Town/City of:_____

APPLICATION FOR GENERAL ASSISTANCE

Administrator: Please read the following to the applicant or have the applicant read it in your presence.

PENALTY FOR FALSE REPRESENTATION. Whoever knowingly and willfully makes any false representation of a material fact to the overseer of any municipality or to the department or its agents for the purpose of causing that or any other person to be granted assistance by the municipality or by the State is guilty of a Class E crime and shall reimburse the municipality for that assistance. Further assistance may be denied until that person reimburses the municipality for the assistance or enters into a written agreement, which must be reasonable under the circumstances, to reimburse the municipality or that person has been ineligible for assistance for a period of 120 days, whichever period is longer.
(22 M.R.S.A. § 4315).

1. HOUSEHOLD (Please type or print)

Name of Applicant:	Date of Birth:	Place of Birth	Social Security Number:	Telephone numbers: Home: / Cell: / Message:
Mailing Address:				Length of Use:
Physical Address:				Length of Residence:
Most recent previous address:				Length of Residence:

Applicant is: (Circle One)		Has anyone in the HH ever applied for GA in the past? YES or NO	If yes, Where: / When:	Type of Assistance Received:
Married	Single / Divorced			
Separated	Widowed			

Does anyone in your household have a warrant for their arrest as a result of a felony conviction?	If yes, who?	Have you reached the TANF 60 mo. Limit?	If yes, have you applied for an extension?
Has your household applied for LIHEAP?	Does everyone receive SNAP benefits?	If so, how much?	Do you have a Government funded cell phone?	Has your household filed for an income tax refund?
Did you or anyone in your household serve in the U.S. Military?	Has anyone applied for a VA pension?	Does anyone receive post-secondary Financial Aid?	Subsidized Housing? / Utility Allowance? $	Is everyone in the household a US citizen?
Total number of people in household:	Number seeking assistance:	Total # of people for whom applicant is seeking assistance:	Is anyone sanctioned by TANF? / Is anyone disqualified by GA?	If so, who and date:

PEOPLE LIVING WITH THE APPLICANT	RELATIONSHIP	DOB	Birthplace	SOCIAL SECURITY #	Disabled(D) Veteran (V)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

NAMES AND ADDRESSES OF SPOUSE, EX-SPOUSE, PARENTS, GRANDPARENTS AND CHILDREN'S PARENTS WHO ARE NOT MEMBERS OF THE HOUSEHOLD

1. Name:		2. Name:	
Mailing Address:		Mailing Address:	
Relationship:	Telephone #:	Relationship:	Telephone #:
3. Name:		4. Name:	
Mailing Address:		Mailing Address:	
Relationship:	Telephone #:	Relationship:	Telephone #:

2. EMPLOYMENT INFORMATION - APPLICANT

Is applicant currently employed?		If **YES**, type of job:	
If yes, name of employer:		Address of Employer:	
Start Date:	How many hours per week?	Date last wages received?	Amount?

LIST TWO PREVIOUS EMPLOYERS (if needed):

Name:	Address:	Start Date:	End Date:
Name:	Address:	Start Date:	End Date:

Are you disabled?	Do you have an active SSI/SSDI application?	If so, what stage of the process are you in?	Do you have an attorney? If so, who?
			Have you filed an IAR?

Under what circumstances did the Applicant leave his/her last place of employment?	Date of Separation from employment:

If unemployed, has applicant registered with the Maine Job Bank/Career Center?	Highest level of education completed:	Was applicant in the military? Branch?
Job Skills:		

EMPLOYMENT INFORMATION – OTHER HOUSEHOLD MEMBER - Name: _____

Is member currently employed?		If **YES**, type of job:	
If yes, name of employer:		Address of Employer:	
Start Date:	How many hours per week?	Date last wages received?	Amount?

LIST TWO PREVIOUS EMPLOYERS :

Name:	Address:	Start Date:	End Date:
Name:	Address:	Start Date:	End Date:

Are they disabled?	Do they have an active SSI/SSDI application?	If so, what stage of the process are they in?	Do you have an attorney? If so, who?
			Have they filed an IAR?

