

NWIACC Enrollment Office:
 215 West 4th Street
 Spencer IA 51301
 Fax: 712.262.9016 email to: intake@nwiacc.org



FUNDING APPLICATION	
Commitment Fees-Sheriff and Attorney, Jail-Based Services, Block Grant Funds	
Application Date: _____	
First Name: _____	Last Name: _____ MI: _____
Nickname: _____	Birthdate: _____
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No If you are not a citizen, are you in the country legally? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SSN# _____	Primary Phone #: _____
Current Address: _____ <small style="display: block; text-align: center;">Street City State Zip Code County</small>	
Address begin date: _____	
Did you move to this address for the purpose of attending college? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently a student? <input type="checkbox"/> Yes <input type="checkbox"/> No Use as current mailing address: <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what is your current mailing address: _____	
Current Residential Arrangement (please check one): <input type="checkbox"/> Private Residence <input type="checkbox"/> Foster Care/Family LifeHome <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Homeless/Shelter/Street <input type="checkbox"/> Other	
<u>Emergency Contact Person:</u>	
Name: _____ Relationship: _____	
Address: _____ Phone: _____	
Guardian appointed by the Court? <input type="checkbox"/> Yes <input type="checkbox"/> No Payee Appointed by Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name: _____ Name: _____	
Health Insurance Information (Check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare A, B,D <input type="checkbox"/> No Insurance <input type="checkbox"/> Private Insurance Company Name _____	
Disability Group/Primary Diagnosis (if known): <input type="checkbox"/> Mental Illness <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Brain Injury	
Referral Source: _____	Phone: _____
What services are you applying for? _____ _____	
I certify that the above information is true and complete to the best of my knowledge, and I authorize regional or county staff to check for verification of the information provided including verification with other Iowa Regions and County Government and the state of Iowa Department of Human Services (DHS) and the Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the Region or County in establishing my ability to pay for services requested, and in ensuring that appropriate of services requested. I understand the information in this document will remain confidential.	
_____ Applicant's Signature (or Legal Guardian)	_____ Date
_____ Signature of other completing form if not Applicant or Legal Guardian	_____ Date