TOWNSHIP GENERAL ASSISTANCE OFFICE

2323 South Fourth Street
DeKalb, IL 60115

Phone: (815) 758-8282
Fax: (815) 758-0124

ATTENTION: PLEASE READ COMPLETELY

If you are requesting Financial Aid to meet basic maintenance needs on a monthly basis (General Assistance), there are a few things you need to understand before you begin the application process.

- General Assistance (GA) is a public assistance program mandated by state law for qualified individuals with financial needs.
- GA can provide monthly payments (flat grant) to help individuals meet basic needs.
- Eligibility for the GA program is based on income, assets, residency, and cooperation with the program.
- An applicant must have no minor children under 18 unless applicant is the non-custodial parent.
- Applicants **must** apply for all benefits they may be entitled to. This includes Unemployment, TANF (Cash Assistance), SNAP (Food Assistance), child support (if this applies to you), etc.
- The General Assistance program has work requirements. Please refer to the following documents in this application for more information*: Assistance Job Search Requirements, Notice of Rights and Responsibilities of Community Work Program Participants, and Agreement to Participate in the Community Work Program.*
- If you are unable to work due to a disability, medical documentation and proof of filing for Disability and/or SSI are required.
- Documents on the Verification Request Form (included in application) are required by the State of Illinois General Assistance Handbook and are **required** to make a determination of eligibility.
- Applicants must meet all financial and non-financial eligibility requirements.
- Individuals approved for GA are required to participate in monthly redeterminations.
- Noncooperation with program guidelines may result in discontinuation of benefits.
- General Assistance and Emergency Assistance cannot be issued at the same time.

How to Apply for Assistance:

1. Fill out the application documents as completely as possible. Sign all documents. If you need assistance with completing the application, call us at 815-758-8282 and we will schedule a time to assist you.
2. Collect all documents listed on the Verification Request Form (included in your application).
3. When you have completed steps 1 and 2, call the General Assistance office to schedule an applicant interview. Bring completed application and all documents to the interview.

APPOINTMENT POLICY: Your appointment is scheduled at a set time, if you are more than 15 minutes late, you will need to reschedule your appointment by calling our office at 815-758-8282.

DEKALB TOWNSHIP GENERAL ASSISTANCE OFFICE
Mary Hess, Supervisor

2323 S. Fourth Street
DeKalb, IL 60115

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VERIFICATION REQUEST FORM

CLIENT: _____

In order to process your application, the following verifications are required. Inform the Caseworker if an item does not apply to you.

1. Application completed with date and signature
2. Assets: Stocks, Bonds, CD's, 401(k), Money Markets, Annuities, etc.
3. Bank Statements for all accounts (checking, savings, credit union, prepaid bank card) held individually or jointly
4. Birth Certificates for all household members
5. DHS benefits letter or application receipt for AABD, RRA, SNAP & TANF
6. Drivers License or State ID for each adult in the unit
7. Eviction Notice or Landlord Statement
8. Lease, Mortgage Statement, letter from landlord, or rent receipt
9. Legal Permanent Residency Card or Naturalization Certificate if born outside of US
10. Life Insurance Policies
11. Marriage Certificate, Divorce Decree or Legal Separation documents, including Child Support Order
12. Medical Insurance Card or current Medicaid Card
13. Prison, Parole or Probation Records
14. Proof of Income for the last 30 days from all sources, including paystubs and/or gifts from friends or relatives
15. Proof of payments received in the last 30 days from Child Support, Social Security, Pensions,
16. Social Security Cards for all household members
17. Social Security/SSI Award Letter or application receipt
18. Title, Registration, or Payment Book for all vehicles
19. Utility Bills
20. Verification of Unemployment Compensation (dated within the last 30 days)
21. W-2 form(s) and completed tax return **(required if applying between February 1 - July 1)**
22. Worker's Compensation documents

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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 medial 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 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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STATEMENT OF PURPOSE FOR COLLECTION OF SOCIAL SECURITY NUMBERS IDENTITY PROTECTION POLICY

The Identity Protection Act, 5 ILCS 179/1 et seq., requires each local and State government agency to draft, approve, and implement an Identity Protection Policy that includes a statement of the purpose or purposes for which the agency is collecting and using an individual's Social Security number (SSN). This statement of purpose is being provided to you because you have been asked by the Township to provide your SSN or because you requested a copy of this statement.

