POWESHIEK COUNTY COMMUNITY SERVICES

Ashley Fallis
Director of General Assistance
P: (641) 236-9199
F: (641) 236-1349
E: Ashley.fallis@cicsmhds.org
www.poweshiekcounty.org

Dear Applicant,

General Assistance is a County funded program that can help people with emergency financial needs if you currently reside in Poweshiek County and have so for at least 30 days. Along with this letter, you will find the enclosed application and supplemental forms. In order to process your application, you will need to complete all the enclosed forms entirely.

In addition to the forms, you will need to submit the following:

- A copy of your bill you are requesting assistance with
- Proof of income for all household members
- ID Card or driver's license for each adult residing in the home
- Contact Information for your landlord (if rent assistance is being requested)
- Any other forms as requested by the Director of General Assistance

Eligibility and need shall be determined within approximately ten days after the application is properly completed and presented to the Director and all necessary members of the household sign the application form. Any resulting disbursements will be made as soon as possible after. Disbursement of general assistances funds will be made directly to the vendor.

Should you receive funding through general assistance, you will be required to sign a repayment agreement and to reimburse the county for benefits received. Once the agreement is signed, if you fail to repay the value of the benefits or at least fail to attempt to repay, you will be ineligible for receiving any future funding from General Assistance.

If you have any questions while completing this application, please do not hesitate to contact me at 641-236-9199 or afallis@poweshiekcounty.org.

Thank you,

Ashley Fallis

Ashley Fallis
Director of General Assistance

Office Use Only:
Date Received: _____
CSN #: _____
Additional Info Needed ☐Yes ☐ No
Approved ☐ Yes ☐ No
If no, reason _____

POWESHIEK COUNTY COMMUNITY SERVICES
APPLICATION FOR GENERAL ASSISTANCE

**Please use Blue of Black ink to complete this form

Name _____Social Security # _____
Date of Birth _____ Marital Status _____ Veteran ☐ Yes ☐ No
Current Address: _____ Apartment # (if applicable) _____
City/State _____ Zip Code _____ County _____
When was the move-in date of your current address? List month and year _____
Phone Number _____ Referral Source ☐Self ☐ Relative ☐ Agency ☐Other
Provide a Copy of Driver's License/Valid ID ☐ Copy of Social Security Card ☐ SS# _____
Previous Names, Including Maiden Name _____
Are you your own guardian? ☐ Yes ☐ No If no, Name/Phone # _____
Email Address _____ Alternate Contact #_____

LIST ALL MEMBERS OF THE HOUSEHOLD (children in the home full-time, relatives, roommates, etc.)

NAME	RELATIONSHIP	BIRTHDATE	SSN w/ COPY OF CARD
	Head of Household		

LIST ALL PREVIOUS ADDRESSES FOR THE LAST 12 MONTHS

MOVED IN	MOVED OUT	STREET/APT #	CITY/STATE	COUNTY	ZIP CODE

ASSISTANCE REQUEST

☐ Rent ☐ Lights ☐ Water ☐Gas ☐ Fuel (for heating/cooking) ☐ Medical Assistance ☐ Burial

Amount Requesting _____Total Owed _____ *All assistance mailed directly to your provider
Are you currently receiving a Housing Subsidy? ☐ Yes ☐ No Monthly Rent $_____
Do you have an eviction notice or disconnect notice? ☐ Yes ☐ No **If yes, please provide a copy

Landlord Name _____ Landlord Phone Number _____
Are you related to your landlord? ☐ Yes ☐ No

If applying for burial/cremation, was GA contacted prior to arrangements made? ☐ Yes ☐ No *If no, assistance is NOT available
Have you ever received General Assistance from Poweshiek or any other County? ☐ Yes ☐ No For: _____

EDUCATION LEVEL

☐ High School Diploma ☐ GED ☐ College Number of years attended _____ Degree (if applicable) _____

HOUSEHOLD EMPLOYMENT

**List all adults residing in the home

NAME	EMPLOYER	EMPLOYER ADDRESS	START DATE	HOURLY RATE/SALARY	HOURS WORKED PER WEEK

Is anyone in your household presently unemployed? ☐ Yes ☐ No Who? _____
When did this person last work? _____ Has this person registered with Workforce Development? ☐Yes ☐ No

Is anyone in your household currently on strike? ☐ Yes ☐ No
Has anyone in your household quit a job in the last 60 days? ☐ Yes ☐ No
Has anyone moved into or out of your home in the last 30 days? ☐ Yes ☐ No Who? _____

Provide PAST 30 days income ALL sources – including employment, unemployment, SSI, SSDI, etc.