Under what circumstances did this member leave his/her last place of employment?	Date of Separation from employment?

If unemployed, has member registered with the Maine Job Bank/Career Center?	Highest level of education completed?	Was member in the military? Branch?
Job Skills:		

EMPLOYMENT INFORMATION – OTHER HOUSEHOLD MEMBER - Name: _____

Is member currently employed?	If **YES**, type of job:

IF yes, name of employer:		Address of Employer:	
Start Date:	How many hours per week?	Date last wages received?	Amount?

LIST TWO PREVIOUS EMPLOYERS:

Name:	Address:	Start Date:	End Date:
Name:	Address:	Start Date:	End Date:

Are they disabled?	Do they have an active SSI/SSDI application?	If so, what stage of the process are they in?	Do they have an attorney? If so, who?
			Have they filed an IAR?

Under what circumstances did this member leave his/her last place of employment?	Date of Separation from employment?

If unemployed, has member registered with the Maine Job Bank/Career Center?	Highest level of education completed?	Was this member in the military? Branch?
Job Skills:		

3. ASSISTANCE REQUESTED

ASSISTANCE REQUESTED: Please place check mark next to each type of assistance being requested and enter the amount of the request.

✓	ASSISTANCE	AMOUNT	✓	ASSISTANCE	AMOUNT
	1. Food	$		7. Household/Personal Supplies	$
	2. Rent	$		8. Prescriptions/Medical	$
	3. Mortgage	$		9. Water	$
	4. Electricity	$		10. Sewer	$
	5. LP Gas	$		11. Other (Specify):	$
	6. Heating Fuel	$		**TOTAL ASSISTANCE REQUESTED**	$

4. USE OF INCOME - PRIOR 30 DAYS (Office use only)

Income:	$
	$
	$
Total: (A)	$

Household Receipts	
Food	$
Housing	$
Utilities	$
Propane	$
Fuel	$
Household	$
Personal	$
Med/Presc.	$
Water	$
Sewer	$
Other:	$
	$
Total: (B)	$
Notes:	

(Use of income may not bar eligibility for applicants in a life threatening emergency or initial applicants)

Other Receipts	
Phone	$
Internet	$
Cable	$
Tobacco	$
Alcohol	$
Magazines	$
Pet Food	$
Fines/bails	$
Other:	$
	$
Total: (C)	$
Total Income: (A)	$
Less Total Receipts: (B)	$
Plus Misspent Money: (C)	$
Plus Difference Between (A)-(B)+(C) - Unaccounted	$
(A) Total Added to Line "N, section 5":	$

5. PROJECTED 30 DAY INCOME

INCOME: Check **YES** or **NO** for each type of income. Enter the amount of all money to be received (in the next 30 days) by: (1) the applicant; (2) the applicant's family; and (3) unrelated household members. Report how often income is received.

TYPE OF INCOME	✓	MONEY APPLICANT RECEIVES		MONEY FAMILY RECEIVES		MONEY OTHERS RECEIVE		OFFICE USE ONLY
		AMOUNT	FREQUENCY	AMOUNT	FREQUENCY	AMOUNT	FREQUENCY	MONTHLY TOTAL
A. Employment		$		$		$		$
B. TANF		$		$		$		$
C. Social Security		$		$		$		$
D. Military/Veteran Benefits		$		$		$		$
E. Retirement or Pension Plan		$		$		$		$
F. Unemployment Benefits		$		$		$		$
G. Worker's Compensation		$		$		$		$
H. Child Support/ Alimony		$		$		$		$
I. SSI-Supplemental Security Income		$		$		$		$
J. Bank Accounts & Cash on Hand		$		$		$		$
K. Income/In kind from Relatives		$		$		$		$
L. Other (please specify)		$		$		$		$
For Repeat Applicants Only: M. Investment Asset(s) Value (See Section 5, C)								$
N. Misspent Income & Unverified Expenditures (during the last 30 days)								$
SUBTOTAL – MONTHLY HOUSEHOLD INCOME								$
O. LESS: Total verified monthly work-related expenses: Child Care: $_____ Mileage: (RT miles ____ * # of days a week: ____ * # of weeks per month: _____ * ordinance mileage: _____)= _____ Other: _____								$
TOTAL – MONTHLY HOUSEHOLD INCOME								$

