



APPLICATION FOR GENERAL ASSISTANCE

City or Township: _____ Date Issued: _____
 County: _____ Date Returned: _____
 Record Number: _____

Information required in this application applies to the head of the family and all dependents for whom the application is made.

1. General Information

Last Name: _____ Phone: _____
 Husband's First Name and Middle Initial: _____ Wife's First Name and Middle Initial: _____
 Other Names or Spellings: _____

Address: _____ Date Moved In: _____ Monthly Rent: _____

Previous Three Addresses (including city and state):

Address 1: _____ Date Moved In: _____
 Address 2: _____ Date Moved In: _____
 Address 3: _____ Date Moved In: _____

My family and I have lived in this township since _____ this county since _____
 and this state since _____

Our last address before moving to Illinois was _____

I am now asking for assistance for myself and the following members of my family, who reside with me.

Name			Date of Birth			Birthplace		Relationship	Illinois Department of Employment Security Registration Number	Social Security Number
First	Middle	Last	Month	Day	Year	City	State			
								Self/ Applicant		

In addition to those listed above, the following relatives, boarders, lodgers and other persons, for whom I am not seeking assistance, are living in the same house.

Name			Age	Relationship	Present Means of Support	Amount Paid Monthly for Board, Lodging, or Share of Household Expenses
First	Middle	Last				

2. Why do you need assistance?



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3. Personal and Occupational Information

Marital Status: Married Single Widowed Divorced Separated Deserted

If married, date of marriage: _____ Location of Marriage: _____

If separated, state reason: _____

The present address of my spouse, with whom I am not living, is: _____

Is there a court order for child support? Yes No

Living Arrangement: Rent Own

If rent, Landlord's Name: _____ Landlord's Address: _____

Related to Landlord? Yes No If related, relationship to landlord: _____

Military Service: Does any member of your family have current or previous military service? Yes No

If "Yes", who has current or previous military service? _____

Date of Enlistment: _____ Date of Discharge: _____ Serial Number: _____

If family member has current/previous military service, he/she:
 received Adjusted Compensation did not receive Adjusted Compensation receives pension or other income from such service does not receive pension or other income from such service

Past Employment: List last employer and two longest term employers for applicant and any other family member with work history.

Family Member	Name and Address of Employer	Type Work	Monthly Wage	Start Date	End Date	Reason for Leaving

Present Income and Other Financial Information: Fill in every blank. If none, write "None".
 Resources:

Sources	Person Receiving	Employer's Name and Address or Description of Resource	Weekly Amount
Employment: Salary			
Employment: Commissions			
Profits from: Business			
Profits from: Employment in Home			
Profits from: Sales			
Other: (specify)			

Public Assistance and Related Public Benefits

Sources	Person Receiving	Amount	Source	Person Receiving	Amount
TANF			RSDI		
AABD			Other		
General Assistance			Other		



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Other Cash Resources

Sources	Name of Person	Amount	Sources	Name of Person	Amount
Cash on Hand			Lodges/Unions		
Savings			Annuities		
Bank Accounts			Alimony/Child Support		
Unemployment Benefits			Estates/Court Orders		
Worker's Compensation			Friends/Relatives		
Veteran's Benefits			Government Bonds		
Other Income			Other Income		

Banks Accounts Held by Any Family Member

Family Member Holding Account	Name and Address of Bank	Amount of Deposit or Date of Last Withdrawal

Safety Deposit Boxes Held by Any Family Member

Family Member Holding Box	Location of Box	Contents

Personal Property (i.e., securities, stocks, bonds, jewelry, livestock) Held by Any Family Member

Owned By	Description	Present Sale Value

Real Estate Owned, in Whole or Part, by Any Family Member

Recorded Owner	Address	Description	Present Value	Date Purchased	Date Last Taxes Paid	Amount Last Taxes Paid	Present Monthly Income

Vehicles and Farm Equipment Owned by Any Family Member

Owner	Year	Make	Model	Date Purchased	License Number	Year Issued	Present Sale Value



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Life Insurance Policies, Current or Lapsed, Held by Any Family Member

Person Insured	Name of Company	Type Policy	Amount	Monthly Premium	Date Last Premium Paid	Loans Made	
						Date	Amount

Medical, Hospital, Surgical, or Other Health Benefits Available to Any Family Member

Name of Company	Type of Coverage	Annual Premium

I understand that if I want someone else to apply for General Assistance for me, and I am mentally and physically able to apply, I must provide a written statement that gives the person permission to apply on my behalf. The statement must include the full name, address and telephone number of the person applying for me. The statement must say that I am still responsible for the information that the person applying for me gives to the local General Assistance office. The statement must also say that I am liable for repaying benefits that were received due to incorrect or incomplete information provided by an approved representative.

This application must be signed by the applicant, however, if the person is too ill, or otherwise mentally or physically unable to complete an application, this application may be filed by the spouse, parent, child, adult sibling, or other relative. If there are no relatives this application may be signed by any other person able to furnish necessary information with reasonable competence.