RESOURCES

Complete this form to include ALL household members

	Yes	No	Amount	Location	Name of Person
Cash					
Checking Account					
Savings Account					
IRA/CD/s/BOND					
Stocks/Trust					
Burial Contract					
Life Insurance					
Real Estate (Property)					
other					

Do you or anyone in your household own cars, trucks, boats, campers, motorcycles, or other vehicles?

MAKE	MODEL	YEAR	AMOUNT OWED

Have you applied for all other types of benefits for which you may be eligible?

Program	Applied	Approved	Denied	Amount/Reason for Denial
SSDI or SSI (disability)				
FIP				
Medical				
Veteran's Benefits				
Unemployment Benefits				
Heating Assistance				
Food Stamps				

Have you received any lump sum payments in the last year? (insurance, social security, inheritance, other) ☐ Yes ☐ No
Amount: _____ Date Received: _____

MONTHLY EXPENSES

Rent/Mortgage Payment	
Lot Rent	
Gas	
Electric	
Water/Sewer	
Taxes/Home Insurance	
Telephone/Cell Phone	
Groceries	
Dining Out	
Daycare/Sitters	
Child Support	
Student Loan	
Tuition	
Lessons	
Car Payment	
Insurance	
Gas	
Public Transportation	
Repairs	
Clothing/Shoes	
Laundry	
Dr/Dental/Insurance	
Prescriptions	
Cable/Internet	
Movies	
Sports	
Credit Card	
Life Insurance	
Church	
Pets	
Loans	
Cigarettes	
TOTAL EXPENSES	

MONTHLY INCOME

	Name:	Name:
Earned Income:		
Wages		
Income from Property		
National Guard		
Odd Jobs		
Business or Investment Earnings		
Other		
Other Income		
SSI		
SSDI		
Social Security		
Pensions		
Food Stamps		
FIP		
Child Support		
Alimony		
Unemployment		
Veterans' Benefits		
Workers' Comp		
Other Income		
Total Earned		
Total Other		
TOTAL INCOME		

LIST ALL OUTSTANDING BILLS AND CHARGE ACCOUNTS

Company	Amount

"I have to the best of my ability given the above information truthfully. A false statement or incorrect statement on an application for assistance may be cause for denial."

_____

Signature of Applicant ALL ADULT RESIDENTS must sign Date

_____

Signature of Director of General Assistance Date

POWESHIEK COUNTY COMMUNITY SERVICES
General Assistance
200 4th Avenue West
P.O. Box 401
Grinnell, Iowa 50112
P| 641.236.9199
F| 641.236.1349

General Assistance Release of Information

I, _____, hereby certify that the facts set forth in the completed General Assistance application dated _____ are true and complete to the best of my knowledge. A false statement or incorrect statement on an application for assistance may be cause for denial of benefits.

_____

(Signature of Applicant) All ADULT RESIDENTS must sign (Date)

_____

(Signature of Director) (Allow 10 days for application review & decision) (Date)

AUTHORIZATION TO OBTAIN INFORMATION:

"I hereby authorize the following Poweshiek County offices, General Assistance, Veterans Affairs, Public Health, Auditor, Treasurer, Attorney, Sheriff, and the Iowa Department of Human Services, Social Security Administration, UIHC, Iowa Workforce Development, Crisis Center, Child Support Recovery Unit, other medical providers, landlords, utility providers, and ***Community Service providers including MICA, Salvation Army, Ministerial Alliance (including area churches), CICS, Campbell Fund and others as deemed necessary to coordinate funding,*** *as well as current or previous employers, probation, parole officers, or law enforcement officials* ***to release*** *confidential information concerning my personal situation to the Poweshiek County General Assistance office and/or Director if such information is deemed necessary. I understand that in order for information to be disclosed from the Poweshiek County General Assistance office and/or Director, a separate Authorization to disclose information will be completed except for payment, treatment, or operations purposes where an authorization is not required. If any other persons not listed above have information that the General Assistance Director needs to process my request, a separate authorization to obtain information will also be completed."*

Expires When: This authorization is good for 12 months from the date signed. I may write to General Assistance and my sources to revoke this authorization at any time. GA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

I have read this form and agree to the disclosures above from the types of sources listed.

