



IOWA INDIVIDUAL ASSISTANCE PROGRAM

HOUSEHOLD APPLICATION CHECKLIST

Client Name: _____

Date of Disaster: _____

1. ☐ Iowa Disaster Assistance Application – DISASTER DATE, and Signed / Dated
2. ☐ NICAIO Basic Intake Form (Unless the household applied for Energy Assistance in the current fiscal year)
3. ☐ Photo ID of all adult residents (18 years and older)
4. ☐ Proof of Residency
 - o Copy of utility bill, phone bill or driver's license.
5. ☐ Proof of Income: 200% Poverty Income Level (Most recent 30 days)
6. ☐ Proof of Home Ownership, if home repair category.
7. ☐ Insurance Coverage, if applicable. (Homeowners OR Renters Insurance)
 - o Need a **statement/rejection letter** from the Insurance Company as proof that the claim is less than the deductible amount of insurance.
8. ☐ Vehicle Damage, if applicable.
 - o Need current copy of vehicle registration.
 - o Need current copy of liability insurance card.
9. ☐ Air Conditioning claim, if applicable
10. ☐ Original Receipt(s) attached for applicant to receive direct REIMBURSEMENT assistance. The purchase must be after the disaster date.
11. ☐ Estimate(s) attached for applicant to receive VOUCHER assistance.

Iowa Individual Disaster Assistance Grant Program (IIAGP) Application

1. Applicant Information (personal information)

Include a copy of government-issued identification for all adults living in the household.

a. First and Last Name		
b. Social Security Number	c. Phone Number	Cell Number
d. Email Address		
e. Address Affected by Disaster		
f. County	g. City, State, Zip Code	
h. <i>Current Address if Different from Above</i>		
i. County	j. City, State, Zip Code	
k. Insurance Company Name	Insurance Company Phone Number	
l. Alternate Contact Information (name and phone number)		
m. Total Number of Adults in Household	Total Number of Children in Household	
n. Total Annual Household Income \$	<p>Note: Household annual income must be 200 percent or less of the federal poverty level for a household of that size.</p>	
For questions call 1-877-347-5678		

2. Loss Information

Include receipts for replaced items. If no receipts, request voucher program.

Date of Disaster	Disaster type: <input type="checkbox"/> Tornado <input type="checkbox"/> Flood <input type="checkbox"/> Other:	
Temporary housing: \$	Food Assistance: \$	Receipts provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Request voucher program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Personal property: \$	Home repair: \$	
Total requested: \$	<p><i>The title of the property must be in the name of the applicant.</i></p>	

3. Brief Description of Damage Caused by the Disaster and List Damaged Items

4. Attestation

I attest that the information provided on this form is true and accurate. I am providing this information to the Iowa Department of Human Services ("Department") for expenses under the Iowa Individual Assistance Disaster Grant Program ("Program"). I authorize the Department to release this information to other aid organizations and persons for purposes of administering the Program. I attest that persons receiving assistance in the household are legal residents of the United States. I understand that If I am not eligible for benefits under the Program, if I have insurance that covers losses claimed, or if I have received assistance from other programs for the same claimed items, I hereby agree to repay to the Department any funds acquired through the Program within 60 days.

5. Reconsiderations

You, or the person helping you, may request reconsideration if you do not agree with any action taken on your application.

Your request for reconsideration must be completed within 15 days from the date on the denial letter.

You may submit your written request for reconsideration by submitting a detailed request to:

Iowa Department of Human Services
Attn: Division of Field Operations – Emergency Assistance
5th Floor, 1305 E Walnut Street
Des Moines, IA 50319-0114

If you need assistance filing a request for reconsideration, ask your disaster case manager.

6. Discrimination

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees, and clients without regard to race, color, national origin, sex, religion, age, disability or veteran status; hereafter referred to as protected category.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services
Attn: Hoover Building, 5th Floor – Bureau of Policy Coordination
1305 E Walnut Street
Des Moines, IA 50319-0114

or via email contactdhs@dhs.state.ia.us

The Iowa Department of Human Services is an equal opportunity provider.

Applicant Signature	Date
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Please submit all application materials to your local Community Action Agency.
www.iowacommunityaction.org

Instructions for Completion of the IIAGP Application

Section 1. Applicant information.

