PLEASE ANSWER ALL QUESTIONS

MINISTRY OF SOCIAL DEVELOPMENT

APPLICATION FORM

PUBLIC ASSISTANCE PROGRAM

DATE: __________

1. NAME: ____________________________  OTHER NAME (S) ________________

   First       Last       Initial

   SEX: Male ( ) Female ( )

   ADDRESS/PARISH ______________________

   VILLAGE ____________________________

   Day/ Month/Year __________________________

   D.O.B: __________ / AGE: ______

   LAND MARK: ______________________

   Next of Kin / CONTACT PERSON: ____________________________

   PHONE: ______________________

2. PRESENT OCCUPATION: PLEASE TICK APPROPRIATELY IF SELF EMPLOYED

   (a) SHOP KEEPER ( )

   (b) SEAMSTRESS / TAILOR ( )

   (c) FARMER ( )

   (d) VENDOR ( ) MARKET ( ) FISH ( ) TOURIST ( )

   (e) OTHER ( )

3. PLEASE INDICATE SALARY RANGE $100-300 ( ), $400-500 ( ), $600 &OVER MONTHLY ( )

4. SOURCES OF INCOME: PLEASE TICK

   (a) RECEIVING GOVERNMENT PENSION ( )

   (b) RECEIVING NIS ( )

   (c) RECEIVING PRIVATE / OVERSEAS PENSION ( )

   (d) CHILD OR CHILDREN SUPPORT ( )

   (e) RENTAL OF PROPERTY ( )

   (f) OTHER, PLEASE SPECIFY ( )

5. DO YOU POSSESS THE FOLLOWING:

   (a) LAND ( )

   (b) HOUSE ( )

   (c) BANK ACCOUNT ( )

   (d) VEHICLE ( )

   (e) OTHER PLEASE SPECIFY: __________

6. ARE YOU A MEMBER OF A BURIAL SOCIETY (a) YES ( )

   (b) NO ( )
7. ARE YOU A BENEFICIARY OF ANY GOVERNMENT OR NON GOVERNMENT ASSISTANCE PROGRAMME

PLEASE SPECIFY: ____________________________

Government

Non-Government

8. DO YOU PRESENTLY SUFFER FROM ANY SERIOUS MEDICAL CONDITION:

IF YES PLEASE SPECIFY: ____________________________ MONTHLY MEDICAL EXPENSES $_____

9. ARE YOU PHYSICALLY OR MENTALLY CHALLENGED: ____________________________

10. HOW MANY PERSONS LIVE WITH YOU: ____________________________

   (a) STATE WHO SUPPORTS THE HOME AND RELATIONSHIP: ____________________________

11. TYPE OF RESIDENCE OF APPLICANT:

   (a) OWN HOME ( )
   (b) GERIATRIC (HOME FOR THE AGE ( )
   (c) RENTING ( )
   (d) OTHER ( )

12. INDICATE THE FACILITIES AND CURRENT SERVICE YOU UTILIZE:

   TELEPHONE ( ) MONTHLY COST $ ______ ELECTRICITY ( ) MONTHLY COST $ ______
   WATER ( ) MONTHLY COST $______ CABLE ( ) MONTHLY COST $ ______ CELL ( ) ______
   BATHROOM / TOILET FACILITIES: INDOOR ( ) OUTDOOR ( ) PUBLIC ( ) NONE ( )

SIGNATURE OF APPLICANT: ____________________________

ASSESSMENT/SOCIALWORKER: ____________________________

RECOMMENDATION: ____________________________

_______________________________________________________________

SIGNATURE OF INVESTIGATING OFFICER: ____________________________ DATE: ____________

APPROVAL OFFICER(S) SIGNATURE: ____________________________ DATE: ____________

_______________________________________________________________

_______________________________________________________________ DATE: ____________