



**DISABILITY LEGAL SERVICES OF INDIANA, INC. INTAKE FORM AND FINANCIAL AFFIDAVIT**

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**NOTICE:**

- The information you provide on this form will be used to help determine if Disability Legal Services of Indiana, Inc. (“DLSI”) 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, DLSI or your assigned attorney may terminate his/her attorney-client relationship with you and you will have to find an attorney not associated with DLSI.
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Today’s date \_\_\_\_\_

How did you hear about DLSI? \_\_\_\_\_

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

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**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	<input type="checkbox"/>	SSI	<input type="checkbox"/>	Head Start	<input type="checkbox"/>
SNAP	<input type="checkbox"/>	SSDI	<input type="checkbox"/>	CHIP	<input type="checkbox"/>
Worker's Comp.	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Waiver	<input type="checkbox"/>

**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	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Vehicle(s)	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Checking Account	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Savings Account	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Retirement Account	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Other Accounts	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

**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 DLSI.
- I understand that I am not a client of DLSI until I execute a retainer agreement with DLSI staff.
- I further understand that DLSI will make every effort to let me know within two weeks whether I qualify for legal representation based upon DLSI’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 DLSI 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 DLSI.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Please return this form to Disability Legal Services of Indiana, Inc. by mail, email, or fax.

Mail: 5954 North College Ave, Indianapolis, IN 46220

Fax: 317-282-0608

Email: [keident@disabilitylegalservicesindiana.org](mailto:keident@disabilitylegalservicesindiana.org) or [mhuybers@disabilitylegalservicesindiana.org](mailto:mhuybers@disabilitylegalservicesindiana.org)

Please note that if you email this form to DLSI 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: \_\_\_\_\_

<b>Household Members</b>	
<b>Federal Poverty Guideline</b>	
<b>Household Income</b>	
<b>Qualified Household Expenses</b>	
<b>Adjusted Household Income</b>	

Date application reviewed and correspondence sent: \_\_\_\_\_