

JACKSON COUNTY GENERAL ASSISTANCE

Jackson County Courthouse
201 West Platt Street
Maquoketa, IA 52060

Becki Chapin, Director Phone: 563-652-1710 Option 3 then option 2
Email: bchapin@co.jackson.ia.us

GENERAL ASSISTANCE APPLICATION For Burial or Cremation

READ THIS FIRST!

To apply for Jackson County General Assistance:

1. Fill out and return application to the General Assistance Office within 72 hours of time of death.
2. Gather all the items requested.
3. Call the Intake Officer to schedule an intake.
4. Bring the completed application and ALL the items requested to the intake.
5. The Intake Officer will answer any questions and check the items brought against the requirements.

IF ANY items are missing, the application cannot be accepted! No assistance can be given!

Name of Deceased: _____

Date of Death: _____ Place of Death: _____

Date of Birth: _____ Social Security Number: _____

As family member/representative of the above named deceased individual, I hereby state that I am unable to pay for the burial costs and am requesting that Jackson County provide assistance. I have provided, to the best of my knowledge, all information available to me concerning the decedent's assets at time of death and decedent's eligibility for county assistance. I understand that any cash or cash accounts belonging to the decedent and any death/burial benefit due must be paid to the Funeral Director and that those amounts shall be credited against the amount payable by Jackson County.

*** Failure to comply with this requirement may result in my being responsible for the full cost of burial.**

I understand that I may elect to pursue other options for burial directly with the Funeral Director **without county assistance**, however I choose not to. **I have read, understand and agree to comply with Jackson County's requirements and restrictions for indigent burial assistance.**

Signature of Family/Representative

Date

Relationship to Deceased

I have read, understand and agree to comply with Jackson County's requirements and restrictions for indigent burial assistance and I certify that no individual has agreed or contracted to pay for any portion of the above named decedent's burial costs. I agree to accept any memorials, direct payment from decedent's assets, death benefit from any other source and county payment in full payment and satisfaction of the services provided.

Funeral Home Name

Address

City

State

Zip

Signature of Funeral Director/Designee

Date

Applicant – Family Representative

Please bring the following items to your interview with the General Relief Director:

- _____ Proof of identification of deceased (Photo identification and/or Social Security Card)
- _____ Bank statements to verify balances at financial institutions for deceased
- _____ Funeral home estimate for services
- _____ Proof of income for deceased (**last four weeks**)

To be Completed for the Deceased Individual, before death, and their entire Household, including any surviving spouse.

Name of Deceased: _____ **Date of Death:** _____

Employment \$ _____ Family Investment Program (FIP)\$ _____

Pension \$ _____ Child Support and/or Alimony \$ _____

Social Security \$ _____ Interest or Dividends \$ _____

Unemployment Compensation \$ _____ Other Specify \$ _____

Worker's Compensation \$ _____

Checking Account Amount: \$ _____ Financial Institution: _____

Savings Account Amount: \$ _____ Financial Institution: _____

Social Security Death Benefit Amount: \$ _____

Residential Trust Account Amount: \$ _____ Financial Institution: _____

Life Insurance Value: \$ _____ Company Name: _____

Stocks/Bonds Amount: \$ _____ Company Name(s): _____

Vehicle Value: \$ _____ Model/Year: _____

Real Estate Amount: \$ _____ Location: _____

Other: _____

APPLICANT INFORMATION:

Name: _____			
Last	First	MI	
Address: _____			
Street	City	State	Zip
Home Phone: (____) - ____ - _____		Cell Phone: (____) - ____ - _____ E-Mail: _____	

Printed Name of Applicant: _____

Signature of Applicant / Relationship: _____ / _____

**RESPONSIBLE RELATIVE HOUSEHOLD MEMBERS
INCOME VERIFICATION WORKSHEET**

To be Completed by each Individual with Income Living in the Household of a Responsible Relative
(including the Responsible Relative)

Name of Deceased: _____ **Date of Death:** _____

Printed Name of Individual with Income Living in Household of a Responsible Relative:

