Disability Legal Services
of Indiana

DISABILITY LEGAL SERVICES OF INDIANA, INC.
APPLICATION FOR ASSISTANCE

NOTICE: The information on this form will be used to help determine if Disability Legal Services of Indiana, Inc. (DLSI) can assist you with your legal needs. The information you provide must be truthful, to the best of your knowledge. If you are accepted as a client, and if it is later determined that the information you have provided on this form is incomplete or untrue, DLSI or your assigned attorney may terminate his/her attorney-client relationship with you and DLSI will bear no responsibility to provide you with another attorney.

Are you: ( ) a person with a disability
( ) a parent or guardian of someone with a disability

How would you classify your legal needs? ( ) education dispute
( ) guardianship matter
( ) estate planning matter

I. INFORMATION ABOUT YOU (Please Print)

Name: ____________________________ Date of Birth: ____________________

Address: __________________________ Home Phone: ___________________

__________________________ Cell Phone: _____________________

County: __________________________ Email: ___________________________

Marital Status: ____________________

Gender: __________________________ Primary Language: ______________

Ethnicity (optional): _______________ Citizenship: _____________________

II. FINANCIAL INFORMATION

In order to determine if you qualify for our services, please provide the following financial information for all persons living in your home.

Name: ____________________________ Monthly income:_________________

Age: ______________________________ Source of income:_______________

Spouse/Partner: __________________ Monthly income:________________
Age: ____________________________ Source of income:_______________

Child/Dependent: ________________ Monthly income:________________
Age: ____________________________ Source of income:_______________

Child/Dependent: ________________ Monthly income:________________
Age: ____________________________ Source of income:_______________

Child/Dependent: ________________ Monthly income:________________
Age: ____________________________ Source of income:_______________

Does anyone in the household receive public assistance or services including, but not limited to:

TANF	( )	SSI	( )	Head Start	( )
SNAP	( )	SSDI	( )	CHIP	( )
Worker's Comp.	( )	Medicaid	( )	Waiver	( )

Do you own any of the following assets: If so, state the current value.

	YES	NO	Value/Balance
Home	( )	( )	$_____________________________
Vehicle(s)	( )	( )	$_____________________________
Checking Account	( )	( )	$_____________________________
Savings Account	( )	( )	$_____________________________
Real Estate	( )	( )	$_____________________________
Investment Accounts	( )	( )	$_____________________________
Retirement Accounts	( )	( )	$_____________________________
Trust Accounts	( )	( )	$_____________________________

Do you have any of the following expenses that may be considered in determining eligibility? If so, please describe in "Other".

	YES	NO	Monthly Cost
Child Care Expenses	( )	( )	$___________
Medical Insurance Premiums (after tax)	( )	( )	$___________
Unreimbursed Medical Expenses	( )	( )	$___________
Disability-related Expenses	( )	( )	$___________
Other:			$___________

III. CERTIFICATION AND UNDERSTANDING OF APPLICATION TERMS

Applicant understands that completing this application for assistance does not create any attorney-client relationship and does not guarantee me or anyone in my household representation by DLSI or an attorney. I further understand that DLSI will attempt to inform me within three weeks whether I qualify for legal representation based upon DLSI's eligibility guidelines. I certify and affirm that I have read the above or had it read to me. I fully understand the information contained herein; and it is true and correct to the best of my knowledge. I understand that I will be required to verify the financial information in this form. I hereby request that this application be considered in determining eligibility to receive legal services from DLSI.

Date: ________________________ Signature: ________________________________

Please return this form to Disability Legal Services of Indiana, Inc.
Mail: 5954 North College Ave, Indianapolis, IN 46220
Fax: 317-282-0608
Email: mjones@disabilitylegalservicesindiana.org

FOR DLSI USE ONLY:

Date received in office: ________________________

Household Members	
Poverty Guideline	
Household Income	
Qualified Household Expenses	
Adjusted Household Income	

Application: ( ) accepted under 150%
( ) accepted 150-200%
( ) accepted 200-250%
( ) accepted 250-300%
( ) rejected

Eligibility letter sent: ______________________
Attorney assigned: ________________________________