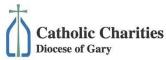
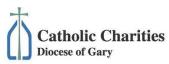


GENERAL APPLICATION

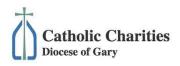
OFFICE LOCATION:	hicago (Gary	○ Hammo	nd	
HEAD OF HOUSEHOLD IDENTIFICA	ATION			(CT: I	dentification Tab)
First Name:	Middle Name:		Last Na	ame:	·
Maiden Name:	Date of Birth:	/ /	SSN:		
Email Address:			l		
Street Address:					_
City:	State:			Zip Code:	
Phone Number: ()	Alt. Phone Number: ()				
Type: OHome Work	Type:				
HEAD OF HOUSEHOLD DEMOGRA	PHICS	<u> </u>			CT: Demographics Tab)
Gender: Male Female		Ethnicity:	○ Hispanic/Lat○ Non-Hispani○ Decline to position	ino ic/Latino	
Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander Multi-Racial, please list: White Decline to provide information		Highest Level of Education Attained: College Degree or higher High School Diploma or GED Incomplete High School Diploma			
Marital Status: Single Marrie	ed Oivorced (Widowed			
DISABLED: YES NO Employment Status Full-Time Part- Unemployed	Time	if yes, please	YES	○ NO military branc	:h:
By submitting this application, I affirm that the as a client, any false statements, omissions, or		•			
Client Signature			Date		



CO-HEAD OF HOUSEHOLDS IDENT	IFICATION AND DE	MOGRAPHICS	(CT: Identification Tab)	
First Name:	Middle Name:		Last Name:	
Maiden Name:	Date of Birth: /	/	SSN:	
Phone Number: () Type:	Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander Multi-Racial: Please list: White		Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to provide Information	
Highest Level of Education Attained:	O Decline to provide DISABLED:		Veteran: YES NO	
College Degree or higher High School Diploma or GED Incomplete High School Diploma	YES ○ NOEmployment StatusFull-Time	O Part-Time	if yes, please indicate which military branch:	
ADDITIONAL HOUSEHOLD MEMB	○ Unemployed			
Please complete the following information		ers.		
Name:		Relationship:		
Name.		Relationship.		
Gender:		Date of Birth:		
SSN:				
Ethnicity: Hispanic/Latino Non-Hispanic/Latino		Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or another Pacific Islander White Multi-Racial: Please list:		
Name:		Relationship:		
Gender:		Date of Birth:	JJ_	
SSN:				
Ethnicity: Hispanic/Latino Non-Hispanic/Latino		○ As ○ BI ○ N: ○ W	lack or African American ative Hawaiian or another Pacific Islander	



Name:	Relationship:
Gender:	Date of Birth:/
SSN:	
Ethnicity:	Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or another Pacific Islander White Multi-Racial: Please list:
Name:	Relationship:
Gender:	Date of Birth:/
SSN:	
Ethnicity:	Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or another Pacific Islander White Multi-Racial: Please list:
Name:	Relationship:
Gender:	Date of Birth:/
SSN:	
Ethnicity: Hispanic/Latino Non-Hispanic/Latino	Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or another Pacific Islander White Multi-Racial: Please list:
By submitting this application, I affirm that the facts set forth in it are true ar client, any false statements, omissions, or other misrepresentations made by	I and complete to the best of my knowledge. I understand that if I am accepted as a me on this application may result in a termination of services.
Client Signature	 Date



INCOME/EXPENSE WORKSHEET

HEAD OF HOUSEHOLD IDENTIF	FICATION	(CT: Income/Expense Tab)		
First Name:	Middle Name:	Last Na	ame:	
Date of Birth: / /		SSN:		
INCOME CATEGORY	MONTHLY AMOUNT	EXPENSE CATEGORY	MONTHLY AMOUNT	
Wages	\$	Rent/Mortgage	\$	
Unemployment	\$	NIPSCO	\$	
Sick Benefits	\$	Water	\$	
Pension	\$	Sewer	\$	
Social Security	\$	Trash	\$	
S.S. Disability	\$	Rent/Home Insurance	\$	
A.F.D.C./TANF	\$	Phone	\$	
Trustee Assistance	\$	Internet	\$	
Food Stamps	\$	Cable	\$	
Child Support	\$	Cellular Phone	\$	
Foster Care	\$	Medical	\$	
Other:	\$	Property Taxes	\$	
Other:	\$	Car Note Payment	\$	
Other:	\$	Car Insurance	\$	
Other:	\$	Furniture Payment	\$	
Other:	\$	Credit Card(s)	\$	
Other:	\$	Child Support	\$	
Other:	\$	Other:	\$	
TOTAL MONTHLY INCOME	\$	TOTAL MONTHLY EXPENS	ES \$	
	1	1	-	
ADDITIONAL HOUSEHOLD MEI	MBER INFORMATION:			

