**TOWN OF ORONO, MAINE** **BY APPOINTMENT ONLY – CALL (207)866-2556**

# APPLICATION FOR GENERAL ASSISTANCE *(Please refer to Page 5 for Burials)*

**PENALTY FOR FALSE REPRESENTATION**. Whoever knowingly and willfully makes any false representation of a material fact for the purpose of causing that or any other person to be granted assistance by the municipality 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 assistance or enters into a written agreement, which must be reasonable under the circumstances, to reimburse or that person has been ineligible for assistance for a period of 120 days, whichever period is longer. (22 M.R.S.A. § 4315**).**

**TYPE: In-person / Phone Interview** **Date / Time of Appointment: _____**

## 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) | | Has anyone in the HH ever applied for GA in the past? **YES or NO** | If yes, Where: / When: | Type of Assistance Received: |
|---|---|---|---|---|
| Single | Married | | | |
| Divorced | Separated | | | |
| Widowed | | | | |

| | | | | |
|---|---|---|---|---|
| Does anyone in your household have a warrant for their arrest because 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? |
| Did you or anyone in your household serve in the U.S. Military? | Has you been on a government funded rental program or voucher program? | Does anyone receive post-secondary 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 by TANF? / Is anyone disqualified by GA? | 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. | | | | | |

**Please list any other person(s) or caregiver(s) and phone numbers which may be part of this process:**

_____

**NAMES / ADDRESSES OF SPOUSE, EX-SPOUSE, PARENTS, GRANDPARENTS AND CHILDREN'S PARENTS WHO ARE NOT MEMBERS OF THE IMMEDIATE 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 INFO – 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?<br>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 INFO – 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?<br>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. PERSONAL ASSETS – PROPERTY WHICH HAS EQUITY

**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 items of value (Guns / Coins / Jewelry) | | $ | |

## 4. 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 | MONTH 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** | | | | | | | | $ |

**5. EXPENSES FOR THE 30-DAY PERIOD…**

| MONTHLY EXPENSES | ACTUAL COST FOR NEXT 30 DAYS | MAXIMUM AMOUNT (OFFICE USE ONLY) | ALLOWED AMOUNT (OFFICE USE ONLY) |
|---|---|---|---|
| 1. Food | $ | $ | $ |
| 2. Rent – Landlord Name and Address: | $ | $ | $ |
| 3. Mortgage – Mortgage Holder: | $ | $ | $ |
| 4. Electricity –Hot Water Y/N<br>Electric Heat Y/N | $ | $ | $ |
| 5. LP Gas | $ | $ | $ |
| 6. Heating Fuel TYPE: | $ | $ | $ |
| 7. Household/Personal Supplies | $ | $ | $ |
| 8. Prescriptions/Medical | $ | $ | $ |
| 9. Water / Sewer | $ | $ | $ |
| 10. Cable / Internet / Cell Phone | $ | $ | $ |
| 11. Other (specify) | $ | $ | $ |
| | $ | $ | $ |
| **TOTAL MONTHLY HOUSEHOLD EXPENSES** | **$** | **$** | **$** |

**6. OTHER EXPENSES -UNSECURED DEBTS**

| **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.** | | **$** |

**7. GENERAL ASSISTANCE REQUESTED – WHAT YOU NEED…**

**ASSISTANCE REQUESTED: Please place check mark next to type of assistance being requested and enter the amount.**

| ✓ | ASSISTANCE | AMOUNT | | ✓ | ASSISTANCE | AMOUNT |
|---|---|---|---|---|---|---|
| | 1. Food | $ | | | 7. Personal Supplies | **$** |
| | 2. Rent | $ | | | 8. Prescriptions/Medical | **$** |
| | 3. Mortgage | $ | | | 9. Water / Sewer | **$** |
| | 4. Electricity | $ | | | 10. Other (Specify): | **$** |
| | 5. LP Gas | $ | | | **TOTAL ASSISTANCE REQUESTED** | **$** |
| | 6. Heating Fuel | $ | | | | |

**NOTE: PLEASE DETAIL ANY ADDITIONAL INFORMATION WHICH IS NOT OUTLINED IN THIS APPLICATION WHICH SHOULD BE CONSIDERED…**

_____

_____

_____

## SUPPLEMENTAL PART B. BURIAL OR CREMATION REQUEST FOR GENERAL ASSISTANCE **ONLY

**ONLY COMPLETE IF SEEKING ASSISTANCE WITH BURIAL OR CREMATION SERVICES… The father, mother, grandfather, grandmother, children, or grandchildren, by consanguinity, or the spouse or registered domestic partner (RDP) are responsible for the burial or cremation costs of the eligible person in proportion to their respective abilities.
MRS Title 22, Chapter 1161, §4313

