Town/City of_____ 06/21/24

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. Whoever knowingly and willfully makes any false representation of a material fact to the overseer of any municipality or to the department or its agents for the purpose of causing that or any other person to be granted assistance by the municipality or by the State is guilty of a Class E crime and shall reimburse the municipality for that assistance. Further assistance may be denied until that person reimburses the municipality for the assistance or enters into a written agreement, which must be reasonable under the circumstances, to reimburse the municipality or that person has been ineligible for assistance for a period of 120 days, whichever period is longer. (22 M.R.S.A. § 4315).

1. HOUSEHOLD (Please type or print)

Name of Applicant:	Date of Birth:	Social Security Number:	Household size: (Total people in household)
Mailing Address:			Number of people seeking assistance:
Physical Address:			
Telephone number:			Applicant Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Most recent previous address:			
Previous GA application made? ☐ YES ☐ NO	When?	Where?	
Is anyone in the household currently disqualified from receiving GA? ☐ YES ☐ NO If yes, who?	When?	Reason for disqualification?	

PEOPLE LIVING IN THE HOUSEHOLD	RELATIONSHIP	DATE OF BIRTH	BIRTHPLACE	SOCIAL SECURITY NUMBER	Able Bodied (A) Disabled (D) Minor(M)/Vet (V)

2. HOUSEHOLD INFORMATION

Does everyone in the household receive SNAP benefits? ☐ YES ☐ NO	Does everyone in the household have Maine Care? ☐ YES ☐ NO	Has your household applied for LIHEAP? ☐ YES ☐ NO	Have you reached the TANF 60 month time limit? ☐ YES ☐ NO	Is anyone sanctioned by TANF? ☐ YES ☐ NO
Does anyone in the household have a warrant for their arrest as a result of a felony conviction? ☐ YES ☐ NO	Did you or anyone in your household serve in the U.S. Military? ☐ YES ☐ NO	Has your household filed an income tax return? ☐ YES ☐ NO If yes, list date and amount:	Do you have subsidized housing? ☐ YES ☐ NO If yes, list your monthly amount:	
	Has anyone applied for a VA Pension?	Has anyone received an income tax refund? Date: Amount:	Has anyone received a lump sum? Date: Amount:	
Is everyone in the household a U.S. Citizen? ☐ YES ☐ NO NOTE: If any household member does not have permanent status, affidavit must be completed.		Is any other person, or agency assisting with your household expenses (rent, electric, heat etc.)? If yes, please explain:		

NAMES AND ADDRESSES OF EMERGENCY CONTACTS WHO ARE NOT IN THE HOUSEHOLD (PARENTS, GRANDPARENTS AND ADULT CHILDREN WHO ARE NOT MEMBERS OF THE HOUSEHOLD)

1. Name:		2. Name:	
Mailing Address:		Mailing Address:	
Relationship:	Telephone #:	Relationship:	Telephone #:

3. EMPLOYMENT INFORMATION – APPLICANT

Section 3-A **Complete section 3-A if one or more members of your household are employed.**

Currently employed household member #1:	**Currently employed household member #2:**
Name:	Name:
Employer:	Employer:
Date of last paycheck:	Date of last paycheck:
Amount of last paycheck:	Amount of last paycheck:
Date of next paycheck:	Date of next paycheck:
Additional Comments:	

Section 3-B **Complete section 3-B if one or more members of your household are able to work but are unemployed.**

Able-Bodied unemployed household member #1:	**Able-Bodied unemployed household member #2:**
Name:	Name:
Previous Employer #1:	Previous Employer #1:
Reason Job Ended:	Reason Job Ended:
Last Date of Employment:	Last Date of Employment:
Previous Employer #2:	Previous Employer #2:
Reason Job Ended:	Reason Job Ended:
Last Date of Employment:	Last Date of Employment:
Highest Level of Education Completed:	Highest level of Education Completed:
Additional Comments:	

Section 3-C **Complete section 3-C if one or more members of your household are unable to work for medical reasons.**