- a. Your first and last name
- b. Your Social Security number
- c. Your main phone number and cellphone number
- d. Your email address
- e. The address that was affected by the disaster
- f. County of the address that was affected by the disaster
- g. City, state, and zip code of the address that was affected by the disaster
- h. If you are residing at a different address than the one listed above
 - i. County
 - j. City, state, and zip code
- k. Your insurance company name and phone number
- l. Alternate contact Information – name and phone number
- m. Total number of adults in the household and total number of children in the household
- n. The total annual income for all household members

Please be prepared to supply the following documentation when requested:

- Photo ID
- Proof of residence
- Proof of income (pay stubs, W-2, tax return, public benefit letter of decision, social security letter, etc.)
- Insurance coverage and filings (if applicable)
- Receipts (if requesting reimbursement for a disaster-related expense)
- Photos of damage (if applicable)

NOTE: Household annual income must be 200% or less of the federal poverty level for a household of that size.

2021 National Poverty Guidelines

Family Size	1	2	3	4	5	6	7	8	Per person additional
200% of Federal Poverty Level (annual income)	\$25,760	\$34,840	\$43,920	\$53,000	\$62,080	\$71,160	\$80,240	\$89,320	\$9,080

Section 2. Loss information.

Each household **MAY** receive up to \$5,000 for a qualifying household and items that qualify under one of the four categories listed below. Please check with your local Community Action Agency (www.iowacommunityaction.org). Receipts **MUST** be in applicant's name.

Temporary Housing – Receipts **MUST** be in applicant's name. IIAGP will cover up to \$65 per day for 30 days of lodging at a licensed establishment such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

Food Assistance – Replacement of spoiled or destroyed food, up to a maximum of \$50 for one person; \$25 for each additional person in the household. Fast food receipts will not be accepted.

Personal Property – Some examples are: Kitchen items, personal hygiene, clothing, bedroom furnishings, etc. Please check with your local Community Action Agency (www.iowacomunityaction.org).

Home Repair – Some examples are: Repair of structural components, repair of floors, wall, ceilings, doors, windows, and carpeting. Please check with your local Community Action Agency (www.iowacomunityaction.org).

Assistance will be denied for the following: Preexisting conditions are the cause of the damage; landlord owned property; and if the title of the property is not in the applicant's name.

Section 3. Brief description of the damage caused by the disaster.

Section 4. – Section 6. Read these sections carefully.

Your original signature is required on the application, along with the date the application was signed.

NORTH IOWA COMMUNITY ACTION ORGANIZATION INTAKE FORM

Method received _____

Date received _____

1. HEAD OF HOUSEHOLD CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
(If different than street address)

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____
Opt for text messaging ☐ YES ☐ NO

2. HOUSING STATUS (CHECK ONE)

☐ OWN ☐ RENT ☐ OTHER PERMANENT HOUSING ☐ HOMELESS ☐ OTHER
MORTGAGE/RENT COSTS PER MONTH \$ _____

2A. IF YOU RENT, ANSWER THE FOLLOWING:

IS GAS INCLUDED IN YOUR RENT? ☐ YES ☐ NO

IS ELECTRIC INCLUDED IN YOUR RENT? ☐ YES ☐ NO

DO YOU RECEIVE RENT ASSISTANCE? ☐ YES ☐ NO

(Is your rent based on a percent of your income?)

3. HOUSEHOLD TYPE (CHECK ONE)

☐ MULTIGENERATIONAL HOUSEHOLD ☐ NON-RELATED ADULTS WITH CHILDREN ☐ OTHER _____
☐ SINGLE PARENT FEMALE ☐ SINGLE PARENT MALE ☐ SINGLE PERSON ☐ TWO ADULTS NO CHILDREN ☐ TWO PARENT HOUSEHOLD

