

ARC-IP

ADDICTION'S RESOURCE CENTER, INC

72& 48HR O.V.I. Driver Intervention Program - INDIGENT FORM

Call/Cell/ Text: 513-201-8819 EMAIL ARCDWT@AOL.COM

W.L. HOUSER-THOMAS PSYD., L.I.C.D.C.-CS

Executive Director

PROGRAM DATE _____ LOCATION _____ COURT _____

Please complete all components, notarization on back (any bank or attorney) include income verification (examples: taxes, pay stubs, written by employer) ****do not include your bills – this is a gross income evaluation.** Return forms 10 days prior to your program, bring original to the program.

CLIENT NAME _____ DOB _____ SOC SEC _____

PHONE _____ ADDRESS _____ ZIP _____

HOUSE HOLD MEMBERS (PLEASE INCLUDE YOURSELF)

	NAME	AGE	RELATIONSHIP
1			
2			
3			
4			
5			

EMPOYER NAME OR LIST INCOME SOURCE

	NAME	YRS	PHONE IF AVAILABLE
1			
2			
3			

MONTHLY INCOME SOURCE AMOUNTS – PLEASE PROVIDE MONTHLY AMOUNT

TYPE OF INCOME	SELF	SPOUSE	HOUSEHOLD MEMBER	TOTAL
EMPLOYMENT (GROSS)				
UNEMPLOYMENT (GROSS)				
WORKER'S COMP				
PENSION				
CHILD SUPPORT				
DISABILITY				
FOOD STAMPS/ WIC/SNAP				
OTHER (stimulus/college assist				
SUBTOTALS				
			ALL INCOME TOTAL>	

Notarize: Client Sign _____ Date _____

Sworn to before me on the _____ day of _____ 20_____

Notary Public Signature _____

DO NOT WRITE BELOW THIS LINE

ELIGIBLE/ NOT ELIGIBLE _____ (SS CK VIA OhioMHAS SYSTEM)

ARC STAFF ONLY TOTAL HH INCOME _____ TOTAL HH MEMBERS _____

FEDERAL POVERTY GUIDELINE FOR INCOME _____ APPROVED _____ DECLINED _____

Please attach taxes and pay stubs