



APPLICATION

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

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