

**HENRY COUNTY GENERAL ASSISTANCE**

*Henry County Public Health 106 N Jackson St, Suite 103 Mt. Pleasant, IA 52641, 319-385-0779, Fax: 319-385-1802*

**Bring your completed application and ALL the verification items listed below with you to make an appointment. Once you have provided all requested verifications, and attended an appointment, a decision on your request will be made within 10 (ten) business days.**

**VERIFICATION NEEDED FOR ALL HOUSEHOLD MEMBERS OVER THE AGE OF 18**

1. **APPLICATION** – You must complete all blanks.
2. **IDENTIFICATION** – **Current Driver’s License or photo ID for all adults.** Social Security card for all minors in household.
3. **PROOF OF ALL HOUSEHOLD INCOME FOR THE LAST 30 DAYS (6 MONTHS FOR SELF-EMPLOYED).**
  - a) Pay stubs or a signed statement from employer verifying gross and net wages including pay dates
  - b) Proof of unemployment compensation benefits
  - c) Proof of child support payments
  - d) Self-employment financial records for the last 6 months
  - e) Personal income record if income is from baby-sitting, mowing, shoveling, handyman repair, mechanical repair, collecting scrap metal, odd jobs, etc.
  - f) **ANY** other source of income
4. **BANK STATEMENTS FOR ALL ACCOUNTS, FINANCIAL PLATFORM SERVICE, SOCIAL PAYMENT PLATFORM SERVICE OR ANY OTHER PAYMENT PLATFORM BALANCES**– most recent checking statement, most recent savings statement, or updated savings book, signed statement from the bank or financial institution for any and all other types of bank accounts, financial platform services, social payment platform services, or any other payment platform **for all household members.**
5. **PRINTED VERIFICATION OF NOTICE OF DECISION FROM DEPARTMENT OF HUMAN SERVICES** for **entire household** showing benefits or denial of **food stamps** benefits or appointment letter if no decision has been made to date.
6. **JOB SEARCHES** - all household members age 18 or older not employed full-time (37.5 hours/week) need 2 (two) current job searches. A valid job search is a statement from a business written on their business card or letterhead and states you (**your name must be included in the statement**) have applied for work at the business and they need to sign and date the statement. Completed and signed employment applications will also be accepted as valid job searches. Any job search that is not exactly as described above will not be accepted. If you are over the age of sixty-six (66) and receiving Social Security income there is no need for job searches.
7. **WRITTEN VERIFICATION OF REGISTRATION WITH IowaWORKS/WORKFORCE DEVELOPMENT or other online job platform-** for **EVERY** household member over the age of eighteen (18) who is not employed full-time. If you are over the age of 66, there is no need for registration.
8. **VERIFICATION THAT YOU HAVE APPLIED FOR UNEMPLOYMENT BENEFITS.**
9. **A WRITTEN DOCTOR’S, P.A.’S OR A.R.N.P. STATEMENT** - that you are unable to do any type of work on a full time basis and how long you will be unable to work (If you have this statement, there is no need to do two (2) job searches or register with IowaWORKS/Workforce Development)
10. **WRITTEN VERIFICATION THAT YOU HAVE APPLIED FOR DISABILITY.** (if applicable)
11. **CURRENT BILLS YOU ARE REQUESTING ASSISTANCE WITH** – for rental assistance bring a landlord verification form (**attached**). For utility assistance you must bring a copy of your current utility bill and the utility must be in the name of the applicant or a household member. If behind on utility bill, must provide proof that back bill will be paid in full before assistance is approved.

Appointment: \_\_\_\_\_

# HENRY COUNTY GENERAL ASSISTANCE APPLICATION

106 N Jackson St. Suite 103, Mt. Pleasant, IA 52641

319-385-0779 Fax: 319-385-1802

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Address: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
(street) (city) (state)

If less than one year at current address, please list

Previous Address: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
(street) (city) (state)

Type of help needed: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_\_

Military Service: Yes \_\_\_ No \_\_\_ Service Branch: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

U.S. Citizen: Yes \_\_\_ No \_\_\_

List EVERYONE in your household:

Name	Birth Date	Relationship
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Marital Status: Married \_\_\_ Single \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Do you have Medical Insurance? Yes \_\_\_ No \_\_\_