6. ASSETS

ASSETS: Check **yes for each asset owned and enter the value. Enter who in the household owns the asset.**

TYPE OF ASSET	✓	VALUE	ASSET OWNED BY
A. Home		$	
B. Real Estate (other than home)		$	
C. Investments: Stocks, Bonds, Retirement Account(s), Life Insurance, etc.		$	
D. Vehicle(s) i.e., car, truck, motorcycle)		$	
Additional:		$	
E. Recreational Vehicle (s) (i.e., camper, ATV, snowmobile, boat)		$	
Additional:		$	
F. Other		$	

7. EXPENSES

MONTHLY EXPENSES	ACTUAL COST FOR NEXT 30 DAYS	MAXIMUM AMOUNT (OFFICE USE ONLY)	ALLOWED AMOUNT (OFFICE USE ONLY)
1. Food	$	$	$
2. Rent – Name and Address of Landlord:	$	$	$
3. Mortgage – Mortgage Holder:	$	$	$
4. Electricity –Hot Water Y/N Electric Heat Y/N	$	$	$
5. LP Gas	$	$	$
6. Heating Fuel TYPE:	$	$	$
7. Household/Personal Supplies	$	$	$
8. Prescriptions/Medical	$	$	$
9. Water	$	$	$
10. Sewer	$	$	$
11. Other (specify)	$	$	$
	$	$	$
TOTAL MONTHLY HOUSEHOLD EXPENSES	$	$	$

8. OTHER EXPENSES

NOTE: The administrator should be aware of the following to gain an understanding of the applicant's financial situation.

A. Do you have any debts (i.e., bank loans, car payments, credit cards)? **YES** **NO**

If **YES,** give (1) name; (2) purpose money was borrowed; and (3) amount (list below).

NAME	PURPOSE	AMOUNT
1.		$
2.		$
3.		$

9. DEFICIT (Office use only)

A. **Overall Maximum Level of Assistance Allowed** (See GA Ordinance Appendix A)	$	D. **Deficit** (If line A is greater than line B)	$
B. **Income** (See Section 5)	$	E. ***Surplus** (If line B is greater than line A)	$
C. **Result** (Line A minus line B)	$	* **Note:** If a surplus exists, applicant is not eligible for regular GA. Proceed to Section 10 to determine if "unmet need" results in eligibility for "emergency" GA	

10. UNMET NEED (Office use only)

A. Allowed Expenses (See Section 7)	$	**D. Unmet Need** (Amount from line C, but only if line A is greater than line B)	$
B. Income (See Section 4)	$	**E. Deficit** (See Section 9, line D)	$
C. Result (Line A minus line B)	$	**F. Amount of GA Eligibility** (The lower of line D and line E)	$

INSTRUCTIONS:

1) If Section 9, line B (income) is greater than line A (overall maximum), then applicant has a surplus of $_____ and will not be eligible for General Assistance **unless** the GA administrator determines there is need for emergency assistance.
2) If Section 10, line A (allowed expenses) is greater than line B (income), the result will be an "Unmet Need" (line D).
3) If there is both an "Unmet Need" (Section 10, line D) and a "Deficit" (Section 10, line E), the applicant will be eligible for the **lower** of the two amounts. This lower amount is the amount of assistance the applicant is eligible for in the next 30-day period, or a proportionate amount for a shorter period of eligibility (i.e., if the applicant needs one week's worth of GA assistance, they should receive ¼ of the 30 day amount).

Administrator: Please read the following to the applicant or have the applicant read it in your presence.

