DEPARTMENT OF AGING & LONG TERM CARE
2024-2025 Found Money Application

Name:_____ Date:_____

__

Mailing Address:_____

_____

If this is not your physical address, what is your physical address:_____

Phone: _____ S.S last 4 digits:_____

DOB:_____Age: _____ Male _____ Female_____

Spouse's Name:_____ Their Age:_____

Number of ALL persons in household:_____

List all household members and ages below:
_____ Age _____
_____ Age _____
_____ Age _____
Race/ethnic group:_____
Do you rent or own home? _____
Income: Employment/wages $:_____
Social Security $_____
S.S.I $_____
Unemployment Comp. $_____
Other (Specify) _____
Total Income:_____

_____

Verification of income (Please make copies of all income sources).

Please circle if one or both apply to you: Life Line Dialysis

Are you disabled? If yes, please explain.

_____

_____

What type of assistance are you applying for?

_____

If applying for gas/oil, where do you get your gas/oil from?

_____

If applying for gas/oil at what percent of gas/oil do you have?_____

Have you applied for assistance with another program? If yes, which agency? _____
What was the outcome? _____

Please circle those that apply to you:
Hot water: Propane_____Electric _____
Cooking: Propane _____Electric _____
Home Heat: Propane_____Fuel Oil _____ Wood_____

Release of Information: I understand that I will be asked to provide proof of information given on this form, including income verification and that giving false information may result in denial of assistance. By my signature, authorization is given for the release of information that is required to determine eligibility for services, to obtain payment and use history of utilities records and/or for purpose of referral.

_____ _____
Applicant Signature Date

_____ _____
Signature of Director Date

Eligible for: _____ Ineligible:_____
Comments
_____
_____

NOTE: Utility bill or quote for service must be in the name of the applicant. Financial assistance is based on emergency need and on availability of funds.
Rev. 01-01-2023