_____

(Signature of Applicant -- All Adult Residents must sign) (Date)

NOTICE OF PRIVACY PRACTICES FOR HEALTH CARE PROVIDERS
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

If you have any questions about this Notice of Privacy Practices contact the Covered Entity's Privacy Officer:
Missy Eilander Poweshiek County Courthouse PO Box 57 Montezuma Iowa, 50171 Phone: 641-623-5443

This Notice of Privacy Practices describes how the Covered Entity may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information ("PHI"). "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
The Covered Entity is required to abide by the terms of this Notice of Privacy Practices. The Covered Entity may change the terms of this notice, at any time. The new notice will be effective for all PHI that the Covered Entity maintains at that time. Upon request, the Covered Entity will provide you with any revised Notice of Privacy Practices.

PERMITTED USES AND DISCLOSURES OF PHI
Your PHI may be used and disclosed by the Covered Entity for the purpose of providing or accessing health care services for you. Your PHI may also be used and disclosed to pay your health care bills and to support the business operation of the Covered Entity.

The following categories describe ways that the Covered Entity is permitted to use and disclose health care information. Examples of types of uses and disclosures are listed in each category. Not every use or disclosure for each category is listed; however, all of the ways the Covered Entity is permitted to use and disclose information falls into one of these categories:

1) Treatment:
The Covered Entity may use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, the Covered Entity would disclose your PHI, as necessary, to a home health agency that provides care to you. Another example is that PHI may be provided to a facility to which you have been referred to ensure that the facility has the necessary information to treat you.

2) Payment
The Covered Entity may use and disclose health care information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. The Covered Entity may also discuss your PHI about a service you are going to receive to determine whether you are eligible for the service, and for undertaking utilization review activities. For example, authorizing a service may require that your relevant PHI be discussed with a provider to determine your need and eligibility for the service.

3) Healthcare Operations
The Covered Entity may use or disclose, as-needed, your PHI in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, the Covered Entity may use or disclose your PHI, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.

The Covered Entity may share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the Covered Entity. Whenever an arrangement between the Covered Entity and a business associate involves the use or disclosure of your PHI, the Covered Entity will have a written contract that contains terms that will protect the privacy of your PHI.

USES AND DISCLOSURES OF PHI REQUIRING YOUR WRITTEN AUTHORIZATION
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that the Covered Entity has taken an action in reliance on the use or disclosure indicated in the authorization.

The Covered Entity also may keep psychotherapy notes. These are given a higher degree of protection and cannot be disclosed without your express permission except to carry out certain treatment, payment, or health care operations including allowing the note taker to use them for treatment, using the notes for training programs, or using the notes in defense of a legal proceeding. You have the opportunity to specifically authorize disclosure of psychotherapy notes on the *Authorization for Release of PHI* form.

We will not use or disclose your PHI for marketing purposes without your written authorization unless the marketing is conducted through a face-to-face communication or involves a gift of nominal value.

We will not accept payment of any kind for your PHI without your written authorization. Sale of PHI is prohibited only as it is defined by law and does not include accepting payment for your treatment.

You may revoke an authorization at any time by notifying us in writing. If this should ever be the case, please be aware that revocation will not impact any uses or disclosures that occurred while the authorization was in effect.

The Covered Entity may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then the Covered Entity may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

1) Others Involved in Your Healthcare
Unless you object, the Covered Entity may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, the Covered Entity may disclose such information as necessary if the Covered Entity, based on its professional judgment, determines that it is in your best interest. The Covered Entity may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, the Covered Entity may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other Individuals involved in your health care.

2) Emergencies
The Covered Entity may use or disclose your PHI in an emergency treatment situation. If this happens, the Covered Entity shall try to obtain your acknowledgment of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT
The Covered Entity may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

1) Required By Law
The Covered Entity may use or disclose your PHI to the extent that the law requires the use or disclosure. You will be notified, as required by law, of any such uses or disclosures.

