



APPLICATION

CLIENT NAME _____ PHONE _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
BIRTH DATE ____ / ____ / ____ GENDER _____ ETHNICITY _____

| |
|---|
| REFERRING AGENCY _____ DATE _____ |
| ADDRESS _____ CITY _____ ST _____ ZIP _____ |
| CONTACT _____ PHONE _____ EMAIL _____ |

IF CLIENT IS CASE MANAGED, CASE MANAGER INFO _____

OTHER RESIDENTS IN HOUSEHOLD:

NAME _____ RELATIONSHIP _____ AGE _____

PROPERTY TITLE: IN CLIENTS NAME? YES _____ NO _____

IF NO, EXPLAIN _____

CLIENT INCOME: SOURCE _____ AMOUNT _____
OTHER HOUSEHOLD INCOME _____ AMOUNT _____
FURTHER INFORMATION _____ TOTAL _____
DISABILITY: (IF ANY) _____

MAY HOUSE REVIEW COMMITTEE CONTACT:

APPLICANT DIRECTLY? YES _____ NO _____

THROUGH AGENCY CONTACT ABOVE? YES _____ NO _____

PRIORITY WORK REQUESTED

ADDITIONAL INFO COMMENTS "STORY"- continue on back if necessary

NOTE: Please forward this referral/application to:

Rebuilding Together Greater Des Moines
1111 9th Street Ste. 265
Des Moines, IA 50314

Fax: 244-4439
Phone: 284-7403
rebuildingtog@msn.com