Why do we collect your Social Security number?

You are being asked for your SSN for one or more of the following reasons:

- Crime victim compensation;
- Vendor services, such as executing contracts and/or billing;
- Law enforcement investigation;
- Child support investigation;
- Internal verification;
- General Assistance;
- Administrative services; and/or
  Other:

What do we do with your Social Security number?

- We will only use your SSN for the purposes for which it was collected.
- We will not:
  - Sell, lease loan, trade, or rent your SSN to a third party for any purpose;
  - Publicly post or publicly display your SSN;
  - Print your SSN on any card required for you to access our services;
  - Require you to transmit your SSN over the Internet, unless the connection is secure or you SSN is encrypted; or
  - Print your SSN on any materials that are mailed to you, unless State or Federal law requires that your number be on documents mailed to you unless we are confirming the accuracy of your SSN.

If you have questions regarding the Identity Protection Policy, please contact the Township representative who issued this form to you.

Name: _____

Signature: _____ Date: _____

Issued By: _____ Date: _____

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AGREEMENT TO COOPERATE WITH SPECIAL SERVICE REFERRALS

I, _____, am (an applicant for / a recipient of) General Assistance (GA), I hereby agree to participate in and cooperate with any special service referrals by the General Assistance Office. I acknowledge that the General Assistance Office's participation and cooperation requirements have been explained to me and I understand that I am required to participate and cooperate in good faith with any special service referrals for medical, psychological, vocational or other services which are designed to enhance and increase my ability to secure and keep gainful employment. I also acknowledge that I am aware that such participation and cooperation includes arriving at the scheduled time and remaining until the services have been rendered by the designated provider and that any unauthorized departure will constitute a missed appointment and non-cooperation.

I understand that my failure or refusal to comply with my obligations or any of the requirements under the Community Work Program will result in a denial of my Application for General Assistance or a termination of my General Assistance benefits and may also result in my being ineligible for General Assistance for a period of 90 days.

Signature: _____ Date: _____

Address: _____

_____

_____

_____

Phone: _____

Witness: _____ Date: _____

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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.

(NEXT PAGE)

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, address and local number of the union, if any, and (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: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), DEKALB TOWNSHIP may use and disclose protected health information about you for purposes of treatment or healthcare operations. We may also use and disclose protected health information for other purposes that are permitted or required by law as described below.
- Protected health information (PHI) is individually identifiable health information collected from you that is created or received by a health care provider, a health plan, or a health care clearinghouse, and that relates to your past, present or future physical or mental health condition, the provision of health care to you, or payments for the provision of health care for you.
- Access to PHI is restricted to persons who need it to carry out their job duties in administering health care. Use and disclosure is limited to the minimum necessary to accomplish the intended purpose.

Our Responsibilities

In accordance with the law, we are required to implement reasonable measures to preserve the privacy of your PHI and to provide notice to you regarding:

1. Uses and disclosures of PHI;
2. Obligations of the department relating to the privacy of your PHI;
3. Your health information rights concerning your PHI;
4. Your right to file a complaint with the privacy officer or the Secretary of the US Department of Health and Human Services and
5. Contact information with respect to DEKALB TOWNSHIP's policies and procedures for handling PHI. The township is required to abide by the terms of this Notice until a revised notice is issued in accordance with HIPAA.

Your Rights With Respect to PHI

You have the following individual rights with respect to your PHI:

1. You have the right to access your PHI as long as we maintain the PHI.
2. You may request an amendment to the information if you believe the PHI is incorrect or incomplete. The Township is not required to agree to the amendment, but you have a right to submit a statement of disagreement to be kept with the disputed record.
3. You have the right to request restrictions on certain uses and disclosures of PHI. Under certain circumstances, the Township is not required to comply with your request, and you will be notified of what is denied.
4. You have a right to an accounting of certain disclosures of your PHI if your PHI has been disclosed for reasons other than treatment, payment for health care or healthcare operations. To exercise these rights, you may write to the address at the bottom of this notice.

