

All others in household (Name/Age)

Monthly income/source of income

If Monthly income varies, list yearly income

Does anyone in the household receive public assistance including, but not limited to: (Check all that apply)

TANF () Yes () No
 Social Security () Yes () No
 Workers' Comp. () Yes () No
 Food Stamp () Yes () No

Disability () Yes () No
 ADFC () Yes () No
 Fuel Assistance () Yes () No

III. ASSETS HELD BY YOU OR MEMBERS OF YOUR HOUSEHOLD

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

Home () Yes Fair Market Value _____ () No
 Car () Yes Fair Market Value _____ () No
 Checking Account () Yes Balance _____ () No
 Savings Account () Yes Balance _____ () No
 Other real estate () Yes Fair Market Value _____ () No
 Other assets () Yes Fair Market Value _____ () No

Other expenses: They following factors may be considered in determining eligibility

Weekly dependent child care expenses necessary for applicant to work \$ _____
 Medical insurance premiums paid with after tax dollars \$ _____
 Un-reimbursed medical expenses for which applicant is obligated to pay \$ _____
 Non-medical expenses associated with applicant's or child's disability \$ _____
 Other significant factors affecting applicant's ability to afford legal assistance: _____

IV. CERTIFICATION AND UNDERSTANDING OF ATTORNEY-CLIENT RELATIONSHIP

I understand that completing this intake form does not create any attorney-client relationship and does not guarantee me or my child representation by an attorney affiliated with DLSI. I further understand that DLSI will make every effort to let me know within two to 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 may be required to provide DLSI with documentation of information listed on this form. I hereby request that this information be considered in determining my eligibility, and/or my child's eligibility, to receive legal services from DLSI.

Date _____ Signature _____

Please mail this form to: Disability Legal Services of Indiana, 5954 N. College Ave, Indianapolis, IN 46220. You may also email this form to DLSI. Send completed form to: mjones@disabilitylegalservicesindiana.org