Company: \_\_\_\_\_

Do you have Life Insurance? Yes \_\_\_ No \_\_\_

Company: \_\_\_\_\_

Do you have Title XIX? Yes \_\_\_ No \_\_\_

**Living Arrangements:**

\_\_\_\_ Renting: Landlord's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Is landlord a relative? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_ Buying: Mortgage Institution: \_\_\_\_\_

\_\_\_\_ Living with friends or relatives: Name: \_\_\_\_\_

\_\_\_\_ Own home

**Resources:**

\_\_\_\_ Cash \$ \_\_\_\_\_

\_\_\_\_ Checking \$ \_\_\_\_\_ **Bank:** \_\_\_\_\_

\_\_\_\_ Savings \$ \_\_\_\_\_ **Bank:** \_\_\_\_\_

\_\_\_\_ Time Certificates \$ \_\_\_\_\_ **Bank:** \_\_\_\_\_

\_\_\_\_ Stocks, Bonds, Etc. \$ \_\_\_\_\_ **Bank:** \_\_\_\_\_

\_\_\_\_ Other assets (specify) \$ \_\_\_\_\_

\_\_\_\_ Real Estate: Location: \_\_\_\_\_

Value \$ \_\_\_\_\_ - Owe \$ \_\_\_\_\_ = Equity \$ \_\_\_\_\_

**Vehicles:**

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Value \$ \_\_\_\_\_

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Value \$ \_\_\_\_\_

**Employment:**

Last year's gross income: \$ \_\_\_\_\_

Are you presently employed? \_\_\_\_ Yes \_\_\_\_ No

Name of person working	Employer	Date you started working

**Unemployed:**

Person not working	Last employer	Dates you started and ended work
<b>Reason for Termination</b>		
Person not working	Last employer	Dates you started and ended work
<b>Reason for Termination</b>		

**INCOME:**

Has anyone in your home received any of the following income in the last 30 days?

Source of Income	Amount	How often Received	Person receiving income
Self-Employment	___ Yes ___ No		
Employment	___ Yes ___ No		
Unemployment Benefit	___ Yes ___ No		
Workman's Comp.	___ Yes ___ No		
Social Security	___ Yes ___ No		
SSI	___ Yes ___ No		
Pension	___ Yes ___ No		
Compensation	___ Yes ___ No		
Disability Payment	___ Yes ___ No		
Child Support	___ Yes ___ No		
Veteran's Benefits	___ Yes ___ No		
Regular Cash			
From Relatives	___ Yes ___ No		
Room & Board Pmts.	___ Yes ___ No		
F.I.P.	___ Yes ___ No		
Food Stamps	___ Yes ___ No		
Other	___ Yes ___ No		

**Every source must be checked above.**

**EXPENSES: (list monthly amounts)**

Loans \$ \_\_\_\_\_  
 Charge accounts \$ \_\_\_\_\_  
 \_\_\_\_\_  
 Other \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

Food \$ \_\_\_\_\_  
 Rent \$ \_\_\_\_\_  
 House payment \$ \_\_\_\_\_  
 Heating \$ \_\_\_\_\_  
 Electric \$ \_\_\_\_\_  
 Phone (excluding long distance)  
 \$ \_\_\_\_\_  
 Water \$ \_\_\_\_\_  
 Car payment \$ \_\_\_\_\_  
 Insurance \$ \_\_\_\_\_ house  
 \$ \_\_\_\_\_ car  
 \$ \_\_\_\_\_ medical

**Medical Expenses:**

Doctor(s):		Monthly	Total
Dr. _____	Amount:	\$ _____	\$ _____
Dr. _____	Amount:	\$ _____	\$ _____

Hospital:			
Name: _____	Amount:	\$ _____	\$ _____
Name: _____	Amount:	\$ _____	\$ _____

Medication:			
List: _____	Amount:	\$ _____	\$ _____
_____			
_____	Pharmacy:	_____	

**CERTIFICATION STATEMENT:** I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand the County General Assist. office will use these statements to determine my eligibility for general assistance. If I provide false statements on this application, or give false statements to the General Assistance worker, this can be considered fraud and may be referred to the County Attorney and/or result in permanent ineligibility of future assistance. I am also aware that giving false information or failure to provide information required for application will result in a denial of assistance and suspension of eligibility for twenty four (24) months. I am aware that this general assistance information may be verified and investigated. I am aware of my responsibility to report any changes in my income which is defined as: cash, gross wages, gross salaries, Social Security, pensions, rents, interest, FIP/ADC, cash payments, child support, unemployment, or other monies available for the support of my household.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE HENRY COUNTY NOTICE OF PRIVACY PRACTICE.