4. HOUSING TYPE (CHECK ONE)

☐ HOUSE ☐ MOBILE HOME ☐ 2, 3, OR 4 UNIT APT ☐ 5 OR MORE UNIT APT ☐ RENT A ROOM ☐ OTHER

5. MAIN SOURCE OF HOME HEATING (CHECK ONE)

☐ ELECTRIC ☐ PROPANE ☐ WOOD/COAL/CORN ☐ NATURAL GAS ☐ FUEL OIL ☐ OTHER _____

IF PROPANE, DO YOU HAVE AN EMPTY OR LOW TANK (20% OR LESS) ☐ YES ☐ NO

6. LANDLORD, PROJECT, COMPLEX INFORMATION

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

7. HOUSEHOLD HEATING & ELECTRIC COMPANY:

DO YOU HAVE A DISCONNECT NOTICE? ☐ YES ☐ NO IF SO, DISCONNECT DATE _____

ARE YOU CURRENTLY DISCONNECTED? ☐ YES ☐ NO

8. HOUSEHOLD INCOME SOURCES (CHECK ALL THAT APPLY)

<input type="checkbox"/> EMPLOYMENT INCOME	<input type="checkbox"/> SELF EMPLOYMENT/FARM INCOME	<input type="checkbox"/> SOCIAL SECURITY RETIREMENT INCOME
<input type="checkbox"/> SSDI (DISABILITY INCOME)	<input type="checkbox"/> VA CONNECTED DISABILITY COMPENSATION	<input type="checkbox"/> SSI (SUPPLEMENTAL SECURITY INCOME)
<input type="checkbox"/> PENSION	<input type="checkbox"/> VA NON-SERVICE-CONNECTED DISABILITY PENSION	<input type="checkbox"/> PRIVATE DISABILITY INSURANCE
<input type="checkbox"/> WORKERS' COMPENSATION	<input type="checkbox"/> UNEMPLOYMENT INSURANCE/BENEFITS	<input type="checkbox"/> TANF/FIP ASSISTANCE
<input type="checkbox"/> GENERAL RELIEF	<input type="checkbox"/> CASH CONTRIBUTIONS FROM FAMILY/FRIENDS	<input type="checkbox"/> ALIMONY/OTHER SPOUSAL SUPPORT
<input type="checkbox"/> CHILD SUPPORT	<input type="checkbox"/> NO INCOME	<input type="checkbox"/> OTHER _____

- DOES YOUR HOUSEHOLD HAVE SAVINGS OVER \$50,000 (include all savings, checking accounts, cd's, & other investments) ☐ YES ☐ NO

- DID ANYONE IN YOUR HOUSEHOLD FILE A TAX RETURN AND RECEIVE THE EITC (earned income tax credit) THIS YEAR? ☐ YES ☐ NO

9. HOUSEHOLD NON-CASH BENEFITS (CHECK ALL THAT APPLY)

<input type="checkbox"/> SNAP (FOOD ASSISTANCE PROGRAM)	<input type="checkbox"/> HCV (HOUSING CHOICE VOUCHER)	<input type="checkbox"/> HUD-VASH (VA SUPPORTIVE HOUSING)
<input type="checkbox"/> WIC (WOMEN, INFANTS, & CHILDREN)	<input type="checkbox"/> PUBLIC HOUSING	<input type="checkbox"/> CHILDCARE VOUCHER
<input type="checkbox"/> LIHEAP	<input type="checkbox"/> PERMANENT SUPPORTIVE HOUSING	<input type="checkbox"/> AFFORDABLE CARE ACT SUBSIDY
<input type="checkbox"/> FREE/REDUCED LUNCHES	<input type="checkbox"/> NONE	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> UNEMPLOYMENT STIMULUS	<input type="checkbox"/> STIMULUS BENEFITS	

HOUSEHOLD MEMBER INFORMATION (ENTER THE NUMBER OF BOX ITEM)

LEGEND FOR COMPLETING THE HOUSEHOLD MEMBER SECTION	RELATION TO HEAD OF HOUSEHOLD	DATE OF BIRTH	SOCIAL SECURITY NUMBER	HEATH INSURANCE	RACE	HIGHEST LEVEL EDUCATION	EMPLOYMENT	DISCONNECTED YOUTH	MARITAL STATUS
	1. PRIMARY CONTACT 2. SPOUSE 3. CHILD 4. FOSTER CHILD 5. GRANDCHILD 6. SIBLING 7. PARENT 8. GRANDPARENT 9. OTHER RELATIVE 10. NOT RELATED	DATE FORM AT: 99/99/ 9999	SSN FORMAT: 999-99-9999 I-94 FORMAT 999999999 99 (11 NUMBERS)	1. MEDICAID 2. MEDICARE 3. STATE CHILDREN'S HEALTH INSURANCE PROGRAM 4. STATE HEALTH INSURANCE FOR ADULTS 5. MILITARY HEALTH CARE 6. DIRECT PURCHASE 7. EMPLOYMENT BASED 8. NONE	1. AMERICAN INDIAN 2. ALASKA NATIVE 3. ASIAN 4. WHITE 5. BLACK OR AFRICAN AMERICAN 6. NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 7. OTHER 8. MULTI-RACE	1. 2 OR 4 YEAR DEGREE 2. 9-12 GRADE 3. DROP OUT K-12 4. GED 5. GRADUATE OTHER POST SECONDARY 6. HIGH SCHOOL GRADUATE 7. HIGH SCHOOL GRADUATE PLUS SOME COLLEGE 8. K-8 GRADE 9. LOW GRADE GRAD 10. UNDER SCHOOL/PRESCHOOL	1. EMPLOYED (FULL-TIME) 2. EMPLOYED (PART-TIME) 3. MIGRANT SEASONAL FARM WORKER 4. UNEMPLOYED (SHORT TERM, < 6 MONTHS) 5. UNEMPLOYED (LONG TERM, > 6 MONTHS) 6. UNEMPLOYED (NOT IN LABOR WORKFORCE) 7. RETIRED	ANY HOUSEHOLD MEMBER (AGES 14-24) WHO IS NEITHER WORKING OR IN SCHOOL	1. DIVORCED 2. MARRIED 3. NEVER MARRIED 4. SEPARATED 5. WIDOWED

