*Answer ALL applicable questions. If dollar amount is none, write zero. Untrue or incomplete responses may result in rejection.*

**TEXAS RIOGRANDE LEGAL AID APPLICATION FORM** Date: 11/16/2017

Answer all questions. Indicate if zero. Untrue or incomplete responses may result in denial of service. PROBLEM CODE: _____ ALT. PROBLEM CODE: _____

**1. I AM A U.S. CITIZEN: SIGN:** _____ **OR**

**1A. I AM A LAWFUL PERMANENT RESIDENT ALIEN:**

**IMMIGRATION #:**_____ **Form reviewed:** ____ **151;** ____ **1151; OR**

**1B. All get advice; other aliens may be eligible; request & complete second form.**

**2. SOCIAL SECURITY #:**____/____/____; **[2A] BIRTHDAY:**____/____/____

**3. PRINT: Last Name:**_____ **First Name:**_____

**Middle Name or Initial:**_____ **Maiden Name:**_____

**4. Address:**_____ **Apt. #:**_____

**5. City:**_____ **State:**_____ **Zip:**_____ **County:**_____

**6. Home Phone:** (___) ___-____ **Work Phone:** (___) ___-____ **Ext.**_____

**7. Alternate/Cell phone/who will answer?** _____

**7a. Email Address:** _____

**8. SEX:** ☐ M ☐ F; **[9] RACE:** ☐ White ☐ Black ☐ Hispanic ☐ Asian Other:_____

**10. Marital status:** ☐ Married ☐ Single ☐ Separated ☐ Divorced

**11. Do you need an interpreter?** ☐ Spanish ☐ ASL ☐ Other _____

**12. Your legal problem:**_____

**13. My problem is with a person/company named:** _____

**14. Spouse's Name:**_____ **Spouse's Birth Date**____/____/____

**15.** How did you learn about legal aid? _____

**16.** The number of **children under 18** who live with you?. . . . . .

**16a.** The number of **adults over 18** who live in the household? . . **(Count yourself):**

**17.** Do you pay ☐ **rent** or ☐ a **mortgage? Yes/No & Monthly payment:** . . . . . $

**If rent is subsidized, tenant rent amount:** . . . . . $

**INCOME: 18. The total MONTHLY EMPLOYMENT INCOME, BEFORE TAXES:**

**For YOU:** $ **For OTHERS in your household:** $

**IF YOU/OTHERS RECEIVED ANY OTHER INCOME, STATE THE AMOUNT MONTHLY:**

| | | | |
|---|---|---|---|
| TANF (Welfare) | You:$ | Others in your household: | $ |
| Social Security | You:$ | Others in your household: | $ |
| SSI | You:$ | Others in your household: | $ |
| VA | You:$ | Others in your household: | $ |
| Child Support Received | You:$ | Others in your household: | $ |
| Other | You:$ | Others in your household: | $ |
| **INCOME SUBTOTAL:** | $0.00 | **INCOME SUBTOTAL:** | $0.00 |

**19. ASSETS:** Do ☐ **YOU** or ☐ **OTHERS in your household** have savings, stocks or CD's: **EXCLUDING IRA or 401 K retirement funds?** ☐ Yes; ☐ No ..... $

**20.** Do ☐ **YOU** or ☐ **OTHERS in your household** own land or a house **OTHER THAN WHERE YOU LIVE?** ☐ Yes ☐ No..... **NET value:** $

**21.** List any other assets and their value: Asset: **NET value:** $

Asset: **NET value:** $

**22. EXPENSES: HOW MUCH DO YOU PAY MONTHLY for:**

a. health insurance premiums, including medicare: ..... $

b. un-reimbursed health care or nursing home costs: ..... $

c. court ordered child support actually paid monthly: ..... $

d. transportation to work or for health care: ..... $

e. paid for baby-sitting/daycare: ..... $

f. large fixed debts, including tax debts owing: ..... $

**23.** Indicate if you were a victim of ☐ Katrina ☐ Rita ☐ Central Texas Flooding ☐ Other disaster: **EXPLAIN:**

**24. NAMES & (Date of birth) OF HOUSEHOLD MEMBERS:**

1. 2.
3. 4.
5. 6. **25.**

**DO YOU WANT TRLA TO REVIEW YOUR SITUATION TO DETERMINE IF YOU MAY BE ELIGIBLE FOR FOOD STAMPS (SNAP), MEDICAID, AND/OR TANF?** ☐ **YES** ☐ **NO**

☐ Phone Citizenship Declaration
☐ Telephone ☐ ARCH
☐ Clinic M or W ☐ Other _____
☐ **DO NOT MAIL TO THIS ADDRESS**

**REJECTED** ☐ Date: ___/___/___
**REJECT CODES:**
☐ regulations ☐ conflict
☐ incomplete ☐ income/assets
☐ resources &/or priorities
☐ citizenship ☐ duplicate
☐ other _____

**ACCEPTED** ☐ **DISCRETIONARY** ☐
**DATE:** ___/___/___
**Case Handler:**_____

**FUNDING SOURCE:**
☐ LSC/BASIC ☐ PAI/VLS
☐ BCLS ☐ HUD
☐ IOLTA ☐ CAN
☐ OUTREACH ☐ VOCA
☐ VAWA ☐ TITLE II
☐ OTHER_____

**INCOME TOTAL:** $0.00
**ASSETS TOTAL:** $0.00

THE JUNIOR LEAGUE of AUSTIN
THE STRENGTH of WOMEN
THE POWER of COMMUNITY

**26. Check if received by:**

| YOU | | OTHERS IN HOUSE |
|---|---|---|
| ☐ | Medicare | ☐ |
| ☐ | Medicaid | ☐ |
| ☐ | QMB/SLMB | ☐ |
| ☐ | (Medicaid) | ☐ |
| ☐ | LT Medicaid | ☐ |
| ☐ | Public Housing | ☐ |
| ☐ | Food Stamps | ☐ |
| ☐ | Chip | ☐ |

**27. Check if the following applies to YOU:**

☐ Disabled
☐ Blind
☐ Paralyzed
☐ Homeless
☐ Deaf/Hearing Impaired
☐ Long Term Illness
☐ Mental Health Issues
☐ Foster Youth
☐ Veteran