In accordance with Maine law (22 M.R.S.A. § 4321) you have the right to be given a written decision concerning your application within 24 hours of submitting a completed application. If you disagree with the administrator's decision on the application, you have the right to a fair hearing before an impartial hearing authority. If you believe that the municipality has violated state law with respect to your application, you have the right to notify the State Department of Health and Human Services in Augusta (1-800-442-6003)

STATEMENT BY APPLICANT: I hereby affirm that the facts in this application are true, correct and complete, and that I have not knowingly withheld any information. I understand the Administrator has the right to verify any information necessary to determine my eligibility and hereby give my consent. I understand if I refuse to give my consent it may result in my not being eligible to receive assistance; therefore, I hereby give my express permission for the Administrator to contact the following specific sources or persons to verify any or all information material to the determination of General Assistance eligibility for my household:

- Employer(s) (past/present);
- Persons, organizations or businesses referenced in this application;
- Past, present and/or future landlords;
- Bank(s) or financial institutions;
- The Department of Health and Human Services or any department of the State of Maine;
- The area Community Action Program;
- Relatives, specify:_____ _____
- Persons/vendors to whom I owe money (i.e. utility company, fuel dealer, car dealership);
- Physician(s) with information related to my ability to work or receive other benefits;
- Housing Authority (local and/or state);
- The following specific sources of information_____ _____

Applicant's Signature:_____

Date:_____

Administrator's Signature:_____

Date:_____

DOCUMENTATION OF PAST 30 DAYS

Income: _____
_____
_____
==========

ALL RECEIPTS

food: _____
housing:_____
utilities:_____
phone: _____
cable: _____
propane:_____
fuel: _____
tobacco:_____
alcohol:_____
h.h./pers.:_____
magazines:_____
pet supplies:_____
other: _____
_____
_____
==========
TOTAL:

MISSPENT MONEY

phone: _____
cable: _____
tobacco:_____
alcohol:_____
magazines:_____
pet supplies:_____
other: _____
other: _____
==========
TOTAL:

Total Income:_____
Less Total Receipts_____
==========

Unaccounted for amt.:_____
Plus Misspent amt.:_____
TOTAL:
(this total is added to the next 30 days income)

Landlord Verification of Rental Unit

(THIS FORM MUST BE COMPLETED BY THE LANDLORD OR UNIT MANAGER)

Tenant's name: _____ Number of tenants occupying unit: _____
Number of adults: _____Number of children: _____

Is this person currently occupying this unit? Yes No
If no, when is the unit available? _____ If yes, when did they move in? _____
Is a security deposit required? Yes No If yes, how much? _____
Is the tenant a relative of the owner? Yes No If yes, relationship: _____

Rent amount $_____/weekly $_____/monthly Rent due date: _____
Does the tenant receive rent subsidy from another agency? Yes No
If yes, what is the tenant's portion of the rent $_____/weekly $_____/monthly

Is the rent current at this time? Yes No
If no, what is the amount owed: _____ and for what period of time: _____
Date rent was last paid: _____ Amount paid: _____

Address of rental unit: _____ Apt/room number: _____
Type of rental unit: single house apartment house mobile homes rooming house other
Total number of rooms: _____ Total number of bedrooms: _____
Utilities included: heat electricity gas hot water water/sewer
If unheated, how is the unit heated? electric gas oil other: _____

Legal owner of the property: _____
Address: _____
Home phone: _____ Cell phone: _____ Business phone: _____
Email: _____

Manager or agent for the above owner: _____
Address: _____
Home phone: _____ Cell phone: _____ Business phone: _____
Email: _____

Make check payable to: _____
Address: _____

NOTICE: This form is not intended to imply that the prospective tenant/tenants are either eligible for assistance or that they will necessarily be renting an apartment from you. It can/will be used to verify residence or accommodations. If the tenant is found eligible for rental assistance, a voucher will be given for payment. The voucher must be signed by the legal owner of the property or their agent and returned to this office for payment. The voucher must be returned within 30 days of the date issued or they will expire and become void. A W-9 tax form will be required before any payments will be issued. All rental payments will be made directly to the landlord, not the tenant. Any rental payments may be subject to a building inspection if one has not been completed in the past year. Any deficiencies must be corrected within a reasonable amount of time specified by the city's Code Enforcement Officer. In accordance with Maine law (17 MRSA §453) any persons found guilty of providing false information may be prosecuted for committing a Class D crime.