DECEASED NAME: _____ ADDRESS: _____

DATE OF DEATH: _____ AGE: _____ SS#: _____

PEOPLE LIVING WITH THE DECEASED: _____

ASSET: REAL ESTATE VALUE: $_____ MORTGAGE AMOUNT: $_____

MOTOR VEHICLES/VALUE: _____ OTHER: _____

**SOURCES FOR ASSISTANCE:**

SOCIAL SECURITY: $_____ DEATH BENEFIT: $_____ VETERAN ADMIN.: $_____

LIFE INSURANCE: $_____ PENSION: $_____ BANK/ACCOUNTS: $_____

| FAMILY MEMBERS | NAME | ADDRESS | TOWN/CITY | STATE/ZIP | PHONE # | AMOUNT ABLE TO PAY |
|---|---|---|---|---|---|---|
| SPOUSE/RDP: | | | | | | $ |
| GRANDPARENTS: | | | | | | $ |
| | | | | | | $ |
| PARENTS: | | | | | | $ |
| | | | | | | $ |
| CHILDREN: | | | | | | $ |
| | | | | | | $ |
| | | | | | | $ |
| | | | | | | $ |
| | | | | | | $ |
| GRANDCHILDREN: | | | | | | $ |
| | | | | | | $ |
| | | | | | | $ |
| | | | | | | $ |
| GO FUND / DONATIONS | | | | | | $ |
| **TOTAL OF FAMILY CONTRIBUTIONS / GOFUND / IN-KIND DONATIONS** | | | | | | $ |

PERSONAL REPRESENTATIVE OF THE DECEASED'S ESTATE:

NAME: _____ PHONE #: _____ SIGNATURE: _____

ADDRESS: _____

FUNERAL DIRECTOR'S NAME: _____ PHONE #: _____

ADDRESS: _____ DATE CONTACTED: _____

***PLEASE DO NOT WRITE BELOW THIS LINE***

General Assistance Administrator: _____ Date: _____

◯ CREMAINS ◯ FULL-SIZE Amount Authorized: _____

## CLIENTS UNDERSTANDING AND RELEASE OF INFORMATION

This release must be read and signed before any general assistance application is considered.

Name: _____ Social Security Number: _____

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 that the General Assistance Administrator has the right to verify and discuss 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 permission for the General Assistance Administrator to contact the following specific sources or persons to verify and discuss any/all informational material to the determination of General Assistance eligibility for my household:

- Any or all persons including relatives, organizations, or businesses referenced in this application including but not limited to: Independent Attorneys, Advocates and or Case Managers.
- 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 Orono including but not limited to: Probation Officers, Law Enforcement Officers, Motor Vehicle Department, Social Security Administration, Homeland Security, Immigration & Naturalization, Maine Department of Labor, Unemployment, Vocational Rehabilitation, etc.
- Area social service agencies, including but not limited to: Penobscot County Community Action, PCHC, The Salvation Army, Catholic Charities, The Maine Way Inc., Representative Payee Services, etc.
- 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; Counseling Services, Inc., Partial Hospital Services of SMHC, or other mental healthcare facility and/or professional.
- Housing Authority of the City of Old Town, The Housing Foundation or other subsidized housing programs.
- **By signing this, I also grant my case manager: _____ or assigned advocate: _____ to work with the Town of Orono on my behalf for the purpose of obtaining general assistance.**

I understand that for the purpose of life and safety reasons, the Town of Orono Code Enforcement Officer/Health Officer may complete an 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 Orono Police Department or DHHS fraud investigators. This release is valid for one (1) year from the date signed. **I hereby consent to be considered for the Orono General Assistance Program.**

Applicants Signature _____ Date _____

Administrator Signature _____ Date _____

**Administrator: Please check with client to be sure they understand the following information.**

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)

**APPLICANTS: DO NOT COMPLETE – OFFICE WORKSHEET**

## 8. 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":** | $ |

## 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 **unless** 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 **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).

**Name: _____ DOB: _____ SS #_____**

Was the State contacted? YES or NO Did you leave message? YES or NO When: _____

Spoke to Agent: _____ Date / Time: _____

| ASSISTANCE | AMOUNT | | ✓ | ASSISTANCE | AMOUNT |
|---|---|---|---|---|---|
| 1. Food | $ | | | 6. Personal Supplies | **$** |
| 2. Rent | $ | | | 7. Prescriptions/Medical | **$** |
| 3. Mortgage | $ | | | 8. Water / Sewer | **$** |
| 4. Electricity | $ | | | 9. Other (Specify): Funeral, etc. | **$** |
| 5. LP Gas / Oil / Heat Product | $ | | | **TOTAL ASSISTANCE REQUESTED** | **$** |

**WAS EITHER APPLICANT TERMINATED OR VOLUNTARILY QUIT? YES OR NO**

**IS THIS AN ACTIVE SOCIAL SECURITY DISABILITY CASE? YES OR NO**

**IF REPEAT APPLICATION, WERE CONDITIONS MET? YES OR NO**

**State of Maine Income Allowance for _____ Adults & _____ Children is: $_____**

Were there any variables which must be considered during the approval process?

_____

_____

_____

**WILL THE STATE COVER 70%? YES or NO Approved Amount: $_____**

Please list the conditions or services client must complete for release of funds or re-application:

_____

_____

_____

_____

Any other information provided from the state which must be noted?

_____

_____

If applicant is denied or disqualified, please detail the reasons why the decision was made:

_____

_____

_____

**Agent: _____ Notice Mail Date: _____**