*** Amounts per month ***

Employment \$ _____ Family Investment Program (FIP) \$ _____

Pension \$ _____ Child Support and/or Alimony \$ _____

Social Security \$ _____ Interest or Dividends \$ _____

Unemployment Compensation \$ _____ Other Specify \$ _____

Worker's Compensation \$ _____

Checking Account Amount: \$ _____ Financial Institution: _____

Savings Account Amount: \$ _____ Financial Institution: _____

Social Security Death Benefit Amount: \$ _____

Residential Trust Account Amount: \$ _____ Financial Institution: _____

Life Insurance Value: \$ _____ Company Name: _____

Stocks/Bonds Amount: \$ _____ Company Name(s): _____

Vehicle Value: \$ _____ Model/Year: _____

Real Estate Amount: \$ _____ Location: _____

Other: _____

Signature of Household Member: _____

Relationship to Responsible Relative: _____

(Make extra copies of this sheet as needed)

OTHER INFORMATION:

Have you applied anywhere else for assistance in the last 6 months? Yes ___ No ___

If yes, where and determination? _____

If you have not lived at your present address for at least one full consecutive year, list your previous addresses and the dates you lived there:

AUTHORIZATION SIGNATURE / AGREEMENT TO REPAY:

I understand that by signing this Agreement to Re-pay, and accepting any relief assistance from Jackson County General Relief Department that I may be required to repay the full amount of any assistance granted, if or when I am able to do so, and that failure to do so shall result in denial of future assistance.

I understand that giving false information in this application and/or to the General Assistance staff is unlawful, can be considered fraud and may be referred to the Jackson County Attorney for court action. It may also result in my becoming permanently ineligible for future assistance. Also, giving false information on this application or to the General Assistance staff, or refusing to provide requested information, may result in denial of assistance and being ineligible for more assistance for one (1) year.

I understand that according to the Code of Iowa, my estate may be subject to recovery by the county for assistance granted. I further understand that my homestead may be subject to recovery by the county for assistance granted in if there is no surviving spouse or child as defined in Section 234.1.

Do Not Sign! Signature(s) must be notarized or signed in presence of General Assistance Director or Intake Officer!

(Signature of Applicant) Date

(Signature of Co-Applicant) Date

(Signature of Director or Intake Officer) Date

STATE OF IOWA, COUNTY OF _____

Signed and sworn before me, on this _____ day of _____, 20____,

by _____
Name(s) of Persons

Notarized by: _____, Notary Public

Print Name: _____ (Seal)

My commission expires: _____

FOR OFFICE USE ONLY

___ Resident ___ Non-Resident (county of residency?): _____

___ Poor ___ Needy (County of Legal Settlement?) _____

___ Approved ___ Denied

Authorization to Release Information

I hereby authorize Jackson County General Assistance to release the information I have provided (including use of social security numbers) for the purpose of checking the accuracy of that information by contacting any local, state or federal government agency, private business, church, firm, agency, any financial institution, YWCA DV/SA Resource Centers of Jackson & Clinton Counties and _____.

I also authorize Jackson County General Assistance to inform vendors to whom assistance would be paid on my behalf, including my landlord, whether my application has been approved or denied.

In addition, I hereby authorize all of the previously named agencies and persons as well as all persons (doctors, employers, Department of Human Services (DHS), other Relief or Veterans Affairs Offices, banks, etc.) to release confidential information to Jackson County General Assistance if it deems such information necessary. This release is valid for one (1) year from the date of signature.

I solemnly swear that the statements I have made are true and correct to the best of my knowledge and belief.

Do Not Sign!

Signature must be notarized or signed in the presence of the General Assistance Director or Intake Officer!

(Signature of Applicant)	Date
(Signature of Co-Applicant)	Date
(Signature of Director or Intake Officer)	Date

STATE OF IOWA

COUNTY OF _____

Signed and sworn before me, on this _____ day of _____, 20____,

by _____
Name(s) of Persons

Notarized by: _____, Notary Public

Print Name: _____ (Seal)

My commission expires: _____