Town of Winslow

General Assistance Office

114 Benton Ave, Winslow, ME 04901
(207) 872-2776 ext. 5209 FAX (207) 872-1999

The following items of documentation must be brought with you to your appointment. Documentation is necessary to determine your household's eligibility for assistance. Returning applicants are required to show any income received was spent on necessities.

Proof of Income:

____check stubs or copies of checks
____employer statement of earnings
____child support stubs or copies of checks
____verification of applying for or receiving TANF and/or Food Supplement (SNAP)

Receipts:

____rent receipt showing amount paid for rent/security deposit
____utility receipts: CMP, oil/gas, water, sewer, (phone/cable/satellite not eligible)
____grocery receipts
____other receipts for basic needs (medication, childcare, diapers etc.)

Proof of Identity (first time applicants):

____driver's license of applicant and all other household members
____social security cards for all household members
____other picture ID or Birth Certificate for those without driver's license

Other Documentation:

__Eviction Letters
__Landlord Form & Lease
__Letter from Shelter
__Dr.'s note or Form
__Employer Form
__Minor Form
__Register at Career Center
__EBT Card
__Disconnect Notice
__Court Documents
__Unemployment benefit form
__Social Security Benefit Statement
__ Income Tax Return/Refund Receipts
__Bank Statement
__ ____
____

APPOINTMENT DATE: ________________TIME:____________________

It is *your* responsibility to be on time and have with you all necessary documents and information. Please note that a reschedule for a missed or late appointment can take more than a week. If you cannot make your appointment, please call this office as soon as possible at 872-2776 ext. 5209.

Town/City of: **WINSLOW**

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? 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:			

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:	$		**(Use of income may not bar eligibility for applicants in a life threatening emergency or initial applicants)**	
	$			
	$			
Total: (A)	$			
Household Receipts			**Other Receipts**	
Food	$		Phone	$
Housing	$		Internet	$
Utilities	$		Cable	$
Propane	$		Tobacco	$
Fuel	$		Alcohol	$
Household	$		Magazines	$
Personal	$		Pet Food	$
Med/Presc.	$		Fines/bails	$
Water	$		Other:	$
Sewer	$			$
Other:	$		**Total: (C)**	$
	$		**Total Income: (A)**	$
Total: (B)	$		**Less Total Receipts: (B)**	$
Notes:			**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 – **Number of Bedrooms**: **Name & 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)	**$**		**D. Unmet Need** (Amount from line C, but <u>only</u> if line A is greater than line B)	**$**
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 Winslow
General Assistance Office
Lisa Gilliam, General Assistance Administrator (207) 872-2776 ext. 5209
114 Benton Ave, Winslow, ME 04901
FAX (207) 872-1999

EMPLOYMENT VERIFICATION FORM

Date: ____________________

RE: ____

Dear Employer,

The above named individual has applied to this office for assistance. We ask for your cooperation with providing information regarding his/her current or previous employment with you. We request this information pursuant to Maine law – **M.R.S.A. Title 22, Section 4314 (3)**.

Sincerely,
Town of Winslow Maine General Assistance Office

Date First Worked ______________ Date of First Paycheck ____________ Net Amount _____________

Date Last Worked ______________ Date of Last Paycheck ____________ Net Amount _____________

Date(s) of Any Future Outstanding Paychecks _____________________

Hourly Rate __________________ Avg Hours per Week _____________ Paid (circle) wkly / bi-wkly

Reason(s) for Separation ____

If this person is currently out of work and receiving Worker's Compensation Benefits, please complete the following:

Benefit Start Date __________ Net Amount of Weekly Benefit _____________ Expected Return _____________

Please list each date this individual has received a check from your company and the net amount paid for the dates indicated below:

Period of Inquiry _____________ to ______________

Pay Date __________ Net Amount __________ Pay Date __________ Net Amount __________

Pay Date __________ Net Amount __________ Pay Date __________ Net Amount __________

Pay Date __________ Net Amount __________ Pay Date __________ Net Amount __________

Signed _____________________________________

Business _____________________________________

Address _____________________________________

____

Phone _____________________________________

Client Signature _____________________________________

Town of Winslow
General Assistance Office
Lisa Gilliam, General Assistance Administrator (207) 872-2776 ext. 5209
114 Benton Ave, Winslow, ME 04901
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GENERAL ASSISTANCE RENTAL INFORMATION AGREEMENT

