ABILITY**ALLIES**
Advocacy For Students With Disabilities

ABILITY ALLIES INTAKE FORM AND FINANCIAL AFFIDAVIT

- The information you provide on this form will be used to help determine if Ability Allies (formerly Disability Legal Services of Indiana) can assist you with your legal needs.
- The information you provide must be truthful to the best of your knowledge.
- If you are accepted as a client and it is later determined that the information you provided on this form is incomplete or untrue, Ability Allies or your assigned attorney may terminate his/her attorney-client relationship with you, and you will have to find an attorney not associated with Ability Allies.

Today's date_____

How did you hear about **Ability Allies**?_____

Briefly describe the nature of your legal need. Please note that Ability Allies assists primarily with educational matters, including access to education, accommodations, special education services, discipline matters, etc.

_____

_____

Are you seeking assistance for an educational matter involving a child placed in your home by the Indiana Department of Child Services (foster child/kinship placement)? If so, you may qualify for free assistance.
Yes____ **No**_____

I. INFORMATION ABOUT YOU (Please Print)

Name_____

Date of Birth_____ Primary Phone_____

Secondary Phone_____ E-Mail_____

Address_____

City_____ State_____ Zip Code_____

I prefer to be contacted by: Phone ( ) Mail ( ) E-mail ( )

County of Residence: _____ Marital status_____ Ethnicity_____

First Language: English ( ) Español ( ) Other _____

II. INCOME INFORMATION (To Determine if you Qualify for Services)

If monthly income varies, list yearly income for prior year.

Your name_____ Monthly or yearly income_____
Your age _____ Source of income _____

Your Spouse, if applicable _____ Monthly or yearly income_____
Date of Birth _____ Source of income_____

List all other persons living in your household and their monthly income and source of income. Please indicate if any child/dependent below has been placed in your home by the Indiana Department of Child of Services (foster child/kinship placement).

Child/Dependent:_____ Monthly or yearly income_____
Date of Birth _____ Source of income_____

Child/Dependent:_____ Monthly or yearly income_____
Date of Birth _____ Source of income_____

Child/Dependent:_____ Monthly or yearly income_____
Date of Birth _____ Source of income_____

Child/Dependent:_____ Monthly or yearly income_____
Date of Birth _____

List any additional dependents on a separate page and include that page with your application.

Does anyone in the household receive public assistance or services including, but not limited to: (Check all that apply)

TANF	( )	SSI	( )	Head Start	( )
SNAP	( )	SSDI	( )	CHIP	( )
Worker's Comp.	( )	Medicaid	( )	Waiver	( )

III. ASSETS HELD BY YOU OR MEMBERS OF YOUR HOUSEHOLD

Do you own any of the following assets: If so, state the current value.

	YES	NO	Value/Balance
Home	( )	( )	$_____
Vehicle(s)	( )	( )	$_____
Checking Account	( )	( )	$_____
Savings Account	( )	( )	$_____
Retirement Account	( )	( )	$_____
Other Accounts	( )	( )	$_____

Other expenses: The following factors may be considered in determining eligibility

	YES	NO	Monthly Cost
Child Care Expenses	( )	( )	$_____
Medical Insurance Premiums (After-Tax)	( )	( )	$_____
Unreimbursed Medical Expenses	( )	( )	$_____
Disability-related Expenses	( )	( )	$_____
Other:			$_____

IV. CERTIFICATION AND UNDERSTANDING OF ATTORNEY-CLIENT RELATIONSHIP

- I understand that completing this intake form does not create any attorney-client relationship and does not guarantee representation by an attorney affiliated with Ability Allies.
- I understand that I am not a client of Ability Allies until I execute a retainer agreement with Ability Allies staff.
- I further understand that Ability Allies will make every effort to let me know within two weeks whether I qualify for legal representation based upon Ability's eligibility guidelines.
- I certify and affirm that I have read the above or had it read to me.
- I fully understand the information contained herein, and it is true and correct to the best of my knowledge.
- I understand that I will be required to provide Ability Allies with documentation regarding the information listed on this form.
- I hereby request that this information be considered in determining my eligibility and/or my child's eligibility to receive legal services from Ability Allies.

Date_____ **Signature**_____

Please return this form to **Ability Allies** by mail, email, or fax.
Mail: 5954 North College Ave, Indianapolis, IN 46220
Fax: 317-282-0608
Email: keident@abilityallies.org
Please note that if you email this form to Ability Allies via the website, the application may be accessible/viewed by others and therefore may not be confidential. Please do not send any additional documentation with the application.

FOR ABILITY ALLIES USE ONLY:

Date received in office: _____

Household Members	
Federal Poverty Guideline	
Household Income	
Qualified Household Expenses	
Adjusted Household Income	

Date application reviewed and correspondence sent: _____