

Parent / Guardian Name: \_\_\_\_\_

Residential Address (applicant must reside in Iowa)

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Death: \_\_\_\_\_ Age at time of Death \_\_\_\_\_

Type of Expense: (Please circle one)

Funeral      Burial      Cremation      Cemetery Costs      Grave Marker

Reimbursement amount requested: \$ \_\_\_\_\_

- I would like reimbursement to be paid directly to myself.
- I would like reimbursement to be paid to the following facility, crematory, funeral home or monument retailer  
: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Income verification: (Must be below 145% of 2015 poverty guidelines-see chart on back of form)

- Monthly Income: \$ \_\_\_\_\_ (**supply copy of tax forms**)
- Yearly Income: \$ \_\_\_\_\_ (**supply copy of tax forms**)
- Number of people in household: \_\_\_\_\_

I verify that the information provided is true and accurate to the best of my knowledge. I understand that Page County Public Health will disburse payments within 45 days of an approved application. **I understand that I must submit a copy of the invoice from the funeral home, crematory or monument retailer for reimbursement. I further understand I must submit a copy of the death certificate of my child to Page County Public Health for application of funds.**

Maximum amount to be disbursed is \$2000 per family.

\_\_\_\_\_  
(Parent / Guardian Signature) (Date)

**Please return this application to:** Page County Public Health 112 E Main St Clarinda, IA 51632

**For Page County Public Health office use only:**

Application approved Yes \_\_\_\_\_ No \_\_\_\_\_

Reason for denial (over income, not Iowa resident, death occurred prior to July 1, 2014, deceased is over age of 18)

\_\_\_\_\_  
(Page County Public Health Witness) (Date)

\_\_\_\_\_  
(Board of Health Approval) (Date)

Amount paid: \$ \_\_\_\_\_ ( No more than \$2000/family) Date pd: \_\_\_\_\_

Persons in family or household	2015 Poverty Guidelines (100% of poverty)	145% of Poverty
1	\$11,770	\$17,067
2	\$15,930	\$23,099
3	\$20,090	\$29,131
4	\$24,250	\$35,163
5	\$28,410	\$41,195
6	\$32,570	\$47,227
7	\$36,730	\$53,259
8	\$40,890	\$59,291
For each additional person add	\$4,160	\$6,032.00

Reference

<http://aspe.hhs.gov/poverty/15poverty.cfm>