Charles A Lutzow Jr., Supervisor
3702 U.S. Highway 14 Crystal Lake, IL 60014
(847) 639-2700 Fax (847) 639-4529

THE FOLLOWING DOCUMENTS ARE REQUIRED TO PROCESS YOUR APPLICATION FOR ASSISTANCE. PLEASE BRING THEM TO YOUR SCHEDULED APPOINTMENT.

- Driver's license, state ID, passport or picture identification.
- Social Security cards and/or Social Security numbers for every person in the family unit. If you don't have the Social Security cards, bring in an official document with the numbers on it, such as an income tax return, W-2 form, old pay stub, etc.
- Birth certificates for all members of the family unit. If born outside of the United States, bring your permanent residency card, immigration work permit or naturalization certificate.
- Names, date of birth and social security numbers of all persons living in the household that are not members of the family unit.
- Current bank statements and a printout from the bank showing the past 30 days activity and your current balance on any and all accounts you have. Stocks, bonds, retirement accounts & trust fund information.
- Lease, rental agreement, Section 8 info, mortgage statement or letter from your landlord. Eviction notice.
- All bills you want considered for payment. This includes regular monthly bills and disconnection notices.
- Verification of any household income for the past 30 days. This would include pay stubs, child support, pensions, unemployment, Social Security, or any other income, i.e., gifts or loans from family or friends.
- Prison and/or probation records. Criminal history.
- Link card and medical card. Insurance card if applicable.
- Verification you are registered at IDES, McHenry County Workforce Network, for Illinois JobLink. You may register in person at the Workforce Center at 500 Russel Court, Woodstock, IL or online. To register on-line with Illinois JobLink do the following: Go to www.illinoisjoblink.com and click on "Find a Job" and then "create an account". Go to "Search Jobs", then to "Quick Search". Print the first page of referrals. You must print this monthly & verify that you are using Job Link to look for employment.
- If you are unable to work, a statement from your doctor stating you cannot work, for what reason and for how long.
- Verification there is an application pending for Social Security Disability (SSDi) and/or Supplemental Security Income (SSI), if applicable, for any members of the family unit.

Some of the above may not apply to you. Please bring in all the documents you have. Other information may be requested from you.

State of Illinois
Department of Human Services

APPLICATION FOR GENERAL ASSISTANCE

City or Township: Algonquin Township

County: McHenry County

Date Issued:

Date Returned:

Record Number:

Information required in this application applies to the head of the family and all dependents for whom the application is made.

1. General Information

Last Name:

Phone:

Husband's First Name and Middle Initial:

Wife's First Name and Middle Initial:

Other Names or Spellings:

Address:

Date Moved In:

Monthly Rent:

Previous Three Addresses (including city and state):

Address 1:

Date Moved In:

Address 2:

Date Moved In:

Address 3:

Date Moved In:

My family and I have lived in this township since ______ this county since ______

and this state since ______

Our last address before moving to Illinois was ______

I am now asking for assistance for myself and the following members of my family, who reside with me.

Name			Date of Birth			Birthplace		Relationship	Illinois Department of Employment Security Registration Number	Social Security Number
First	Middle	Last	Month	Day	Year	City	State			
								Self/ Applicant		

In addition to those listed above, the following relatives, boarders, lodgers and other persons, for whom I am not seeking assistance, are living in the same house.

Name			Age	Relationship	Present Means of Support	Amount Paid Monthly for Board, Lodging, or Share of Household Expenses
First	Middle	Last				

2. Why do you need assistance?

IL 444-0040 (R-02-10)

State of Illinois
Department of Human Services

APPLICATION FOR GENERAL ASSISTANCE

3. Personal and Occupational Information

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced ○ Separated ○ Deserted

If married, date of marriage: ____________ Location of Marriage: ____________

If separated, state reason: ____________

The present address of my spouse, with whom I am not living, is: ____________

Is there a court order for child support? ○ Yes ○ No

Living Arrangement: ○ Rent ○ Own

If rent, Landlord's Name: ____________ Landlord's Address: ____________

Related to Landlord? ○ Yes ○ No If related, relationship to landlord: ____________

Military Service: Does any member of your family have current or previous military sevice? ○ Yes ○ No

If "Yes", who has current or previous military service? ____________

Date of Enlistment: ____________ Date of Discharge: ____________ Serial Number: ____________

If family member has current/previous military service, he/she:

○ received Adjusted Compensation ○ did not receive Adjusted Compensation ○ receives pension or other income from such service ○ does not receive pension or other income from such service

Past Employment: List last employer and two longest term employers for applicant and any other family member with work history.

