Mail form to
P.O. Box 220652
Kirkwood, MO 63122

Important: You must live in the Kirkwood School District to receive help.

Application for Assistance

APPLICANT INFORMATION

Name		**Today's Date**	
Street Address			
City, State, Zip		**Marital Status**	
Birth date		**Church**	
Home phone		**Church Phone**	
Cell phone		**Pastor**	

LIST ALL OTHERS RESIDING AT APPLICANT ADDRESS

First Last		Birth date	Relationship to Applicant	Full or part time

EMPLOYMENT INFORMATION (Provide current employer information for all employed household residents)

Name	Employer Name	Employer Address	Employer phone

WHAT ASSISTANCE ARE YOU REQUESTING? (Circle) Rent Electric Gas Water Food

Utility Name (Ameren, Laclede, etc) (or Landlord name and address)	Utility Account Number (or Landlord phone number)	Minimum Amount Due	Total Due	Disconnection/Eviction Notice (Yes/No)?

LIST AGENCIES THAT ARE HELPING YOU WITH YOUR BILLS

Agency	Assistance Received (Type and $ amount)	Date Received

HOUSEHOLD MONTHLY BUDGET SUMMARY (Enter $ amounts. Consolidate entries from all sources.)

INCOME	Amount	Unemployment	Amount	EXPENSES	Amount		Amount
Salary, Wages		Food Stamps		Mortgage/Rent		Cable/Internet	
Tips		WIC		Electric		Telephone	
Child Support		Pension		Gas		Cell phone	
TANF, Welfare		Rx Costs		Water/Sewer/Trash		Credit cards	
SSA Retirement		Insurance		Food		Automobile	
SSA Disability (SSI)		Other		Gasoline			
Child Care		Total Income				Total Expense	

ADDITIONAL COMMENTS:

Sign this application and authorization below to be considered for services.

P.O. Box 220652
Kirkwood, MO 63122
314-965-0406

DATE: _____

Release of Confidential Information

I authorize Kirk care to contact any of the people or offices listed by me on this application for verifying the information that I have provided. All information is true, complete and accurate. Any misinformation will be grounds for denying all benefits from Kirk Care. I also understand additional information may be required by an assessment team. This assessment team may visit me during this process. All information collected by Kirk Care staff and volunteers is strictly confidential. Kirk Care is committed to protecting the privacy of all clients. However, in some cases, it may be necessary or desirable for Kirk Care to either receive and/or share information with others. The purpose of obtaining and/or sharing this information is to ensure clients receive the assistance needed.

HEREBY AUTHORIZES (TYPE YOUR NAME HERE)

Kirk Care to access and release any information or records that are relevant for the purpose of providing assistance for my needs for a twenty-four-month period.

If you wish to limit this release of specific information, please specify the information that may be released.
My typed name below signifies my written agreement with the above authorization.

Client Signature _____ Date _____