Town/City of _____ 01/07/14

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. Any person who knowingly and willfully makes any written or oral false statement of a material fact to the administrator for the purpose of causing himself/herself to be granted assistance will be ineligible for the assistance for 120 days and may be prosecuted for committing a Class E crime, which carries a penalty of up to a $1,000 fine and one year in jail (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			
Separated	Divorced / 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?
Are you a Veteran?	Has anyone applied for a VA pension?	Does anyone receive 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 through GA or TANF?	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:_____