Signature _____ Date _____
(Owner or Agent)

REQUEST FOR CONFIDENTIAL MEDICAL INFORMATION

*This section to be signed by the **General Assistance Applicant***

Name	Social Security Number ___ - ___ - ____
Mailing Address	
Municipality	Name of Health Care Provider
Mailing Address of Health Care Provider	

- I understand that I may refuse authorization to disclose all or some healthcare information but that refusal may result in the denial of my General Assistance application.
- I hereby give my consent to the above-named municipality to receive medical information from the above-named health care provider regarding my ability/inability to work in order to determine my eligibility for General Assistance.
- My consent to release this information is effective until *(date not to exceed thirty months from date of authorization),* and I authorize subsequent disclosures regarding this information during this time period.
- I understand that I may revoke this authorization at any time by executing a written revocation and providing a copy of that revocation to the person I have authorized to release this information. My revocation is not effective until the person I authorize to release information has received notice of my revocation. Revocation of this authorization may result in the denial of General Assistance benefits.
- I understand that I am entitled to a copy of this authorization form.

_____

Signature of General Assistance Applicant Date

*This section to be completed by the **General Assistance Administrator***

Name	Municipality	Telephone
Mailing Address		

*This section to be completed by the **Health Care Provider***

The above-named person has applied for General Assistance (GA) from the above-named municipality. In order to determine GA eligibility, information regarding the applicant's illness/disability preventing him/her from working must be obtained. Please answer the following at your earliest opportunity and return this form to the General Assistance Administrator listed above.

1. Does the applicant have any illness, injury, or disability that limits his/her ability to work? ☐ Yes ☐ No
2. Are there any restrictions on the kinds of work the applicant can perform, how many hours he/she can work, etc. ☐ Yes ☐ No
3. If you answered yes to #2, please explain: _____
4. Can the applicant perform the following:

	Yes	No
• Look for work	☐	☐
• Attend an education or training program	☐	☐
• Work full-time	☐	☐
• Work 20 hours or less a week	☐	☐

(If yes, how many hours _____)

Please use the reverse side, or additional paper if necessary.

5. If there are any physical or psychological limitations regarding the applicant's ability to work, how long do you expect this condition to last before he/she may work?
6. Would you recommend any vocational education, physical rehabilitation, or other services to help the applicant and if so, what?

_____ _____

Signature of Health Care Provider Date

MUNICIPALITY OF _____
GENERAL ASSISTANCE
_____STREET
_____, ME 04___
207 _____ FAX: 207 _____

Doctor's Statement

TO: _____ DATE: _____

CLIENT NAME: _____ DOB: _____

CLIENT ADDRESS: _____

This client of the **GENERAL ASSISTANCE PROGRAM** has stated they are presently disabled.

In order to determine the eligibility of the above-named client to receive the assistance he/she is requesting, we need the following information:

1. Nature and extent of the illness, disability or injury: _____

_____

2. In your opinion is the client able to:	YES	YES (WITH LIMITATIONS)	NO
(a) work at a regular job/employment?	____	____	____
(b) seek work/do job searches?	____	____	____
(c) attend school or classes?	____	____	____
(d) do city workfare?	____	____	____

IF **YES WITH LIMITATIONS**, please state limitations, i.e. light duty, limited hours/days, restrictions on lifting, movement, standing, etc. _____

_____

3. If disabled, length of time he/she will be unable to work or perform items under #2 above: _____
   If unknown at this time, give date of next evaluation: _____
4. If disabled, in your opinion, would this client benefit from the services of the Dept. of Vocational Rehabilitation for retraining or education? _____
5. In your opinion, is this client so disabled that he/she should apply for disability benefits? _____
6. Does this illness or condition require medication? _____

   If so, please specify: _____
7. If client is not considered permanently disabled, what can this client do to help themselves become work-ready?