Disabled unemployed household member #1:			**Disabled unemployed household member #2:**		
Name:			Name:		
Disability preventing work?	☐ YES	☐ NO	Disability preventing work?	☐ YES	☐ NO
Medical statement verifying?	☐ YES	☐ NO	Medical statement verifying?	☐ YES	☐ NO
Active SSI/SSDI application?	☐ YES	☐ NO	Active SSI/SSDI application?	☐ YES	☐ NO
Completed IAR on file?	☐ YES	☐ NO	Completed IAR on file?	☐ YES	☐ NO
Do you have an attorney?	☐ YES	☐ NO	Do you have an attorney?	☐ YES	☐ NO
What stage are you at in your application for SSI?SSDI?			What stage are you at in your application for SSI?SSDI?		
Additional Comments:					

4. ASSISTANCE REQUESTED

ASSISTANCE REQUESTED: Please list 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**	**$**

5. USE OF INCOME - REPEAT APPLICANTS ONLY - PRIOR 30 DAYS (Office use only)

Income:	$			
	$			
	$			
Total: (A)	$			
Household Receipts			**Other Receipts**	
Food	$		Phone	$
Housing	$		Internet	$
Electricity	$		Cable/Subscription Services	$
Propane	$		Alcohol/Tobacco	$
Heating Fuel	$		Restaurants/Entertainment	$
Household	$		Vacations/Travel	$
Personal	$		Pet Food	$
Prescriptions/Medical	$		Fines/Bails	$
Water	$		Other:	$
Sewer	$			$
Other:	$		**Total: (C)**	$
	$			
	$		**Total Income: (A)**	$
Total: (B)	$		**Less Household Receipts: (B)**	$
Notes:			**Total Other Receipts: (C)** (Misspent Money)	$
			D. Unaccounted Money (A)-(B)-(C)	$
			E. Total of Misspent + Unaccounted (Added to Line O, section 6): **(C + D)**	$

6. PROJECTED 30 DAY INCOME

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. SSI – Supplemental Security Income	$		$		$		$
D. State Supplement ($10 if receive SSI)	$		$		$		$
E. Social Security (other)	$		$		$		$
F. Unemployment or Workers Comp	$		$		$		$
G. Military/Veteran Benefits	$		$		$		$
H. Retirement or Pension Plan	$		$		$		$
I. Child/Spousal Support	$		$		$		$
J. Bank Accounts and Cash On Hand	$		$		$		$
K. Income In Kind	$		$		$		$
L. Post-Secondary financial aid, grants	$		$		$		$
M. Other (please specify)	$		$		$		$
For Repeat Applicants Only: N. Investment Asset(s) Value (See Section 7, C)							$
O. Misspent Income & Unverified Expenditures (during the last 30 days) (See Section 5, Line E)							$
SUBTOTAL – MONTHLY HOUSEHOLD INCOME							$
P LESS: Total verified monthly work-related expenses: Child Care: $_____ Mileage: (RT miles ____* # of days a week: * # of weeks per month: * ordinance mileage:)= 0.00 Other:							$
TOTAL – MONTHLY HOUSEHOLD INCOME							$

7. 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 vehicles	$	
E. Recreational Vehicle (s) (i.e., camper, ATV, snowmobile, boat)	$	
F. Other	$	

8. EXPENSES

MONTHLY EXPENSES	ACTUAL COST FOR NEXT 30 DAYS	MAXIMUM AMOUNT (OFFICE USE ONLY)	ALLOWED AMOUNT (OFFICE USE ONLY)
1. Food	$	$	$
2. Rent – Number of Bedrooms: 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 essential needs (specify)	$	$	$
	$	$	$
TOTAL MONTHLY HOUSEHOLD EXPENSES	**$**	**$**	**$**

9. 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.		**$**

10. 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 6)	**$**		E. ***Surplus** (If line B is greater than line A)	**$**
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	

11. UNMET NEED (Office use only)

A. Allowed Expenses (See Section 8)	**$**		**D. Unmet Need** (Amount from line C, but only if line A is greater than line B)	**$**
B. Income (See Section 6)	**$**		**E. Deficit** (See Section 10, line D)	**$**
C. Result (Line A minus line B)	**$**		**F. Amount of GA Eligibility** (The lower of line D and line E)	**$**

INSTRUCTIONS:

1) If Section 10, 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 11, 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 11, line D) and a "Deficit" (Section 11, 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:_____

Secondary Applicant's Signature: _____ Date: _____

Administrator's Signature:_____ Date:_____