ADDITIONAL HOUSE	HOLD MEMBER	R INFORMATION:		
Name:				
Income Sources (che	ck all that apply	and include monthly	amount):	
	\$	_ p/month		\$ _ p/month
○SS	\$	_ p/month	○ SI	\$ _ p/month
○SSD	\$	_ p/month	○ PENSION	\$ _ p/month
○ EMPLOYMENT	\$	_ p/month	○ UNEMPLOYMENT	\$ _ p/month
○ CHILD SUPPORT	\$	_ p/month	O FOOD STAMPS	\$ _ p/month
○ WORKERS COMP.	/DISABILITY \$_	p/month		
Name:				
Income Sources (che	ck all that apply	and include monthly	amount):	
	\$	_ p/month		\$ _ p/month
○SS	\$	_ p/month	○ SI	\$ _ p/month
○SSD	\$	_ p/month	○ PENSION	\$ _ p/month
○ EMPLOYMENT	\$	_ p/month	○ UNEMPLOYMENT	\$ _ p/month
○ CHILD SUPPORT	\$	_ p/month	O FOOD STAMPS	\$ _ p/month
○ WORKERS COMP.	/DISABILITY \$_	p/month		



Name:		
Income Sources (check all that apply and include mo	nthly amount):	
p/month	MEDICAID	\$p/month
SS \$p/month	○ SI	\$p/month
SSD \$p/month	O PENSION	\$p/month
EMPLOYMENT \$p/month	_	\$p/month
CHILD SUPPORT \$p/month	O FOOD STAMPS	\$p/month
WORKERS COMP./DISABILITY \$ p/me		F/
,		
Name:		
Income Sources (check all that apply and include mo	nthly amount):	
p/month		\$ p/month
○ SS \$ p/month	○ SI	\$ p/month
SSD \$p/month	O PENSION	\$ p/month
EMPLOYMENT \$p/month	UNEMPLOYMENT	\$p/month
CHILD SUPPORT \$p/month	O FOOD STAMPS	\$ p/month
WORKERS COMP./DISABILITY \$p/me	<u> </u>	,
,		
Name:		
Income Sources (check all that apply and include mo	nthly amount):	
	() MEDICAID	\$ p/month
○ TANF \$p/month ○ SS \$p/month	SI	\$p/month
SSD \$p/month	PENSION	\$p/month
EMPLOYMENT \$p/month	_	\$p/month
CHILD SUPPORT \$p/month	OFOOD STAMPS	\$ p/month
WORKERS COMP./DISABILITY \$ p/month		у р/month
WORKERS COIVIF., DISABILITY 3	Onth	
Nama		
Name:	nthly amount).	
Income Sources (check all that apply and include mo		¢ "/w.s.a.th
TANF \$p/month	MEDICAID	\$p/month
SS \$p/month	○ SI	\$p/month
SSD \$p/month	O PENSION	\$ p/month
	○ UNEMPLOYMENT	·
CHILD SUPPORT \$p/month	O FOOD STAMPS	\$ p/month
○ WORKERS COMP./DISABILITY \$ p/m	onth	
Have you received assistance from any other Agency	Yes \(\) No	
,		
If yes, please name agency:		
Book to the control of the control o		
By submitting this application, I affirm that the facts se		· · · · · · · · · · · · · · · · · · ·
understand that if I am accepted as a client, any false	statements, omissions, or c	otner misrepresentations made by me on thi
application may result in a termination of services.		
Client Signature	 Date	
Cheffe dightature	Date	



Client's Plan to be completed by Catholic Charities Staff Member

1)	What were the circumstances that caused client to fall behind in your rent and/or utility payments?
21	What is the future plan to help with monthly expenses?
۷)	what is the future plan to help with monthly expenses?