2) Public Health
The Covered Entity may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. The Covered Entity may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3) Communicable Diseases
The Covered Entity may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease.

4) Health Oversight
The Covered Entity may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

5) Abuse or Neglect
The Covered Entity may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, the Covered Entity may disclose your PHI if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6) Food and Drug Administration
The Covered Entity may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

7) Legal Proceedings
The Covered Entity may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

8) Law Enforcement
The Covered Entity may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. these law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on Covered Entity premises, and (6) medical emergency (not on the Covered Entity's premises) and it is likely that a crime has occurred.

9) Coroners, Funeral Directors, and Organ Donation
The Covered Entity may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

10) Research
The Covered Entity may disclose your PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

11) Criminal Activity

Consistent with applicable federal and state laws, the Covered Entity may disclose your PHI, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Covered Entity may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an Individual.

12) Military Activity and National Security
When the appropriate conditions apply, the Covered Entity may use or disclose PHI of Individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. The Covered Entity may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

13) Workers' Compensation
Your PHI may be disclosed by the Covered Entity as authorized to comply with workers' compensation laws and other similar legally established programs.

14) Inmates
The Covered Entity may use or disclose your PHI if you are an inmate of a correctional facility and the Covered Entity created or received your PHI in the course of providing care to you.

15) Required Uses and Disclosures
Under the law, the Covered Entity shall make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the Covered Entity's compliance with the requirements of 45 C.F.R. section 164.500 et. seq.

YOUR RIGHTS

The following are a list of your rights with respect to your PHI and a brief description of how you may exercise these rights:

RIGHT TO INSPECT AND COPY YOUR PHI

This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as the Covered Entity maintains the PHI. A "designated record set" contains medical and billing records and any other records that the Covered Entity uses in making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the Covered Entity Privacy Officer if you have questions about access to your medical record.

RIGHT TO REQUEST A RESTRICTION OF YOUR PHI

This means you may ask the Covered Entity not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The Covered Entity is not required to agree to a restriction that you may request, except in the case of a disclosure you have restricted under 45 C.F.R. §164.522(a)(1)(vi) related to restricted disclosures to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you have (or someone other than you but not the health plan has) paid out-of-pocket, in full. If the Covered Entity believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If the Covered Entity does agree to the requested restriction, it may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the Covered Entity. You may request a restriction in writing to the Covered Entity Privacy Officer. To request a restriction, you must provide us, in writing 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM THE COVERED ENTITY BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

The Covered Entity will accommodate reasonable requests. The Covered Entity may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. The Covered Entity will not request an explanation from you as to the basis for the request. Please make this request in writing to the Covered Entity Privacy Officer.

RIGHT TO REQUEST AN AMENDMENT TO YOUR PHI

This means you may request an amendment of PHI about you in a designated record set for as long as the Covered Entity maintains this information. In certain cases, the Covered Entity may deny your request for an amendment. If the Covered Entity denies your request for amendment, you have the right to file a statement of disagreement with the Covered Entity and the Covered Entity may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All requests for amendments must be in writing.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PHI

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures the Covered Entity may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

THE COVERED ENTITY'S DUTIES AND OTHER INFORMATION

The Covered Entity is required by law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI, and abide by the terms of the notice currently in effect.

We must inform you of any breach of your PHI that compromises your PHI and that is held or transmitted in an unsecured manner, within 60 days after we discover, or by exercising reasonable diligence, should have discovered the breach.

We reserve the right to change our policies and practices regarding how we use or disclose PHI, or how we will implement Individual rights concerning PHI. We reserve the right to change this notice and to make the provisions in our new notice effective for all information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. The revised notice will be posted and available at our places of service.

COMPLAINTS

You may file a complaint to the Covered Entity or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Covered Entity. You may file a complaint against the Covered Entity by notifying the Covered Entity Privacy Officer. The Covered Entity will not retaliate against you for filing a complaint.

You may contact the Covered Entity Privacy Officer, Diana Dawley, Poweshiek county Auditor, (641) 623-5443 for further information about the complaint process.

This notice was published and becomes effect April 1, 2014.