**RELEASE OF INFORMATION:** I hereby authorize the following Henry Co. offices: CPC, Veteran's Affairs, Public Health, Auditor, Treasurer, Attorney, Sheriff and further, DHS, Comm. Action, IA Workforce, Police Depart., Social Security, landlords, utility providers, current or previous employers, probation, parole officers and law enforcement officials, Child Support Recovery and \_\_\_\_\_ to release confidential information concerning my personal situation to the Henry Co. General Assistance office if such information is deemed necessary. I also authorize Henry Co. General Assistance to release to the previously named agencies and persons confidential information if such information is deemed necessary. Release is to be effective for one (1) year from date of signature.

**LEGAL CLAIM:** I understand that the Code of Iowa provides that "Any county having expended any money for relief or support of a poor person, under the provisions of this chapter, may recover the same from any of his kindred mentioned herein, from such poor person should he become able or from his estate; from relatives by action brought within two years from the payment of such expenses, from such person's estate by filing the claim as provided by law." (252.13)

**DISPOSITION:** You will receive a decision as to the disposition of your application in writing within ten (10) working days unless more information is required. If you do not agree with the action of the County General Assistance, you may appeal the decision.

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

**SECTION 13-APPEALS**

1. Right to a Hearing:
  - a. applicants are entitled to a hearing if assistance is denied; or
  - b. failure to determine applicant's eligibility, and if found eligible, grant assistance within ten (10) days of the of the application; or
  - c. amount of assistance granted.
2. Informing of Decision and Right to Appeal:
  - a. applicants shall be informed in writing of the decision and basis for the decision relating to their application on the date the application is initially reviewed; and
  - b. notice to appeal the decision will be in the form of written communication on the Notice of Decision provided regarding the approval or denial of their general assistance application; and
  - c. the applicant may be represented by themselves or a representative of their choice;
  - d. if the applicant represents themselves by attorney, attorney fees shall be the responsibility of the applicant;
3. Appeal Request:
  - a. applicants must provide written notice within ten (10) days of the date on the Notice of Decision to the Director of General Assistance requesting an appeal of the determination; and
  - b. the applicants written request for an appeal must provide the applicants current address and telephone number and state the reason(s) for the appeal; and
  - c. the written request for an appeal may be delivered in person to the General Assistance office or by regular mail, if delivered by regular mail the cancellation date on the envelope must be within ten (10) days of the date on the general assistance Notice of Decision; and
  - d. an appeal request cannot be denied except where the applicant has abandoned or withdrawn the request in writing on or prior to the day of the appeal hearing; and
  - e. an applicant's failure to show for the appeal hearing shall be considered an abandoned appeal and the Notice of Decision will remain in effect; and
  - f. an applicant withdraws or abandons an appeal they have no further standing to have the original decision reconsidered.
4. Appeals Hearing:
  - a. upon receipt of a properly submitted appeal request the Director shall forward the appeal to the Board of Supervisors; and
  - b. the Board of Supervisors shall place the matter on the agenda, in accordance with Chapter 21, Code of Iowa, for the next regularly scheduled board meeting, provided that such appeal shall not be heard sooner than five (5) days after the appeal request has been submitted; and
  - c. the applicant shall be informed immediately, by telephone and ordinary mail, of the date and time of the hearing before the Board of Supervisors; and
  - d. the applicant and his or her representative, upon written authorization, shall be granted access by the Director or designee access to their general assistance file if a request is made; and
  - e. the Board of Supervisors shall hear the appeal de novo at the time scheduled in the agenda unless continuance is requested by the applicant; and
  - f. the board may set reasonable time limits for the present action of the parties at any appeal; and
  - g. the applicant shall be permitted to submit whatever evidence desired in support of the appeal including testifying, having other witnesses testify, offering documentary evidence and reasonable cross examination of other witnesses, if present (the technical rules of evidence shall not apply); and
  - h. the applicant's general assistance file shall be admitted into evidence; and
  - i. the Board may question the applicant and the Director shall present the Board with reasons for the determination; and
  - j. the appeal will be tape recorded and will not be an open meeting under Chapter 21, Code of Iowa, since confidential files will be in evidence; and
  - k. when the Board deliberates the appeal, no parties shall be present; and
  - l. the Board shall make a decision on the appeal within five (5) working days; and
  - m. the decision shall be only on the basis of the evidence submitted before the Board; and
  - n. the applicant shall be informed in writing by regular mail to the last known address of the applicant within five (5) working days after the Board's decision; and
  - o. the Board's decision shall state the reasons for the action, together with any statute or ordinance applied; and
  - p. the decision shall state that an appeal may be taken from the Board's determination and the method by which such appeal may be taken; and
  - q. any appeal to the district court shall be allowed by the applicant from the Board's decision within the time and by the manner and procedures established under the Iowa Administrative Procedures Act, Chapter 17A , Code of Iowa.

