Town/City of WEST PARIS 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)	Single	Has anyone in the HH ever applied for GA in the past? YES or NO	If yes,		Type of Assistance Received:
Married	Divorced		Where:		
Separated	Widowed		When:		

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?	Is everyone in the household a US citizen?
			Utility Allowance? $	
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 <u>unless</u> 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 <u>lower</u> 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:_________________________

Town of West Paris

Application for General Assistance Addendum

As part of the application process for General Assistance it is critical that all pertinent information is gathered to determine eligibility. Please answer the following questions circling on one response per question.

How many bedrooms in your home/apartment?	1 2 3 4 Other _______________
Is the cost for heat included in your rent payment?	Yes No
Are the costs for utilities included in your rent payment?	Yes No
Do you have a subsidy?	Yes No

I have spent or received money from friends or relatives on the following items. Please check all that apply:

- ☐ Dog(s), How many? __________
- ☐ Cat(s), How many? __________
- ☐ Other Pets, Kinds and how many? __________
- ☐ Cable Television, How much do you pay monthly? __________
- ☐ Satellite Television, How much do you pay monthly? __________
- ☐ Internet Service, How much do you pay monthly? __________
  - o Is it required for your work search? Yes No
- ☐ Cellular Telephone, How much do you pay monthly? __________
  - o Is it required for your work search? Yes No
- ☐ Other Utility Bills: Describe __________________________
- ☐ Tobacco Products
- ☐ Alcoholic Beverages
- ☐ Gifts or Presents: Describe __________________________

- ☐ I am willing to do workfare Yes No
  (Workfare means working for the town at minimum wage in exchange for assistance.)
- ☐ I am actively looking for work. Yes No
- ☐ I have registered at the Career Center. Yes No
- ☐ I have applied for (#) _____ of jobs this week, (#) _____ of jobs this past month.

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.

Applicant's Signature: ____ Date: ____________________

TOWN OF WEST PARIS
General Assistance Client Release

Name: ______________________________ Social Security Number: ______________

STATEMENT BY APPLICANT: I understand that the General Assistance Administrator has the right to verify any information necessary to determining my eligibility and hereby give my consent. I understand if I refuse to give my consent, it may result in not being eligible to receive assistance. Therefore, I hereby give my express permission for the General Assistance Administrator to contact the following specific sources or persons to verify any/all informational material to the determination of General Assistance eligibility for my household:

- Any or all persons, organizations, or businesses referenced in this application;
- The applicant/household's past, present and/or future landlord;
- The applicant/household's bank(s) or financial institutions;
- The applicant/household's present, past or potential employer(s).
- The Department of Health and Human Services or any Department of the State of Maine, the Federal Government, or the Town of West Paris, including but not limited to: Probation Officers, Motor Vehicle Department, Social Security Administration, Homeland Security, Immigration & Naturalization, Maine Department of Labor, Unemployment, Vocational Rehabilitation, etc.;
- Area social service agencies;
- Relatives;
- Persons/Vendors to whom the applicant/household owes or regularly pays money, including but not limited to: any utility company, the area fuel dealer(s), automobile dealerships, etc.;
- Any physician who has information related to the ability of the applicant to work or receive other benefits;
- Any subsidized housing programs;
- Attorneys.
- The following specific sources of information (specify):______________________________
____
____

I understand that for the purpose of life and safety reason, and the Town of West Paris Code Enforcement Officer will complete inspection on my unit, if one has not been completed in the past year. I also understand that if I commit General Assistance fraud, information pertaining to the fraud may be released to the Oxford County Sheriff's Department or DHHS fraud investigators. This release is valid for one (1) year from the date signed.

Applicants Signature ______________________________ Date ______________

Administrator Signature ______________________________ Date ______________

Town of West Paris, Maine

General Assistance Minor Form
For applicants under 25 years of age

25 Kingsbury Street, PO Box 247, West Paris, ME 04289
(207) 674-2701 FAX (207) 674-2703

Dear ______________________________

Please be advised that on ___________ your son/daughter, ________________________ contacted this office for General Assistance from the Town of West Paris for basic necessities (i.e. rent, food, household personal items, utilities, heat, medication, etc.) According to Maine law – MRSA, Title 22, Section 4319 – you are legally responsible for providing support for your son/daughter within your financial capabilities.

> MRSA Title 22, Section 4319 states in part, "A parent of a child under 25 years of age living in or owning property in the State shall support their children in proportion to their respective ability." It also states in part, "A municipality or the State, after providing general assistance to a dependent of a legally responsible parent who is financially capable of providing support, may then seek reimbursement or relief for that support by initiating a complaint to the Superior Court or District Court, including by small claims action, located in the division or county where the legally responsible parent resides. The court may cause the legally responsible parent to be summoned and upon hearing or default may assess and apportion a reasonable sum upon those who are found to be of sufficient ability for the support of the eligible person and shall issue a writ of execution.