POWESHIEK COUNTY COMMUNITY SERVICES
General Assistance
200 4th Avenue West
P.O. Box 401
Grinnell, Iowa 50112
P| 641.236.9199
F| 641.236.1349

Notice of Privacy Practices Acknowledgement Form – General Assistance

I, _____, hereby acknowledge that on the date indicated below, I received a copy of ***Poweshiek County's Notice of Privacy Practices.***

_____

Signature of Applicant(s) Date

_____

Signature of Legal Guardian or Personal Representative (if applicable) Date

_____

Signature of Director of General Assistance Date

POWESHIEK COUNTY COMMUNITY SERVICES
General Assistance
200 4th Avenue West
P.O. Box 401
Grinnell, Iowa 50112
P| 641.236.9199
F| 641.236.1349

General Assistance Reimbursement Agreement

DATE: _____ Assistance Received: _____

Pursuant to Iowa Code Chapter 252, I (Applicant's Name) _____ agree to reimburse Poweshiek County for the full amount of aid received to the extent that I am able to do so and agree that I am able and will pay monthly installments of ____$5.00____ beginning _____ and on the ___5th____day of each month thereafter until paid in full.

I also understand that my failure to perform this agreement will disqualify me from receiving future assistance from the Poweshiek County General Assistance Program. Should I fail to make payments, any future request for assistance will be an automatic denial.

_____

Signature of Applicant(s) Date

_____

Signature of Director of General Assistance Date

Please remit payment to:

Poweshiek County Community Services
200 4th Avenue West
P.O. Box 401
Grinnell, Iowa 50112

FUNDING ASSISTANCE CONTACTS

Resources within Poweshiek County:

Organization	Phone	Address	Funding Approved	Amount	If no, reason for denial:
Campbell Fund **GRINNELL ONLY**	641-236-2600 Sharon	927 4th Avenue Grinnell, Iowa 50112	☐ Yes ☐ No		
MICA	641-236-3923 Mindy	611 4th Avenue Grinnell, Iowa 50112	☐ Yes ☐ No		
Salvation Army	641-623-3275 Darla	300 E Washington Montezuma, Iowa 50171	☐ Yes ☐ No		
SEG Emergency Loan 0% Interest	701-566-0734 Dan	PO Box 481 Grinnell, Iowa50171 grinnellmicrofinance@gmail.com	☐ Yes ☐ No		
Veteran's Affairs (if a veteran)	641-236-5722 Russ	200 4th Avenue West Grinnell, Iowa 50112	☐ Yes ☐ No		
CICS –current mental health diagnosis	641-236-9199 Brenda	200 4th Avenue West Grinnell, Iowa 50112	☐ Yes ☐ No		
Grinnell Housing Authority	641-236-2611 Susan	927 4th Avenue Grinnell, Iowa 50112	☐ Yes ☐ No		
Ministerial Alliance **BROOKLYN ONLY**	641-522-9298	503 Clay Street Brooklyn, Iowa 52211	☐ Yes ☐ No		
Ministerial Alliance **MONTEZUMA ONLY**	641-623-3275 Darla	303 E Washington Montezuma, Iowa 50171	☐ Yes ☐ No		

Churches within the Community:

Church	Phone	Address	Funding Approved	Amount	If no, reason for denial:
First Baptist Church	641-236-4748 Brandie	925 East Street Grinnell, Iowa 50112	☐ Yes ☐ No		
Grinnell Christian Church	641-236-5667 Sixta	1331 Hobart Street Grinnell, Iowa 50112	☐ Yes ☐ No		
Grinnell Friends Church	641-236-6412 Anthony	1115 W St South Grinnell, Iowa 50112	☐ Yes ☐ No		
Grace Community Church	641-236-6621 Pastor Rick	511 6th Avenue Grinnell, Iowa 50112	☐ Yes ☐ No		
Methodist Church	641-236-3757 Shannon	916 5th Avenue Grinnell, Iowa 50112	☐ Yes ☐ No		
Presbyterian Church	641-236-6059 Sheryl	1025 5th Avenues Grinnell, Iowa 50112	☐ Yes ☐ No		
St. Mary's Catholic Church	641-236-7486 Jay	1224 East Street Grinnell, Iowa 50112	☐ Yes ☐ No		
United Church of Christ	641-236-3111 Elizabeth	1026 State Street Grinnell, Iowa 50112	☐ Yes ☐ No		