# Clinton County Government

## APPLICATION FOR PROTECTIVE PAYEE SERVICES

Date: ______________________ SSN: ___________________________________________

Name: ______________________________________ DOB: _________________________

Address: ________________________________________________________________

Phone Number: _____________________ Alternative Number: ______________________

Referred By: _____________________________________________________________
Name Relationship Telephone #

Who is your emergency contact? _____________________________________________

Next of kin: ______________________________________________________________

What other agencies/service providers work with you? __________________________
______________________________________________________________________
______________________________________________________________________

If you are **not** currently living in a facility, list names of all other persons who live in the same house or apartment with you and their relationship to you: (Please use the back of the form if you need more space.)

____________________________________ ____________________________________
Name Relationship to you

____________________________________ ____________________________________
Name Relationship to you

____________________________________ ____________________________________
Name Relationship to you

DO ANY OF THESE INDIVIDUALS HAVE A PROTECTIVE PAYEE? IF YES –
Name: ____________________________________________ Phone #: ________________

HOUSEHOLD FINANCIAL INFORMATION:

| INCOME RECEIVED: | AMOUNT | WHO RECEIVES IT? |
|---|---|---|
| ______SS | ____________ | ______________ |
| ______SSDI | ____________ | ______________ |
| ______SSI | ____________ | ______________ |
| ______VA Pension | ____________ | ______________ |
| ______FIP | ____________ | ______________ |
| ______EMPLOYMENT WAGES | ____________ | ______________ |
| ______FOOD STAMPS | ____________ | ______________ |
| ______CHILD SUPPORT | ____________ | ______________ |

______OTHER ______________ ____________________

RESOURCES: AMMOUNT / BANK

______CHECKING ________________________________
______SAVINGS ________________________________
______LIFIE INSURANCE ________________________________
______BURIAL POLICY ________________________________
______OTHER:___________________ ________________________________

MONTHLY EXPENSES: If you reside with other individuals claim only the amount that you are responsible to pay.

| Type | Amount Due | Date Due | Person/ Agency you pay this to |
|---|---|---|---|
| Rent/Mortgage | ____________ | __________ | __________________________ |
| Electric | ____________ | __________ | __________________________ |
| Heat | ____________ | __________ | __________________________ |
| Water/Sewer | ____________ | __________ | __________________________ |
| Pharmacy | ____________ | __________ | __________________________ |
| Medical | ____________ | __________ | __________________________ |
| Child Support | ____________ | __________ | __________________________ |
| Telephone | ____________ | __________ | __________________________ |
| Cable/Internet | ____________ | __________ | __________________________ |
| Health Insurance | ____________ | __________ | __________________________ |
| Life Insurance | ____________ | __________ | __________________________ |
| Fines | ____________ | __________ | __________________________ |
| Credit Card | ____________ | __________ | __________________________ |
| Other:_____________ | ____________ | __________ | __________________________ |

Total Expenses: _____________

**MEDICAL INSURACE:**

_____Medicare ___Part A ___Part B ___Part D Policy Number: ____________________
_____Medicaid Policy Number: ____________________
_____MEPD Policy Number: ____________________
_____Private Policy Number: ____________________
_____Other Policy Number: ____________________

**ADDITIONAL INFORMATION:**

**Any other information you want our office to know:**_________________________________

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**PLEASE REVIEW BEFORE SIGNING BELOW**

**As a signatory of this document, I certify that the information is true and complete to the best of my knowledge, and I authorize the Clinton County Protective Payee Program staff to check for verification of the information provided. I understand that information in this document will remain confidential**

- I AGREE TO INFORM THE PROTECTIVE PAYEE OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION WITHIN 10 DAYS OF THE CHANGE.
- I UNDERSTAND I WILL BE EXPECTED TO PAY A MONTHLY FEE FOR THE PROTECTIVE PAYEE SERVICES.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF IT IS DETERMINED THAT I WILLFULLY MISREPRESENTED ANY FACTS TO OBTAIN ASSISTANCE, THAN THIS APPLICATION CAN BE DENIED FOR THAT REASON.

________________________________________ ____________________

**SIGNATURE OF APPLICANT OR LEGAL GUARDIAN** **DATE**

**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.

**Return Application to:**

Kim Ralston, Community Assistance Programs Director
kralston@clintoncounty-ia.gov
PH: 563-244-0563 ext. 5533 or Fax: 563-243-9026
Community Assistance Programs
1900 N. 3rd Street
P.O. Box 2957
Clinton, IA 52733-2957