I have this application for General Assistance and declare under penalties of perjury that, to the best of my knowledge and belief, the information supplied in this application and all accompanying statements is true and correct, and that it is a complete statement of all income, assets, or resources belonging to me or to any member of my immediate family.

I agree to notify the Supervisor of General Assistance of any change whatsoever in need, or in the resources listed herein, or any new or additional income or resources. Further, I hereby authorize any person, bank, firm, corporation, transfer agent, agency, institution or the Department of Human Services to furnish the Supervisor of General Assistance whatever information that may be requested relative to accounts, deposits, investments, securities, Railroad System Disability Income benefits, or business of any kind whatsoever.

Applicant Signature: _____ Date: _____ Spouse Signature: _____ Date: _____

I hereby make Application for General Assistance on behalf of the person named below and certify that, to the best of my knowledge and belief, the information furnished herein is a true statement of his/her income, assets and resources.

Applicant: _____ Applicant Representative Signature: _____

Applicant Representative Address: _____ Relationship to Applicant: _____



RELEASE OF INFORMATION

I understand that in order to receive assistance from Dorr Township, it may be necessary for Dorr Township to request or share information about myself, my family, and my situation with other agencies, public and private, who may be able to assist in the establishment of my need, provide personal or financial information or in other ways be helpful to me in determining or maintaining eligibility for receiving assistance. I therefore authorize Dorr Township to share and receive information and discuss my case with such agency personnel as required and authorize all agencies contacted by Dorr Township to provide such information as may be helpful to my case. I further authorize this release to be in effect during the period of my valid General Assistance application or until my application is terminated.

Signature: _____ Date: _____

DORR TOWNSHIP GENERAL ASSISTANCE OFFICE
Sue Brokaw, Supervisor

1039 Lake Ave
Woodstock, IL 60098

Phone: (815) 338-0125
Fax: (815) 338-9647

**NOTICE OF RIGHTS AND RESPONSIBILITIES OF
GENERAL ASSISTANCE APPLICANTS AND RECIPIENTS**

As an applicant or recipient of General Assistance (GA), you have certain **rights**.

- You have the right to apply for GA at any time. Application must be in writing and must contain at least your name, mailing address and signature. Should you desire, you may get help in filling out the application form. Your application must be submitted to the General Assistance Office, however, you may do this by mail.
- You have the right to be treated with courtesy, consideration and respect. You also have the right not to be discriminated against or denied GA because of race, religious belief, color, sex, marital status, sexual preference, national origin, age, handicap or political affiliation. If you feel that you have not been treated courteously or that you have been discriminated against, you have the right to complain to the General Assistance Office without retaliation.
- You have the right to look at the General Assistance Handbook used by the General Assistance Office to determine eligibility and payment amounts. You have the right to ask questions about your case and to examine your case file at a reasonable time in the presence of a representative of the General Assistance Office.
- Under most circumstances, you have the right to prevent the General Assistance Office from disclosing information about your case to anyone.
- Finally, you have the right to appeal any action, inaction or decision of the General Assistance Office with which you disagree.

As an applicant or recipient you also have certain **responsibilities**. Your failure or refusal to fulfill these responsibilities could result in a denial or termination of General Assistance benefits.

- You must provide the General Assistance Office with any information necessary to determine if you are eligible for GA. You must also permit the General Assistance Office access to any information necessary to determine your eligibility. You must cooperate with the General Assistance Office in obtaining this information at any time, even after you have been approved for General Assistance.
- You must keep all scheduled appointments with the General Assistance Office. Unless exempt, you must actively seek work, register every 30 days with the Illinois Department of Employment Security and participate in the Community Work Program.
- You must also advise the General Assistance Office immediately of any changes in your circumstances, such as a change of address, income, assets or household composition, which might affect your eligibility for General Assistance.
- You have a responsibility to utilize all resources at your disposal and to apply for any benefits for which you might be eligible. If the General Assistance Office refers you to another office or agency to apply for benefits or receive training, you must accept and follow-up such referral in good faith.

I acknowledge receiving a copy of this Notice of Rights and Responsibilities this _____ day of _____, 20_____.

Signature: _____

FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Notice of Rights Given On: _____

Notice of Rights Given By: _____

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**NOTICE OF BENEFITS AVAILABLE
UNDER THE GENERAL ASSISTANCE PROGRAM**

MONTHLY BASIC NEEDS ASSISTANCE

- General Assistance (GA) provides monthly assistance for basic maintenance needs, including shelter, utilities, food (even if you receive food stamps), personal essentials (soap, shampoo, toothpaste, etc.), household supplies (laundry soap, detergent) and clothing. If you have certain allowable special needs, such as a therapeutic diet, amounts may be provided for your special needs.
- The maximum amount of monthly benefits for basic maintenance needs will depend upon the size of your assistance unit, who is in the assistance unit and whether you have any income. Hence, you may not receive the maximum permissible amount if you have any income.
- You will not receive cash. If approved, the General Assistance Office will issue "disbursing orders" to vendors to supply you with goods and services. Every month disbursing orders will be issued totaling the amount of your grant. The disbursing orders may only be used to obtain allowable basic maintenance needs.

