PLEASE PRINT CLEARLY

Harris County
Office of Social Services

APPT. TIME _____

APPT. # _____

ARRVL TIME _____

PRELIMINARY APPLICATION

CLIENT'S LEGAL NAME_____ SPOUSE OR SIGNIFICANT OTHER _____

MAIDEN NAME (*IF APPLICABLE*) _____ MAIDEN NAME *(IF APPLICABLE)* _____

D.O.B. / AGE _____ D.O.B. / AGE _____

SOCIAL SECURITY # _____ SOCIAL SECURITY # _____

IMMIGRATION STATUS_____ IMMIGRATION STATUS _____

CARD NUMBER _____ CARD NUMBER _____

RACE / ETHNICITY_____ RACE/ ETHNICITY_____

ADDRESS CITY STATE ZIP CODE COUNTY

_____

TELEPHONE # _____

LANDLORD'S NAME AND TELEPHONE NUMBER

_____

LIST **ALL** HOUSEHOLD MEMBERS

LAST NAME	FIRST NAME	AGE	BIRTHDAY	SOCIAL SECURITY NUMBER

HOUSEHOLD INCOME: (TYPE) _____

ARE YOU A KATRINA EVACUEE? YES _____ NO _____

WHAT TYPE OF ASSISTANCE DO YOU NEED?

UTILITY CUT OFF __LEGAL VACATE _____ EVICTION _____ FORECLOSURE _____ OTHER _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY ABILITY AND HEREBY AUTHORIZE HARRIS COUNTY SOCIAL SERVICES TO REQUEST AND RECEIVE INFORMATION FOR VERIFICATION OF THE SAME.

_____ _____

SIGNATURE *DATE*