Reset Form

SOCIAL SERVICES BLOCK GRANT (SSBG)
APPLICATION AND SERVICES REGISTRATION
State Form 49452 (R3 / 2-10) / DHHS 0003
FAMILY AND SOCIAL SERVICES ADMINISTRATION / DEAF AND HARD OF HEARING SERVICES

Name of Agency Grantee	
Contract Number	Telephone Number ( ) -

This State Agency is requesting disclosure of personal information that is necessary to accomplish the statutory purpose of the State Agency according to IC 12-13-5.2. Disclosure of information relating to racial / ethnic background, sex, marital status, or disability is strictly voluntary. Failure to provide any other information may prevent this application from being processed.

SECTION A – SERVICES are hereby requested by or on behalf of:

1. Last Name of applicant	2. First Name	3. Middle Initial	4. County	5. County Code

6. Address *(number and street, city, state, and ZIP code)*	7. Telephone number ( ) -	☐ V ☐ VP ☐ TTY

8. E-mail Address	9. Other Contact

10. HOUSEHOLD RECIPIENTS Last Name First Name Middle Initial	11. DATE Of BIRTH *(mm-dd-yy)*	12. SEX Male/ Female	*13. RACIAL ETHNIC CODE	**14. MARITAL STATUS	***15. DISABILITY	****16. LIVING ARRANGEMENT	17. OTHER	*****18. GOALS

FAMILY SIZE		*RACIAL /ETHNIC CODE	**MARITAL STAUS	***DISABILITY	****LIVING ARRANGEMENT	*****GOAL CODE
19. Adult		W = White	M=Married	D = Deaf	LI = Independently	I. Self Support
20. Children under 18		B = Black (not of Hispanic origin)	D=Divorced	HH = Hard of Hearing	LP = with parents	II. Self-Sufficiency
		H = Hispanic	S=Single	DD = Developmental Disability	LG = in group home	III. A. Prevent Remedy Abuse or Neglect
21. Total in family		I = Native American/Alaskan	SO= Significant Other	DA = Dual Diagnosis	H = Homeless	B. Preserve, Rehabilitation and Reunite Families
		A = Asian – Pacific Islander		O = Other	O = Other	IV. Prevent Institutional Care
		M = Multiracial				V. Secure Institutional Care
		O = Other	W=Widow			

Social Services will be provided without discrimination because of race, age, color, religion, sex, disability, national origin, or ancestry.
I hereby certify that the above information provided by me is correct and true to the best of knowledge; I understand that I may be required to verify these statements, and give my consent to the agency from which I am requesting Social Services to make any necessary contacts to verify and statements. I understand my rights and obligations, and have received a copy of them at the time of application I am a resident of Indiana.

22. Signature of parent and / or guardian *(if child is under 18 years of age)*	23. Date signed *(month, day, year)*
24. Signature of applicant	25. Date signed *(month, day, year)*