MEDICAL ASSISTANCE

- If approved for GA, you are entitled to have certain medical care paid for unless you are denied medical assistance for a specific reason. Medical assistance is disbursed by direct vendor payment; that is, the General Assistance Office pays the medical provider.
- The General Assistance Office only pays for necessary and essential medical services. Preventive care is not considered essential. If you have any questions about what types of medical services can be paid for, you should ask personnel of the General Assistance Office.
- Unless an emergency exists, you must receive prior approval from the General Assistance Office for medical care, otherwise, the General Assistance Office may refuse to pay for such care. You should contact a representative of the General Assistance Office during reasonable hours with a specific request to have medical care authorized.

I acknowledge receiving a copy of this Notice of Benefits Available this _____ day of _____, 20 ____.

Signature: _____

FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Case #: _____

Notice of Benefits Given On: _____

Notice of Benefits Given By: _____

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MEDICAL RESOURCE INQUIRY

Applicant/Recipient: _____

Date: _____

You must provide information to the General Assistance Office about any medical insurance or other medical benefits that covers you and the persons listed in your Application for General Assistance. If you do not provide this information, neither you nor anyone else listed in your Application will receive medical assistance.

Answer all of the questions below. This inquiry should be submitted to the General Assistance Office together with all documents and information you have regarding medical insurance or other medical benefits.

1. Did either you or your spouse work during the last 3 months at a job in which you were covered by group health insurance? Yes No

If yes, you must provide (a) the Social Security Number(s) of the employed person(s), (b) the health group ID card, (c) the name and address of the employer, and (d) the name and address of the insurance company.

2. Do you or your spouse have insurance as a member of any union? Yes No

If yes, you must provide (a) the Social Security Number(s) of the union member(s), (b) the union and health group ID cards, (c) the name, address and local number of the union, and (d) the name and address of the insurance company.

3. Does your Application include a child(ren) who has a parent not living with you and, if so, does the absent parent have medical insurance covering either you or the child(ren)? Yes No

If yes, you must provide (a) the Social Security Number of the absent parent, (b) the health group ID cards covering you and the child(ren), (c) the name and address of the absent parent's employer, (d) the name, address and local number of the absent parent's union, if any, and (e) the name and address of the insurance company.

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4. If you are under 19 (or under 23 and a full-time student), do either of your parents include you in their group health insurance? Yes No

If yes, you must provide (a) your parents' names and Social Security Numbers (b) the health group ID cards covering you, (c) the name and address of your parents' employer(s), (d) the name, address and local number of your parents' union, if any and (e) the name and address of the insurance company.

5. Is anyone in your home covered by school insurance?

Yes No

If yes, you must provide (a) the name and address of the school, and (b) the name and address of the insurance company.

6. Are you, your spouse, your parents or your child's other parent in the military or a military veteran?

Yes No

If yes, you must provide a name and address of the military member or veteran.

7. Do you or does anyone else pay for an individual health insurance policy (including an indemnity or income protection policy which pays a certain amount per day such as an AARP policy) for you or anyone in your home?

Yes No

If yes, you must provide (a) the name, birthdate and Social Security Number of the person named as the policyholder, (b) the name and address of the insurance company, and (c) the policy number.

8. If you or your spouse are retired, do you have health insurance coverage as a retiree or as a dependent or a survivor of a retiree? Yes No

If yes, you must provide (a) the Social Security Number of the retiree, (b) the health group ID cards covering you, (c) the name and address of the employer(s), (d) the name and address of the insurance company.

9. Have you or has anyone in your household had a hospital or doctor bill paid by insurance in the past year? Yes No

If yes, you must provide (a) the name and address of the insurance company, and (b) the policy number.

10. Do you have any other resource for the payment of your medical bills other than as mentioned above? Yes No

If yes, please specify and explain:

Signature: _____ Date: _____

General Assistance Documents

You must provide the following documents (if applicable):

- Current lease or mortgage statement including late notice
- McHenry County Housing Authority budget computation for Section 8
- HUD agreement
- Valid driver's license or state ID for all persons 16 years of age or older
- Birth certificates for all persons listed on the application
- Social Security cards for each person listed on the application
- Permanent Resident Card or Certificate of Naturalization if born in a foreign country
- Marriage license or divorce/separation papers
- Paystubs for the last 30 days for all working family members
- Award letter from Social Security
- All bank accounts (checking, savings, etc.) latest statements
- Unemployment compensation records showing eligibility
- Proof of registration with Illinois Job Link within the past 30 days (resume)