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND RETURNED IN PERSON OR VIA FAX 872-1999

Tenant's Name__________________________ Telephone #________________________Cell Phone #_________________

1. Address of rental Unit____Apt#________Floor:_____
   Number of Bedrooms____________________
2. What is the landlord's name (person or firm who owns the building)? __________________________________
   Home phone #_____________________Business phone#________________________Cell phone#____________
3. **Make check payable to:** Name____

   Address____ City/State/Zip_________________________________
4. Owner's Social Security # or Taxpayer Identification # ____
   May be given later for confidentiality purposes but is required. (Social Security # or Taxpayer Id # must coincide with the name provided in #3)
5. What is the unit manager's name? ____
   Home phone#___________________Business phone #___________________Cell phone #_____________________
6. Rent amount $____________ Does this renter have a subsidy? YES NO What is tenant's portion? __________
   (Any attempt to collect rent over the above contracted amount, when the tenant is receiving City assistance, will disqualify a Vendor from receiving any future General Assistance rental payments.)
7. What utilities are included in the rent? (please circle) water, sewer, hot water, electric, gas for cooking, heat
8. How is the unit heated? (please circle) Electric, Gas, Oil, Kerosene, Other _________________________________
9. Number of tenants occupying this unit: ______________
   Names of those occupying this unit: ____
   ____
   ____
10. If occupying unit – when did tenant move in? _____________ If not, when is unit available? _________________
11. Does a relative of the tenant own or have a legal interest in the property? Yes ___ No ___
12. If you are a LLC, are you a sole proprietor (single owner) requiring a 1099? Yes ___ No ___

Applicants receive a written decision stating whether assistance has been granted and the amount of the assistance.

***I certify that this unit meets all State and Local licensing land use codes, and that this unit includes working carbon monoxide and smoke detectors, which meet State codes.**

NOTICE; This Rental Information Agreement is not intended to imply that the prospective tenant is either eligible for assistance or that they will necessarily be renting an apartment from you. All rental payments are made directly to the landlord, not the tenant and that payments can take several weeks.

The Town of Winslow will not discriminate on account of sex, sexual orientation, age, race, religion, disability, or political affiliation.

____ ____________________

Landlord Signature **Date**

TOWN OF WINSLOW

GENERAL ASSISTANCE OFFICE
114 BENTON AVENUE WINSLOW, ME 04901
PH: 207 872-2776 EXT. 5209 FAX 207 872-1999
LISA GILLIAM, GENERAL ASSISTANCE ADMINISTRATOR

MEDICAL STATEMENT

TO: ______________________________ DATE: ____________________

CLIENT NAME: ______________________________ DOB: ____________________

CLIENT ADDRESS: ____

CLIENT SIGNATURE: ______________________________

The above named client of the **Winslow General Assistance** program stated she/he is unable to work. In order to determine the eligibility of the client to receive assistance she/he is requesting, we need the following information:

1. Nature and extent of the illness, disability or injury: ______________________________

   ____

2. In your opinion, is the client able to:

	YES	YES (w/ limitation)	NO
Work at a regular job?	____	____	____
Seek employment?	____	____	____
Attend school or training?	____	____	____
Engage in municipal workfare?	____	____	____
Engage in volunteer work?	____	____	____

   If **YES w/ limitations**, please state the limitations (i.e. light duty, limited hours/days, lifting restrictions, etc.)

   ____

   ____

3. If disabled, please provide the length of time the client will be unable to perform items under #2 above:

   ____

4. If disabled, would the client benefit from the services of the Department of Vocational Rehabilitation?

   ____

5. In your opinion, should the client apply for Social Security disability benefits? ____________________
6. Does this medical condition require medication? (Please specify) ____________________

   ____

7. If the client is not considered to be disabled, what can s/he do to help him/herself become work-ready:

   ____

8. Date of last evaluation for disability: ______________________________
9. Additional comments/information, if applicable:______________________________

   ____

Doctor's Name (please print): ______________________________

Doctor's Signature: ______________________________ Date: ____________________

Agency: ______________________________

Any information you provide is confidential by Maine State Statute. The Winslow General Assistance Office has asked the client to see that this information is returned as soon as possible. Thank you for your cooperation. The information may be returned via FAX, mail or as a Word or PDF attachment to lgilliam@winslow-me.gov .