

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.** 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 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 (Last name, First name, Middle Initial)		DOB	Social Security Number	Telephone Number	
Mailing Address (Street, City, State, ZIP code)			Length of Residence		
Applicant's Most Recent Previous Address(Street, City, State, ZIP code)			Length of Residence		
Applicant is: <input type="checkbox"/>	Has the applicant ever applied for General Assistance from this or another municipality?		Type of assistance granted	When	
Single	<input type="checkbox"/> Yes <input type="checkbox"/> No		Municipality		
Number in household:	How many are related?	How many are not related?	Total number of people for whom applicant is seeking assistance:		
PEOPLE LIVING WITH THE APPLICANT		RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY #	
1	Name				
2	Name				
3	Name				
4	Name				
5	Name				
NAMES AND ADDRESSES OF SPOUSE, EX-SPOUSE, PARENTS, GRANDPARENTS AND CHILDREN'S PARENTS WHO ARE NOT MEMBERS OF THE HOUSEHOLD					
1	Name	Age	2	Name	Age
Mailing Address			Mailing Address		
Relationship		Telephone Number	Relationship		Telephone Number
3	Name	Age	4	Name	Age
Mailing Address			Mailing Address		
Relationship		Telephone Number	Relationship		Telephone Number

### 2. EMPLOYMENT INFORMATION

A. Is applicant currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, type of job:			
If Yes, Name of Employer	Address of Employer	Length of Employment	
<b>LIST THREE PREVIOUS EMPLOYERS</b>			
1	Name	Address	Length of Employment
2	Name	Address	Length of Employment
3	Name	Address	Length of Employment
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 CareerCenter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	Highest level of education completed	Was applicant in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No Branch _____	
Job Skills			

B. Are any other members of the household employed?  Yes  No If Yes, who and where? (List below)

	HOUSEHOLD MEMBER	EMPLOYER	TOWN/CITY
1	Name		
2	Name		

### 3. ASSISTANCE REQUESTED

ASSISTANCE REQUESTED: Place a check mark next to each type of assistance being requested. Enter the amounts being requested, if known.

✓	ASSISTANCE	AMOUNT	✓	ASSISTANCE	AMOUNT
	1. Food	\$		6. Heating Fuel	\$
	2. Rent	\$		7. Household/Personal Supplies	\$
	3. Mortgage	\$		8. Other (specify)	\$
	4. Electricity	\$		9. Other (specify)	\$
	5. LP Gas	\$		<b>TOTAL ASSISTANCE REQUESTED</b>	\$ 0.00

### 4. 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, if they pool their income. Check how often income is received.

TYPE OF INCOME	YES NO	MONEY APPLICANT RECEIVES		MONEY FAMILY RECEIVES		MONEY OTHERS RECEIVE		OFFICE USE ONLY
		AMOUNT	HOW OFTEN	AMOUNT	HOW OFTEN	AMOUNT	HOW OFTEN	MONTHLY TOTAL
A. Employment	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
B. TANF	<input type="checkbox"/> <input type="checkbox"/>		Monthly	\$	Weekly		Weekly	\$
C. Social Security	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
D. Military/ Veterans Benefits	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
E. Retirement or Pension Plan	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
F. Unemployment Benefits	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
G. Worker's Compensation	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
H. Child Support/ Alimony	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
I. SSI—Supplemental Security Income	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
J. Bank Accounts & Cash on Hand	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
K. Income from Relatives	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
L. Other (please specify)	<input type="checkbox"/> <input type="checkbox"/>		Weekly	\$	Weekly		Weekly	\$
<b>For Repeat Applicants Only:</b>								
M. Investment Asset(s) Value (See Section 5, C)								\$
N. Misspent Income & Unverified Expenditures (during the last 30 days)								\$
<b>SUBTOTAL – MONTHLY HOUSEHOLD INCOME</b>								\$ 0.00
O. LESS: Total monthly work-related expenses (i.e., actual work-related travel up to ordinance maximums, work-related child care, etc.)								\$
<b>TOTAL – MONTHLY HOUSEHOLD INCOME</b>								\$ 0.00

### 5. ASSETS

Assets: Check yes or no for each asset owned and enter the value. Enter who in the household owns the asset.			
TYPE OF ASSET	YES	NO	ASSET OWNED BY
A. Home	<input type="checkbox"/>	<input type="checkbox"/>	
B. Real Estate (other than home)	<input type="checkbox"/>	<input type="checkbox"/>	
C. Investments: Stocks, Bonds, Retirement Account(s), Life Insurance, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
D. Vehicle(s) (e.g., car, truck, motorcycle)	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
E. Recreational Vehicle(s) (e.g., camper, ATV, snowmobile, boat)	<input type="checkbox"/>	<input type="checkbox"/>	
F. Other	<input type="checkbox"/>	<input type="checkbox"/>	

### 6. EXPENSES

MONTHLY EXPENSES	ACTUAL COST FOR NEXT 30 DAYS	ALLOWED AMOUNT	OFFICE USE ONLY
1. Food	\$	\$	
2. Rent	NAME AND ADDRESS OF LANDLORD: \$	\$	
3. Mortgage – MORTGAGE HOLDER:	\$	\$	
4. Electricity	\$	\$	
5. LP Gas	\$	\$	
6. Heating Fuel	TYPE: (i.e., oil, electricity, etc.) \$	\$	
7. Household/Personal Supplies	\$	\$	
8. Other Basic Needs (please specify)	\$	\$	
	\$	\$	
<b>TOTAL MONTHLY HOUSEHOLD EXPENSES:</b>	\$ 0.00	\$ 0.00	

### 7. 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 (e.g., 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		\$

B. Do you owe any doctors, or have any medical bills?  Yes  No

If Yes, give name and amount (list below)

DOCTOR'S NAME	AMOUNT	DOCTOR'S NAME	AMOUNT
1	\$	2	\$

**8. DEFICIT**

A. Overall Maximum Level of Assistance Allowed (See GA Ordinance Appendix A)	\$
B. Income (See Section 4)	\$ 0.00
C. Result (Line A minus line B)	\$ 0.00

D. Deficit (If line A is greater than line B)	\$
E. *Surplus (If line B is greater than line A)	\$
* NOTE: If a surplus exists, applicant is not eligible for regular GA. Proceed to Section 9 to determine if "unmet need" results in eligibility for "emergency" GA.	

**9. UNMET NEED**

A. Allowed Expenses (See Section 6)	\$ 0.00
B. Income (See Section 4)	\$ 0.00
C. Result (Line A minus line B)	\$ 0.00

D. Unmet Need (Amount from line C, but <u>only</u> if line A is greater than line B)	\$
E. Deficit (See Section 8, line D)	\$
F. Amount of GA Eligibility (The lower of line D and line E)	\$

**INSTRUCTIONS:**

- 1) If Section 8, 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 9, 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 9, line D) and a "Deficit" (Section 9, 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 (e.g., if the applicant needs one week's worth of GA assistance, they should receive 1/4 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 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 landlord;
- bank(s) or financial institutions;
- the Department of Human Services or any department of the State of Maine;
- the area CAP agency;
- relatives, specify: \_\_\_\_\_
- persons/vendors to whom I owe money (e.g., utility company, fuel dealer, car dealership);
- physician(s) with information related to my ability to work or receive other benefits: \_\_\_\_\_
- the following specific sources of information: \_\_\_\_\_

Applicant's Signature: _____	Date: _____
Administrator's Signature: _____	Date: _____