JACKSON COUNTY GENERAL ASSISTANCE APPLICATION
CREMATION OR BURIAL

Applicant Affidavit:

I / We _____, _____relationship to decedent (family member, next of kin, representative), herein after referred to as applicant(s), on behalf of _____decedent, hereby state that (initial each to acknowledge):

_____ I/we are unable to pay for, and the decedent does not have funds available, to pay for costs associated with cremation or burial.

_____ Have provided all information available concerning the decedent's assets at the time of death to the best of My / our knowledge.

_____ Understand any cash or cash accounts belonging to the decedent, any death or burial benefit payable, any memorial funds, or funds raised in support of decedents services, must be used to pay for services and those amounts shall be credited against any amount payable by Jackson County.

_____ 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.

_____ Understand failure to comply may result in the applicant being responsible for the full cost associated with cremation or burial.

_____ I have read, understand, and agree to comply with Jackson County's requirements and restrictions for indigent cremation or burial assistance.

_____ Understand that I/we may elect to pursue other options for cremation or burial directly with the funeral home without county assistance; however

_____ Are requesting Jackson County provide cremation or burial assistance to the above-named decedent.

I further attest that if I, or other family members, receive any funds from outside sources to be applied to the funeral arrangements that this money will be given to Jackson County for reimbursement of the assistance provided for final service arrangements. (Iowa Code 252.13)

_____	_____
Applicant Name	Relationship to Decedent
_____	_____
Signature of Applicant	Date
_____	_____
Signature of Director or Intake Officer	Date

Application Information: Is to be completed for the decedent individual based on information immediately preceding death including any surviving spouse.

THIS SECTION FOR OFFICE USE ONLY

Contact Date: _____/_____/_____ Client ID: _____

Applicant Information – Please Print

Applicant Name: _____ Contact Phone No: _____-_____-_____

Addresss:_____Email:_____

Relationship to Decedent:_____

Decedent Information – Please Print

Decedent Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____ County:_____

Date of Death: _____ / _____ / _____ Place of Death: _____

DOB: _____/_____/_____ SSN: _____ - _____ - _____

Marital Status at the time of death: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Did the decedent have minor children under the age of 18 living at home? ☐ Yes ☐ No

At the time of death did the decedent: ☐ Own ☐ Rent ☐ Nursing Home ☐ Other _____

Decedents Monthly Income:

Employment $ _____ Unemployment $ _____ Family Investment Program

Pension $ _____ Worker's Compensation $ _____ (FIP) Assistance $ _____

Social Security $ _____ Child Support/Alimony $ _____

Social Security Death Benefit: If receiving Social Security, Social Security pays a funeral/death benefit in the amount of $255.00 payable to the surviving spouse or minor children. If assistance is approved, the applicant shall reimburse Jackson County $255.00 upon receipt of this payment.

Decedents Assets:

Life Insurance Value $_____ Company: _____

Residential Trust Account Amount $ _____ Financial Institution: _____

Checking Balance $_____ Financial Institution: _____

Savings Balance $_____ Financial Institution: _____

Stock/Bonds Value $_____ Interest or Dividends $ _____ Other Income $_____

Vehicle Value $_____ Year _____ Make _____ Model _____

Real Estate Value $_____ Location: _____

Other Assets: _____

Surviving Spouse Income – Please Print

To be completed surviving spouse living in the household at the time of death

Name: _____ Relationship to Decedent: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No: _____-_____-_____ Email: _____

Do you have minor children under the age of 18 living in the home with you? ☐ Yes ☐ No

If yes, ages: _____

Monthly Income:

Employment $ _____ Unemployment $ _____ Family Investment Program

Pension $ _____ Worker's Compensation $ _____ (FIP) Assistance $ _____

Social Security $ _____ Child Support/Alimony $ _____

All other sources of income and amount(s) $_____

Assets:

Cash on hand: $_____ Checking: $_____ Savings: $_____

Other Cash Assets: _____

As decedent's spouse living in the same household, I hereby state that the above information is accurate and truthful.

_____

Printed Name

_____ _____

Signature Date

Other Household Income – Please Print

One household income form to be completed by each adult relative living in the household at the time of death

Make copies or ask for additional pages if multiple adult relatives residing in the decedents home.

Name: _____ Relationship to Decedent: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No: _____-_____-_____ Email: _____

Do you have minor children under the age of 18 living in the home with you? ☐ Yes ☐ No

If yes, ages: _____

Monthly Income:

Employment $ _____ Unemployment $ _____ Family Investment Program

Pension $ _____ Worker's Compensation $ _____ (FIP) Assistance $ _____

Social Security $ _____ Child Support/Alimony $ _____

All other sources of income and amount(s) $_____

Assets:

Cash on hand: $_____ Checking: $_____ Savings: $_____

Other Cash Assets: _____

As an adult relative and member of the decedent's household, I hereby state that the above information is accurate and truthful.

_____ _____

Signature of Household Member Date

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Jackson County General Assistance authority to release the information I have provided throughout this application (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, funeral home, YWCA DV/SA Resource Centers of Jackson & Clinton Counties and any others as appropriate to determine assistance under the Jackson County General Relief Program. Furthermore, I specifically authorize release of this information to: (list any other specific providers).

_____

I also authorize Jackson County General Assistance authority to obtain information from, and inform any and all vendors to whom assistance would be paid on my behalf, 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), funeral homes, other Relief or Veterans Affairs Offices, banks, etc.) to release confidential information to Jackson County General Assistance if such information is necessary to process this application. 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.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Co-Applicant Date

_____ _____

Signature of Director or Intake Officer Date