Applicant's eligibility and need for assistance. These documents and the workers investigation of facts shall be made part of Applicant's file. GA Worker shall make a decision within FIVE working days after receiving completed application. A Notice of Decision will be mailed to the Applicant's address.

Prohibition against discrimination: We shall consider this application without regards to race, gender, sexual orientation, mental or physical handicap, religion, national origin, or political belief.

Right of appeal: If you are not satisfied with the action of this office, you may appeal to the Clinton county Board of Supervisors at the Clinton county Administration building in Clinton, IA. This appeal will have to be in writing to the Clinton County Community Assistance Programs Director within 10 days of the date of decision.

As signatory of this document, I certify that this information is true and complete to the best of my knowledge, and I authorize the Clinton County General Assistance Staff to check for verification of the information provided. I understand that the information gathered in this document is for the use of the County in establishing my eligibility to receive financial assistance through General Assistance Office. I understand that the information gathered in this document will remain confidential. Additionally I understand that if at a later date it is determined that the deceased individual did have a life insurance policy or other available resources that those funds will be used to repay the county for the direct cremation expenses.

_____

SIGNATURE OF APPLICANT DATE

COPY TO APPLICANT ACCEPTED ___ DECLINED ___ DATE: _____

***Office Use Only*: Approved OR Denied**

GA Staff Signature_____ **Date**_____

DENIAL REASON:

	Over income/resource
	This office has not received all of the information needed to process his/her application therefore eligibility cannot be determined
	Other:

GA Worker's Notes: