ABILITY ALLIES (formerly Disability Legal Services of Indiana)
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. Inc.) 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** (formerly Disability Legal Services of Indiana)? _______________
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? 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________________(optional)

First Language: English ( ) Español ( ) Other _______________

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

If monthly income varies, list yearly income (note whether monthly or yearly).

Your name___________________________ Monthly or yearly income________________
Your age ___________________________ Source of income _______________________

Your Spouse, if applicable ______________ Monthly or yearly income________________
His/Her birth date ____________________ Source of income________________________

List all other persons living in your household and their monthly income and source of income. If monthly income varies, list yearly income (note whether monthly or yearly). 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________________
His/Her birth date____________________ Source of income________________________

Child/Dependent:____________________ Monthly or yearly income________________
His/Her birth date ___________________ Source of income________________________

Child/Dependent:____________________ Monthly or yearly income________________
His/Her birth date ___________________ Source of income________________________

Child/Dependent:____________________ Monthly or yearly income________________
His/Her birth date ___________________ Source of income________________________

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	( )	( )	$____________
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** (formerly Disability Legal Services of Indiana) 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 DLSI 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: ______________________________