

# DISTRICT 9 PRO BONO COMMISSION

*Do Not Fill in Shaded Areas*

DATE:  BY:  FILE #:  PROBLEM:

NAME:   
 *First, Middle and Last*

ANY PRIOR NAMES:

ADDRESS:  EMAIL:

CITY/ST/ZIP:  PHONE:

HOW LONG IN INDIANA?

HOW LONG IN COUNTY?

HAVE YOU CALLED BEFORE?  Yes  No WHY?

ETHNICITY:	GENDER:	MARITAL STATUS:	HOW LONG?
DOB:	CITIZEN? <input type="checkbox"/> Yes <input type="checkbox"/> No	SSN: <input type="text"/>	
ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No	DISABILITY? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHAT? <input type="text"/>	
CAN YOU READ AND WRITE? <input type="checkbox"/> Yes <input type="checkbox"/> No	DO YOU HAVE A PENDING CRIMINAL MATTER? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>← If "Yes" please explain on page 2.</i>	

**CASE INFORMATION**

COUNTY OF CASE:	CASE FILED BY:	CAUSE #:
OPPOSING PARTY:	RELATIONSHIP TO YOU:	HOW MANY CHILDREN IN THIS RELATIONSHIP?
ADDRESS:	CITY/ST/ZIP:	AGES:
OPPOSING ATTORNEY:		

**FULL DISCLOSURE IS NECESSARY** We reserve the right to ask for proof of income

<b>WEEKLY GROSS INCOME:</b> <small>In dollars and cents, list the amount of your pre-tax WEEKLY gross income that comes from the following types of income sources.</small>	Work: \$ <input type="text"/>	Social Security Income: \$ <input type="text"/>	
	Child Support: \$ <input type="text"/>	Social Security Disability: \$ <input type="text"/>	
<small>If you are married, your weekly gross income includes your spouse's income.</small>	Food Stamps: \$ <input type="text"/>	Supplemental Security Income: \$ <input type="text"/>	
<small>If you get paid hourly at work and do not work the same number of hours each week, figure an average weekly salary based on the number of hours you would work in a three month period.</small>	(Type other source here) \$ <input type="text"/>	Temporary Assistance: \$ <input type="text"/>	
<b>TOTAL WEEKLY GROSS INCOME:</b> <small>This amount is automatically calculated based on the amounts entered above.</small>			
HOW MANY PEOPLE DO YOU SUPPORT? <input type="text"/>	AGES OF CHILDREN IN HOUSEHOLD: <input type="text"/>		
WHO LIVES IN HOUSEHOLD? <input type="text"/>			

ASSETS:	CASH: <input type="text"/>	SAVINGS: <input type="text"/>	AUTO 1: <input type="text"/>	AUTO 2: <input type="text"/>
	PENSION: <input type="text"/>	HOUSE: <input type="text"/>	OTHER REALTY: <input type="text"/>	OTHER: <input type="text"/>

DO YOU PAY ANY CHILD SUPPORT?  Yes  No AMOUNT?  ARREARAGE?

HAVE YOU BEEN IN COURT FOR THIS MATTER?  Yes  No WHEN?

CAUSE #:  WERE POLICE EVER CALLED?  Yes  No

You must complete this Application in its entirety, including the personal & financial information on Page 1, Narrative on Page 2, & the Agreement on Page 4. The completed Pages 1, 2, & 4 must be returned to the Legal Volunteers office either by mail or fax.

**IF ANY PORTION OF YOUR APPLICATION IS LEFT BLANK, IT WILL NOT BE EVALUATED.**

**MAIL OR FAX THIS DOCUMENT AND THE SIGNED AGREEMENT TO:**  
**District 9 Pro Bono Commission**  
**P.O. Box 94**  
**Richmond, IN 47374**  
**Phone: 765-935-5053**

# DISTRICT 9 PRO BONO COMMISSION

**TELL US EVERYTHING ABOUT THIS SITUATION IN THE SPACE PROVIDED BELOW:**  
For Example: Why do you think you need an attorney?

**USE ADDITIONAL SHEET IF NECESSARY**

**DISTRICT 9 PRO BONO COMMISSION RETAINER AGREEMENT**

I, \_\_\_\_\_, have requested referral to a private attorney through the District 9 Pro Bono Commission pro bono program for representation in the following matter: \_\_\_\_\_.

I understand that the pro bono attorney will review and evaluate my case and determine whether or not to accept me as a client. I further understand that the District 9 Pro Bono Commission is responsible for the referral only and has absolutely no authority over the pro bono attorney's decision to accept or decline legal assistance. The nature of the services to be provided will be determined by the pro bono attorney on an ongoing basis.

I may terminate this agreement any time. I understand that I have the responsibility to inform the District 9 Pro Bono Commission of any change in my household, income, and resources. I understand and agree that if I become financially ineligible for representation by the District 9 Pro Bono Commission, they may terminate this agreement. Additionally, if I become ineligible for services for any reason specified in federal law or federal regulation, the District 9 Pro Bono Commission may have to withdraw the referral made to the pro bono attorney.

Date: \_\_\_\_\_

\_\_\_\_\_  
Client Signature

**CLIENT AUTHORIZATION AND RELEASE**

I, \_\_\_\_\_, authorize the District 9 Pro Bono Commission to release records and information pertaining to my case to the pro bono attorney(s).

Date: \_\_\_\_\_

\_\_\_\_\_  
Client Signature

**DECLARATION OF CITIZENSHIP**

I hereby declare that I am a citizen of the United States

Date: \_\_\_\_\_

\_\_\_\_\_  
Client Signature