Junior Auxiliary of Biloxi-Ocean Springs
Child Welfare Program Application Update

The Junior Auxiliary of Biloxi-Ocean Springs (JABOS) assists local families in many capacities through our I Matter project. The purpose of this project is to assist families with basic needs and services until they are able to become self-sufficient. Each family is different and the circumstances surrounding each family determine the amount of assistance and length of time the JABOS may assist any given family. Previous application will be reviewed to complete application update.

Date of Original Application _____

Names & Ages of Adults (Parent/Caregiver) Living in the Home:

- Adult # 1 Name:_____ Age: _____DOB:_____ ☐Male☐Female
  Telephone #:_____Relationship to Child: _____
  Employer:_____Telephone #: _____
  High School Diploma/GED: ☐YES ☐NO Last Grade Attended: _____
  College: ☐YES ☐NO Degree(s) Obtained:_____

- Adult # 2 Name:_____ Age: _____DOB:_____ ☐Male☐Female
  Telephone #:_____Relationship to Child: _____
  Employer:_____Telephone #: _____
  High School Diploma/GED: ☐YES ☐NO Last Grade Attended: _____
  College: ☐YES ☐NO Degree(s) Obtained:_____

Address: _____
City:_____State:_____Zip Code: _____
☐Rent ☐Own Monthly Rent or Payment Amount: $_____

Names, Ages & Schools of Children Living in the Home:

- Child # 1 Name:_____Age: _____ DOB:_____ ☐Male☐Female
  School:_____After-Care: _____
- Child # 2 Name:_____Age: _____ DOB:_____ ☐Male☐Female
  School:_____After-Care: _____
- Child # 3 Name:_____Age: _____ DOB:_____ ☐Male☐Female
  School:_____After-Care: _____
- Child # 4 Name:_____Age: _____ DOB:_____ ☐Male☐Female
  School:_____After-Care: _____

Case Worker Information (if applicable):

Name:_____Agency: _____
Case #:_____Telephone Number: _____

Transportation:

Number of Vehicles Owned/Leased: _____ Own Car: ☐YES ☐NO

If no, explain means of transportation, if any, for adults and children.

_____

_____

Family Income/Financial Assistance:

Job Income	☐YES	☐NO	Monthly $ _____	
Welfare	☐YES	☐NO	Monthly $ _____	
Social Security	☐YES	☐NO	Monthly $ _____	
Food Stamps	☐YES	☐NO	Monthly $ _____	
Aid to Dependent Children	☐YES	☐NO	Monthly $ _____	
Other Assistance	☐YES	☐NO	Monthly $ _____	Specify: _____
Other Income	☐YES	☐NO	Monthly $ _____	Specify: _____

Bills/Expenses:

Rent/Mortgage (from above)	☐YES	☐NO	Monthly $ _____	
Water	☐YES	☐NO	Monthly $ _____	
Power	☐YES	☐NO	Monthly $ _____	
Cable	☐YES	☐NO	Monthly $ _____	
Internet	☐YES	☐NO	Monthly $ _____	
Telephone (Home)	☐YES	☐NO	Monthly $ _____	
Telephone (Mobile)	☐YES	☐NO	Monthly $ _____	Total #: _____
Prescriptions	☐YES	☐NO	Monthly $ _____	
Groceries	☐YES	☐NO	Monthly $ _____	
After School Care	☐YES	☐NO	Monthly $ _____	

Other (Specify:_____) Monthly $ _____

Other (Specify:_____) Monthly $ _____

Other (Specify:_____) Monthly $ _____

Other (Specify:_____) Monthly $ _____

Other (Specify:_____) Monthly $ _____

<u>Medical Insurance</u>

Major Medical:	☐YES	☐NO	Monthly $_____
*Coverage: _____			
Hospitalization:	☐YES	☐NO	Monthly $_____
*Coverage: _____			
Life:	☐YES	☐NO	Monthly $_____
*Coverage: _____			
Dental:	☐YES	☐NO	Monthly $_____
*Coverage: _____			

Other (Specify: _____) ☐Monthly $_____

*Coverage: _____

Car Insurance

Auto ☐YES ☐NO ☐Monthly $_____ ☐Quarterly $_____

*Coverage: _____

Liability ☐YES ☐NO ☐Monthly $_____ ☐Quarterly $_____

*Coverage: _____

Collision ☐YES ☐NO ☐Monthly $_____ ☐Quarterly $_____

*Coverage: _____

Other (Specify: _____) ☐Monthly $_____ ☐Quarterly $_____

*Coverage: _____

Someone to notify in case of emergency (not residing with you):

Name: _____ Relationship: _____

Address: _____ City: _____ State: Zip Code: _____

Telephone Number: _____ E-mail Address: _____

Medical Practioner Information:

- **Adult # 1**

  Clinic Name: _____ Physician: _____

  Telephone #: _____ Date of Last Visit: _____

  Long Term Medical Needs: ☐YES ☐NO If yes, please explain: _____

  _____

  Short Term Medical Needs: ☐YES ☐NO If yes, please explain: _____

  _____

  Dental Clinic: _____ Dentist: _____

  Telephone #: _____ Date of Last Visit: _____

- **Adult # 2**

  Clinic Name: _____ Physician: _____

  Telephone #: _____ Date of Last Visit: _____

  Long Term Medical Needs: ☐YES ☐NO If yes, please explain: _____

  _____

  Short Term Medical Needs: ☐YES ☐NO If yes, please explain: _____

  _____

  Dental Clinic: _____ Dentist: _____

  Telephone #: _____ Date of Last Visit: _____

- **Child # 1**

  Clinic Name: _____ Physician: _____

  Telephone #: _____ Date of Last Visit: _____

  Long Term Medical Needs: ☐YES ☐NO If yes, please explain: _____

  _____

  Short Term Medical Needs: ☐YES ☐NO If yes, please explain: _____

  _____

  Dental Clinic: _____ Dentist: _____

  Telephone #: _____ Date of Last Visit: _____

- **Child # 2**

  Clinic Name:_____ Physician: _____
  Telephone #:_____ Date of Last Visit: _____
  Long Term Medical Needs: ☐ YES ☐ NO If yes, please explain: _____
  _____
  Short Term Medical Needs: ☐ YES ☐ NO If yes, please explain: _____
  _____
  Dental Clinic:_____ Dentist: _____
  Telephone #:_____ Date of Last Visit: _____

- **Child # 3**

  Clinic Name:_____ Physician: _____
  Telephone #:_____ Date of Last Visit: _____
  Long Term Medical Needs: ☐ YES ☐ NO If yes, please explain: _____
  _____
  Short Term Medical Needs: ☐ YES ☐ NO If yes, please explain: _____
  _____
  Dental Clinic:_____ Dentist: _____
  Telephone #:_____ Date of Last Visit: _____

- **Child # 4**

  Clinic Name:_____ Physician: _____
  Telephone #:_____ Date of Last Visit: _____
  Long Term Medical Needs: ☐ YES ☐ NO If yes, please explain: _____
  _____
  Short Term Medical Needs: ☐ YES ☐ NO If yes, please explain: _____
  _____
  Dental Clinic:_____ Dentist: _____
  Telephone #:_____ Date of Last Visit: _____

Other providers utilized (Mental Health Therapist, CASA Worker, etc.):

Family Member:_____ Provider: _____
Agency Name:_____ Telephone #: _____
Date of Last Visit:_____ Purpose of this provider: _____
_____

Family Member:_____ Provider: _____
Agency Name:_____ Telephone #: _____
Date of Last Visit:_____ Purpose of this provider: _____
_____

Family Member:_____ Provider: _____
Agency Name:_____ Telephone #: _____
Date of Last Visit:_____ Purpose of this provider: _____
_____

Family Sizes: (Please indicate preferences if applicable)

- **Adult # 1 (Specify Name: _____)**

Shirt _____ Skirt _____ Dress _____
Pants _____ Coat _____ Pants _____
Shoes _____ PJs _____ Bra _____
Underwear _____

- **Adult # 2 (Specify Name: _____)**

Shirt _____ Skirt _____ Dress _____
Pants _____ Coat _____ Pants _____
Shoes _____ PJs _____ Bra _____
Underwear _____

- **Child # 1 (Specify Name: _____)**

Shirt _____ Skirt _____ Dress _____
Pants _____ Coat _____ Pants _____
Shoes _____ PJs _____ Bra _____
Underwear _____

- **Child # 2 (Specify Name: _____)**

Shirt _____ Skirt _____ Dress _____
Pants _____ Coat _____ Pants _____
Shoes _____ PJs _____ Bra _____
Underwear _____

- **Child # 3 (Specify Name: _____)**

Shirt _____ Skirt _____ Dress _____
Pants _____ Coat _____ Pants _____
Shoes _____ PJs _____ Bra _____
Underwear _____

- **Child # 4 (Specify Name: _____)**

Shirt _____ Skirt _____ Dress _____
Pants _____ Coat _____ Pants _____
Shoes _____ PJs _____ Bra _____
Underwear _____

FAMILY GOALS – *Annual Review (RE-APPLICATION)*

IMMEDIATE NEEDS:

What are things that could immediately improve your family situation? Are your immediate needs the same as last year? If so, how can we find a permanent solution for these immediate needs?

LONG TERM NEEDS:

What are some changes that you would like to see in your family in the next 6 months? Year? How do these changes compare to the changes you identified last year?

PROBLEMS (Things that might interfere with progress of family):

We understand that we are applying for assistance through the JABOS in order to improve our current living and/or family situation and attest that all information submitted is the most accurate and up-to-date information. We understand that JABOS will review the application and determine eligibility based on need and the need of other applications received. We also agree that, if chosen, we will work in coordination with JABOS to reach the goals we established in the initial interview.

Signature	Printed Name	Date
Signature	Printed Name	Date

JABOS OBSERVATIONS:

JABOS Member Signature | Printed Name | Date