How Your PHI May Be Used

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services.

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Payment: While the Township generally does not engage in billing, the Township is permitted to use or disclose your PHI for that purpose.

Health Care Operations: The Township may use and disclose PHI about you for day-to-day operations included, but not limited to, quality assessment activities, employee review activities, and training of employees.

Business Associates: The Township may use and disclose your PHI to business associates to facilitate health care, payment or as necessary health operations.

Required By Law: The Township may use or disclose PHI about you as required by state and federal law. For example, the Township may disclose your PHI when required by national security laws or public health disclosure laws. The Township is required to disclose your PHI to the Secretary of the US Department of Health and Human Services when the Secretary is investigating or determining the Department's compliance with HIPAA.

Legal Proceedings: The Township may disclose your PHI as required by law in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, and in response to a subpoena, discovery request, or other lawful process under the conditions required by applicable law.

Worker's Compensation: The Township may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work related injuries.

Other Permitted Uses and Disclosures: The law permits the Township to make the following types of uses and disclosures under certain circumstances. While the Township generally does not disclose PHI for these purposes, they may disclose PHI to a health oversight agency (such as Medicare or Medicaid); for government functions (for reasons of national security); to avert a serious health or safety threat, or for postmortem identification.

Other Uses: Other uses and disclosures require your written authorization. If such authorization is given, you may revoke it at any time in writing, and this revocation will be in effect for future uses and disclosure of PHI requiring authorization.

Complaints and Inquiries
You may file a complaint with the Township Privacy Officer or the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Township, you may write to the address below. You will not be retaliated against for filing such a complaint.

Future Changes In the Notice
DEKALB TOWNSHIP reserves the right to change their privacy practices and the terms of this Notice, making the new notice provisions effective for all PHI maintain by the Department.

Contact Information
For assistance, you may contact the Township Supervisor at:

DEKALB TOWNSHIP
2323 S. Fourth Street
DeKalb, IL 60115
(815) 758-8282

I have received a copy of the DEKALB TOWNSHIP Notice of Privacy Practices on _____ (Date).

Signature: _____ Date: _____

Please print your name: _____

DEKALB TOWNSHIP GENERAL ASSISTANCE OFFICE
Mary Hess, Supervisor

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ASSISTANCE JOB SEARCH REQUIREMENTS

The Public Aid Code, State of Illinois, requires unemployed General Assistance individuals to register for work, to seek work, to accept jobs, and to participate in work programs as a condition for assistance. The General Assistance Job Search Program is administered by DEKALB TOWNSHIP.

The General Assistance Job Search Program consists of the following:

JOB SEARCH: After your application for General Assistance is approved, you will be required to look for employment on your own. You will be required to make at least **20** employment applications every month. You will be required to fill out a Job Search Form including the company phone number.

We will accept half of the required applications as on-line applications, but only if verification is provided that application was filed an accepted. If you apply at a local business, and they instruct you to apply through the internet, have the business stamp the job search sheet and indicate on-line application required and you must run off the verification of an on-line application and supply with your job search sheet.

COOPERATION: A General Assistance client must:

- **Maintain current registration for employment with IDES**
- **Turn in a Job Search Form every due date**
- **Accept a job referral or offer as a condition of GA eligibility**
- **Report when he/she finds a job**

APPLICANTS/RECIPIENTS: Failure to do so will result in **DENIAL OF THE APPLICATION OR THE TERMINATION OF THE ASSISTANCE** and you will be **INELIGIBLE** to receive **GENERAL ASSISTANCE** for a period defined by the **GENERAL ASSISTANCE OFFICE** .

I UNDERSTAND THE ABOVE AND AGREE TO THE STIPULATIONS.