# Henry County General Assistance LANDLORD STATEMENT

Henry County Public Health  
106 N Jackson St. Suite 103, Mt. Pleasant, IA 52641  
Phone: 319-385-0779 Fax: 319-385-1802

I hereby authorize you to furnish to the Henry County General Assistance Office information concerning my application for General Assistance. I release you from liability for disclosing this information even if it is confidential for the period of one (1) year from the date of this Release.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**NOTE TO LANDLORD:**

The remainder of this form needs to be filled out completely by you – not the tenant

This is to confirm that \_\_\_\_\_  
(tenant name)

began residing at \_\_\_\_\_,  
(address) (city, state)

on \_\_\_\_/\_\_\_\_/\_\_\_\_. There are \_\_\_\_\_ adults and \_\_\_\_\_ children residing at this address.  
(date)

The monthly rent is \_\_\_\_\_ and I receive \_\_\_\_\_ in rental assistance payment from the Section 8 Rental Assistance Program.

1. Rent is current: yes no
2. When was the last date the tenant paid rent \_\_\_\_\_ and what was the amount? \_\_\_\_\_

Other comments: \_\_\_\_\_

I am willing to accept General Assistance payment for rent as indicated above. As landlord, I certify by my signature that I am the property owner or owner designee, and not a relative of the tenant. I also verify that this rental property has its own kitchen, bathroom, dining, and bedroom facilities separate from mine and/or other tenants.

When said tenant's eligibility is determined, it is the tenant's responsibility to notify the landlord of the decision.

Name of Landlord: \_\_\_\_\_

Signature of Landlord: \_\_\_\_\_ Date: \_\_\_\_\_

MAIL PAYMENT TO: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Tax ID: \_\_\_\_\_ (leave blank if your tax ID is your social security number)

(Payments to a landlord over \$600 may require Henry County to send a form 1099 Miscellaneous Income)

## Your Information. Your Rights. Our Responsibilities.

This notice describes Henry County may use or disclose protected health information or personally identifiable information about you and how you can get access to this information. **Please review it carefully.**

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical information
- Correct your paper or electronic medical information
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

## Our Uses and Disclosures

We may use and share your information as we:

- Authorize funding for you
- Run our organization
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your information

- You can ask to see or get an electronic or paper copy of your medical information and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct your information

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may deny your request if we did not create the information, you want changed.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Run our organization**

We can use and share your health information to authorize funding, improve your access to services, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

Changes to the Terms of this Notice

**We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**

## **Other Instructions for Notice**

- This notice became effective January 1, 2013
- Contact the Henry County CPC by calling 319-385-4050 or email [sberndt@henrycountyiowa.us](mailto:sberndt@henrycountyiowa.us).
- You can view our complete HIPAA Policy by going to <http://henrycountyiowa.us/offices/cpc/index.htm>
- We never market or sell personal information.
- We will never share any mental health or substance abuse treatment information without your written permission.