MARTIN COUNTY HEALTH AND HUMAN SERVICES
435 SE FLAGLER AVE., STUART, FL. 34994
(772) 288-5785 (Main Number) (772) 223-4829 (Fax)

NAME:_____

SOCIAL SECURITY NO:_____ MARITAL STATUS:_____

IF CHILD, PARENT(S) NAME:_____

TELEPHONE NUMBER:_____ D.O.B:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOW LONG IN COUNTY:_____ CHILDREN IN HOME (AGES):_____

RELATIVES:_____

EMPLOYER NAME & ADDRESS:_____

IF NOT EMPLOYED, SOURCE OF MONTHLY INCOME:_____

FOOD STAMPS (IF YES LIST AMOUNT)_____TOTAL MONTHLY INCOME:_____

VETERAN □ Yes □NO SERVICE CONNECTED □ □NO

FOR HOSPITAL LIEN ONLY

This application is made for the purpose of obtaining county assistance to pay for the cost of my hospitalization. I understand and agree that in return for this payment, the County will place a lien against my property, which I now have or may acquire in the future. I, from the date of this application, will not transfer or convey my property in a way that would prevent the County from receiving payment of the lien. I have read the above statement (or have had it read to me) and agree to the County placing a lien against my property. All parties listed on the title must also agree to the placement of the lien against the property, agree to the above conditions, and sign the form with their consent.

_____ _____
Signature Date Signature Date

STATEMENT OF CITIZENSHIP/ALIEN REGISTRATION STATUS:

□ I, _____ AM A UNITED STATES CITIZEN

□ I, _____ AM A LAWFULLY ADMITTED ALIEN
_____(Client's Name and Registration Number)

Upon my oath, I certify the above information is accurate and correct to the best of my knowledge. I recognize that failure to provide accurate information may disqualify me for services and/or result in civil penalties.

SIGNATURE OF CLIENT/REPRESENTATIVE _____

INTERVIEWER: _____DATE: _____