Signature: _____ Date: _____

Client: _____

Address: _____

_____

_____

_____

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NOTICE OF RIGHTS AND RESPONSIBILITIES OF COMMUNITY WORK PROGRAM PARTICIPANTS

As a participant in the Community Work Program, you have the following rights and responsibilities.

RIGHTS

1. To be notified of a work or training assignment at least 24 hours in advance of the time the work or training assignment is scheduled to begin.

2. To be required to work no more than 8 hours a day and 40 hours a week.

3. To be required to work only enough hours as are sufficient to offset the amount of your monthly General Assistance benefits, based on the prevailing minimum wage.

4. Not to be required to perform work or engage in training involving a substantial threat to your health or safety.

5. To be paid by a sponsor at no less than the prevailing minimum wage if you work for a sponsor more than 8 hours a day, 40 hours a week or beyond the hours you are required to work by the General Assistance Office.

6. To be provided with proper and safe clothing and equipment to perform any work or engage in any training.

7. To be treated like a regular employee or trainee.

8. Not to be discriminated against because of your race, religious beliefs, color, sex, marital status, sexual preference, national origin, age, handicap or political affiliation.

9. To appeal any action, inaction or decision of the General Assistance Office with regard to your participation in the Community Work Program.

RESPONSIBILITIES

1. To sign an Agreement to Participate in the Community Work Program.

2. To participate in and cooperate with the Community Work Program.

3. To timely keep all Community Work Program appointments and interviews.

4. To accept training and work assignments from the General Assistance Office.

5. To make at least twenty (20) job applications a month if you participate in the JSTW program.

6. To report for work or training every day you are scheduled for work or training and not leave a worksite or training site without permission.

7. To contact both the General Assistance Office and the sponsor if you cannot or will not report for work or training.

8. To submit to a complete physical and mental examination at the request of the General Assistance

(NEXT PAGE)

Office.

9. Not to use drugs or alcoholic beverages at a worksite or training site and not to report for work or training in an unfit condition because you took drugs or alcohol.

10. To comply with all orders and directions by those in charge at a worksite or training site.

11. To comply with all worksite and training site rules.

12. To report on time for all work and training assignments.

13. To cooperate and get along with people at a worksite or training site.

14. Not to endanger yourself or others at a worksite or training site.

15. To comply with all municipal ordinances and state and federal laws while at a worksite or training site.

16. To immediately report all worksite and training site accidents and injuries to the General Assistance Office.

17. To satisfactorily complete all work and training assignments.

18. To provide a doctor's statement for all occasions you fail to report, leave or are excused from work or training because of illness or disease.

19. To make-up all work and training hours lost because you were excused from work or training.

20. To notify the General Assistance Office when problems or disputes arise at a worksite or training site.

21. To sign an Agreement to Cooperate with Special Service Referrals and to participate in and cooperate with any special service referrals.

I acknowledge receipt of a copy of this Notice of Rights and Responsibilities of Community Work Program Participants.

Signature: _____ Date: _____

FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Case #: _____

Notice of Rights Given On: _____

Notice of Rights Given By: _____

DEKALB TOWNSHIP GENERAL ASSISTANCE OFFICE
Mary Hess, Supervisor

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AGREEMENT TO PARTICIPATE IN THE COMMUNITY WORK PROGRAM

I, _____, am an (applicant for / recipient of) General Assistance (GA). I hereby agree to participate in and cooperate with the Community Work Program.

I acknowledge that the rules and regulations of the Community Work Program have been explained to me, as have the procedures by which I shall be assigned to a worksite or a training site.

I also acknowledge that I have received a copy of a written Notice of Rights and Responsibilities of Community Work Program Participants. I understand that my failure or refusal to comply with my obligations or any of the requirements under the Community Work Program will result in a denial of my Application for General Assistance or a termination of my General Assistance benefits and may also result in my being ineligible for General Assistance for a period of 90 days.

I am signing this Agreement freely and voluntarily.

Signature: _____ Date: _____

Address: _____

_____

_____

_____

Phone: _____

Witness: _____ Date: _____