You will note that a municipality can seek recovery through court action from liable relatives for the amount(s) it has expended for the support of such dependents. To prevent the possible necessity for such legal action, we are requesting that you meet your legal obligation at this time by making financial arrangements to provide any necessary support for your legal dependent while s/he is living outside your home, or that you provide a home for him/her with you. Prior to our office determining eligibility for your dependent minor, you must complete this financial questionnaire and return it to our office as soon as possible.

Sincerely,

Town of West Paris General Assistance

Responsible Relative(s) ______________________________ Relationship ______________

Address ______________________________ Phone ______________

Net Income for Entire Household

Name ______________________ Weekly ________ OR Monthly ________

Name ______________________ Weekly ________ OR Monthly ________

Name ______________________ Weekly ________ OR Monthly ________

Savings Accounts

Name on Account ________________ Bank ________________ Balance ________

Name on Account ________________ Bank ________________ Balance ________

Checking Accounts

Name on Account ________________ Bank ________________ Balance ________

Name on Account ________________ Bank ________________ Balance ________

Please list all of your expenses ____

____

What reason prevents you from keeping your dependent minor at home? ______________________

____

Signature(s) ______________________________

Town of West Paris, Maine
Primary Care Medical Form

Name: ______________________________ Date of Birth: ______________

Physician's Name: ______________________________

Address: ____

I authorize the release of the following medical information to the Town of West Paris:

Signature: ______________________________ Date: ______________

State regulations require that persons receiving assistance work or participate in activities to prepare them for work unless they are physically or mentally incapable of working.
Below to be completed and signed by a licensed physician ONLY:

Specific Medical Problem(s)—please be as detailed as possible: ______________________________

____

____

Date individual was seen for medical condition(s): ______________ Next appointment: ______________

To what extent is the individual able to work or participate in activities to prepare for work (circle one)?

I am unable to make a determination. Reason: ______________________________

The individual is able to work or participate in activities to prepare for work **without restrictions**:
Full time (40 hours/week) Part time at ______ hours/week

The individual is able to work or participate in activities to prepare for work **with restrictions:**
Full time (40 hours/week) Part time at ______ hours/week

Please list restrictions (i.e. sitting, standing, walking, climbing stairs/ladders, kneeling/squatting, bending, pushing/pulling, lifting/carrying): ______________________________

The individual may participate in education/training programs:
Yes No

The individual is **unable** to work or participate in activities to prepare for work at all:
The disability is permanent The disability is not permanent and is expected to last _____ months

Definition of **Disability** under the Social Security Administration Standards: An individual who has a **medically documented physical and/or mental health condition** when prevents him/her from performing **any type of work for at least one year.** Would you advise this person to apply for permanent Social Security Disability benefits? Yes No

Would you recommend any form of rehabilitation for this individual (circle one)?
Vocational Rehabilitation Substance Abuse Mental Health Other ______________

Signature ______________________________ Date ______________
(Licensed Physician)

Town of West Paris
General Assistance
PO Box 247, West Paris, ME 04289
Phone: (207) 674-2701 Fax: (207) 674-2703

Employment Verification Form

Name: ______________________ Social Security #: ______________

Employer: ______________________

Address: ____

I authorize the release of the following information to the Town of West Paris:

Signature: ______________________ Date: ______________

The above named individual has applied to this department for assistance. We ask your cooperation in giving information regarding their employment with you, based on the provisions of MRS, Title 22, §4313. Any information you can give us will be appreciated.

Employer: Please fill in all of the following information:

Date of hire: ______________ Date of first pay: ______________

Hours per Week: ______________ Rate of pay: ______________

Date employment ended: ______________ Date of last pay: ______________

Amount of last pay: ______________

Benefits available for this employee? Please circle all that apply and provide detailed information below:

Worker's Compensation Unemployment Compensation Long-Term Disability Sick Time

Short-Term Disability Personal Time Earned/Unearned Paid Time off Vacation Time

Amount Received: ______________ Monthly Weekly Bi-Weekly

Start Date: ______________ End Date: ______________

Is this employee available for rehire by your company? Yes No Unsure

If unsure, please explain: ____

____

____

If no longer employed (circle one): Fired Quit Laid-Off Other (explain)

____

____

____

Signature: ______________________ Date: ______________

Print Name/Title: ______________________ Phone Number: ______________