_____

8. Date you last evaluated this patient for this disability _____
9. Additional information/comments, if any: _____

_____

Doctor's Name (please print): _____

Doctor's Signature _____ Dated: _____

Agency: _____

Any information you provide is confidential by Maine State Statute. We have asked the above client to return this information to us by _____, if possible. We thank you for your cooperation. The information may be returned via the client, faxed to 207 _____ or mailed to:

REQUEST FOR CONFIDENTIAL MEDICAL INFORMATION

*This section to be signed by the **General Assistance Applicant***

Name	Social Security Number ___ - ___ - ____
Mailing Address	
Municipality	Name of Health Care Provider
Mailing Address of Health Care Provider	

- I understand that I may refuse authorization to disclose all or some healthcare information but that refusal may result in the denial of my General Assistance application.
- I hereby give my consent to the above-named municipality to receive medical information from the above-named health care provider regarding my ability/inability to work in order to determine my eligibility for General Assistance.
- My consent to release this information is effective until _____ *(date not to exceed thirty months from date of authorization)*, and I authorize subsequent disclosures regarding this information during this time period.
- I understand that I may revoke this authorization at any time by executing a written revocation and providing a copy of that revocation to the person I have authorized to release this information. My revocation is not effective until the person I authorize to release information has received notice of my revocation. Revocation of this authorization may result in the denial of General Assistance benefits.
- I understand that I am entitled to a copy of this authorization form.

_____ _____

Signature of General Assistance Applicant Date

*This section to be completed by the **General Assistance Administrator***

Name	Municipality	Telephone
Mailing Address		

*This section to be completed by the **Health Care Provider***

The above-named person has applied for General Assistance (GA) from the above-named municipality. In order to determine GA eligibility, information regarding the applicant's illness/disability preventing him/her from working must be obtained. Please answer the following at your earliest opportunity and return this form to the General Assistance Administrator listed above.

1. Does the applicant have any illness, injury, or disability that limits his/her ability to work? ☐ Yes ☐ No
2. Are there any restrictions on the kinds of work the applicant can perform, how many hours he/she can work, etc. ☐ Yes ☐ No
3. If you answered yes to #2, please explain: _____
4. Can the applicant perform the following:

	Yes	No
• Look for work	☐	☐
• Attend an education or training program	☐	☐
• Work full-time	☐	☐
• Work 20 hours or less a week	☐	☐

(If yes, how many hours _____)

Please use the reverse side, or additional paper if necessary.

5. If there are any physical or psychological limitations regarding the applicant's ability to work, how long do you expect this condition to last before he/she may work?
6. Would you recommend any vocational education, physical rehabilitation, or other services to help the applicant and if so, what?

_____ _____

Signature of Health Care Provider Date

REQUEST FOR CONFIDENTIAL FINANCIAL INFORMATION

Pursuant to 22 M.R.S.A. § 4314(2)

*This section to be signed by the **General Assistance Applicant***

Applicant's Name	Social Security Number ___ – ___ – ____
Applicant's Mailing Address	
Municipality	Address
Financial Institution	Address

I hereby request and authorize the release (to the above-named municipality) of any and all information pertaining to the accounts held to my credit including: savings and checking accounts, stocks, bonds, certificates of deposits, trusts, retirement accounts, and loan/mortgage payment records.

Signature of General Assistance Applicant: _____ Date: _____

*This section to be completed by the **General Assistance Administrator***

Name	Municipality	Telephone
Mailing Address		

*This section to be completed by the **Financial Institution***

Financial Institution	Address	Name of Account Holder	
Type of Account		Account No.	Balance
Type of Account		Account No.	Balance
Type of Account		Account No.	Balance
Date of most recent withdrawal	Amount of most recent withdrawal	Date of most recent deposit	Amount of most recent deposit
Has account been closed? ☐ Yes ☐ No	Closing date	Safety deposit box? ☐ Yes ☐ No	Other assets (stock, bonds, CDs, etc.)? ☐ Yes ☐ No

Please list other assets and their worth (stock, bonds, CDs, etc.) held by the above applicant.

Signature of person representing the financial institution: _____

Typed or printed: _____ Date: _____

IMPORTANT: In accordance with the above authorization, please return this form to the General Assistance Administrator listed above. Your prompt reply will help expedite my request in this matter. Thank you.