NAME- INCLUDE THE PRIMARY CONTACT	RELATION TO HEAD OF HOUSEHOLD	DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	DISABILITY	HEALTH INSURANCE	HISPANIC LATINO, OR OF SPANISH ORIGIN	RACE	MILITARY STATUS	HIGHEST LEVEL EDUCATION	EMPLOYMENT	U.S. CITIZEN	HOMEBOUND	DIS- CONNECTED YOUTH	MARITAL STATUS
			MALE FEMALE OTHER		YES NO		YES NO		VETERAN ACTIVE NONE			YES NO	YES NO	YES NO	
			MALE FEMALE OTHER		YES NO		YES NO		VETERAN ACTIVE NONE			YES NO	YES NO	YES NO	
			MALE FEMALE OTHER		YES NO		YES NO		VETERAN ACTIVE NONE			YES NO	YES NO	YES NO	
			MALE FEMALE OTHER		YES NO		YES NO		VETERAN ACTIVE NONE			YES NO	YES NO	YES NO	

I certify under penalty of perjury the above information is true. I give permission to the agency processing this application to acquire additional information and to share information with other organizations for the purposes of providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of the information contained in this application. I am hereby making application for the Low-Income Home Energy Assistance Program (LIHEAP) and/or the Weatherization Assistance Program. I further certify the following: I declare that I am the only person in the household who has or will apply for this program(s). I understand that this information will be used, upon request, in determining eligibility for other agency programs or services. Any willful misrepresentation of the information on this form is subject to a penalty of law. I assure that any LIHEAP energy payments received will be used solely for home energy costs. I understand that by signing (either in written form or electronically) this application, I am authorizing the weatherization of my house at no cost to me or my family. This application does not guarantee any weatherization work being done on my house. I hereby give permission to the State of Iowa, the U.S. Department of Energy, U.S. Department of Health and Human Services, and the agency processing this application to obtain additional information from my energy supplier about my household energy usage and payment history. I also give permission to the State of Iowa to release application information to my energy supplier and to provide details about my account and energy use to the LIHEAP and Weatherization Assistance Program.

SIGNATURE: _____ DATE: _____

**North Iowa Community Action Organization
Iowa Disaster Assistance
SELF-DECLARATION OF INSURANCE COVERAGE**

Applicant Name: _____

Applicant Address: _____

Date of Damage at the above address: _____

**I currently carry ☐ HOMEOWNERS ☐ RENTERS insurance coverage at the address above
(attach copy of policy)**

☐ **The policy I carry DOES NOT include flood coverage (attach documentation)**

☐ **The policy I carry DOES include flood coverage (attach documentation)**

☐ **I have submitted a claim to my insurance provider**

☐ **I have not submitted a claim to my insurance provider**

☐ **I plan to submit a claim to my insurance provider**

☐ **I do not plan to submit a claim to my insurance provider**

☐ **I am a HOMEOWNER without insurance coverage (attach address verification)**

☐ **I am a RENTER without insurance coverage (attach address verification & rental lease)**

I attest that the information provided on this form is true and accurate.

Applicant Signature

Date

Applicant Signature

Date

Agency Representative Signature

Date

COUNTY:

Toll-free: 1-800-873-1899

Salvation Army	United Way of North Central Iowa
Red Cross	Mercy One
General Assistance/County Relief	NICAO – M/CH, Family Planning, WIC
Veteran’s Affairs	NICAO – Weatherization
Iowa Works	NICAO – FaDSS
Iowa Department of Human Services	NICAO – Community Partners
Elderbridge Agency on Aging	NICAO – Head Start, Early Head Start
Crisis Intervention Services	NICAO –
Catholic Charities	Long Term Disaster Recovery Committee
Lutheran Service in Iowa	Ministerial Association
Utility Vendor/s:	Church:
Landlord or Mortgage Holder:	Northern Lights Homeless Shelter
Prairie Ridge Integrated Behavioral Healthcare	Trinity House of Hope
PAYEE:	Long Term Recovery Committee
OTHER:	Murphy Trust / CLUMC

CRISIS APPLICATION – NICAQ