Family Member	Name and Address of Employer	Type Work	Monthly Wage	Start Date	End Date	Reason for Leaving

Present Income and Other Financial Information: Fill in every blank. If none, write "None".
Resources:

Sources	Person Receiving	Employer's Name and Address or Description of Resource	Weekly Amount
Employment: Salary			
Employment: Commissions			
Profits from: Business			
Profits from: Employment in Home			
Profits from: Sales			
Other: (specify)			

Public Assistance and Related Public Benefits

Sources	Person Receiving	Amount	Source	Person Receiving	Amount
TANF			RSDI		
AABD			Other		
General Assistance			Other		

APPLICATION FOR GENERAL ASSISTANCE

Other Cash Resources

Sources	Name of Person	Amount	Sources	Name of Person	Amount
Cash on Hand			Lodges/Unions		
Savings			Annuities		
Bank Accounts			Alimony/Child Support		
Unemployment Benefits			Estates/Court Orders		
Worker's Compensation			Friends/Relatives		
Veteran's Benefits			Government Bonds		
Other Income			Other Income		

Banks Accounts Held by Any Family Member

Family Member Holding Account	Name and Address of Bank	Amount of Deposit or Date of Last Withdrawal

Safety Deposit Boxes Held by Any Family Member.

Family Member Holding Box	Location of Box	Contents

Personal Property (i.e., securities, stocks, bonds, jewelry, livestock) Held by Any Family Member

Owned By	Description	Present Sale Value

Real Estate Owned, in Whole or Part, by Any Family Member

Recorded Owner	Address	Descritpion	Present Value	Date Purchased	Date Last Taxes Paid	Amount Last Taxes Paid	Present Monthly Income

Vehicles and Farm Equipment Owned by Any Family Member

Owner	Year	Make	Model	Date Purchased	License Number	Year Issued	Present Sale Value

State of Illinois
Department of Human Services

APPLICATION FOR GENERAL ASSISTANCE

Life Insurance Policies, Current or Lapsed, Held by Any Family Member

Person Insured	Name of Company	Type Policy	Amount	Monthly Premium	Date Last Premium Paid	Loans Made	
						Date	Amount

Medical, Hospital, Surgical, or Other Health Benefits Available to Any Family Member

Name of Company	Type of Coverage	Annual Premium

I understand that if I want someone else to apply for General Assistance for me, and I am mentally and physically able to apply, I must provide a written statement that gives the person permission to apply on my behalf. The statement must include the full name, address and telephone number of the person applying for me. The statement must say that I am still responsible for the information that the person applying for me gives to the local General Assistance office. The statement must also say that I am liable for repaying benefits that were received due to incorrect or incomplete information provided by an approved representative.

This application must be signed by the applicant, however, if the person is too ill, or otherwise mentally or physically unable to complete an application, this application may be filed by the spouse, parent, child, adult sibling, or other relative. If there are no relatives this application may be signed by any other person able to furnish necessary information with reasonable competence.

I have read this application for General Assistance and declare under penalties of perjury that, to the best of my knowledge and belief, the information supplied in this application and all accompanying statements is true and correct, and that it is a complete statement of all income, assets, or resources belonging to me or to any member of my immediate family.

I agree to notify the Supervisor of General Assistance of any change whatsoever in need, or in the resources listed herein, or any new or additional income or resources. Further, I hereby authorize any person, bank, firm, corporation, transfer agent, agency, institution or the Department of Human Services to furnish the Supervisor of General Assistance whatever information that may be requested relative to accounts, deposits, investments, securities, Railroad System Disability Income benefits, or business of any kind whatsoever.

Applicant Signature: ______________________ Date: __________ Spouse Signature: ______________________ Date: __________

I hereby make Application for General Assistance on behalf of the person named below and certify that, to the best of my knowledge and belief, the information furnished herein is a true statement of his/her income, assets and resources.

Applicant: ______________________ Applicant Representative Signature: ______________________

Applicant Representative Address: ______________________ Relationship to Applicant: __________

Charles A Lutzow Jr., Supervisor
3702 U.S. Highway 14 Crystal Lake, IL 60014
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Have you ever applied for General Assistance or Emergency Assistance at this or any other township?

YES_____ NO_____ If Yes, when? ____________

If Yes, which Township? ________________

Have you ever received money, disbursing orders, or benefits from this or any other township?

YES _____ NO ________ If Yes, when? _________

If Yes, how much have you received?

Have you ever applied for or are receiving Social Security Disability or SSI?

YES _____ NO _______ If Yes, how much do you receive? ______

If Yes, which program(s)? __________

I further acknowledge that I have not sought or received payments from any other township, for the past 30 days, including, but not limited to the following: rent, utilities, food, personal allowance, transportation, or gasoline.

I acknowledge that I understand all of the above questions and that my answers are true and correct in all respects.

_________________________ ____________

Signature of Applicant/Recipient Date

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(847) 639-2700 Fax (847) 639-4529

TO ALL GENERAL ASSISTANCE APPLICANTS & RECIPIENTS

General Assistance Medical

This is notification that Algonquin Township will no longer offer medical assistance through the General Assistance Program.

You have 30 days to bring in verification that you have applied for medical assistance through the Affordable Care Act programs. You may contact the McHenry County Department of Health at 815-334-4510 or the Illinois Department of Human Services at 815-338-0234 to apply for the Medicaid and Affordable Care Act benefits.

Failure to comply will result in termination of assistance and sanction for a minimum of 30 days.

If you have any question, you may call the office at 847-639-2700 ext. 7

____________________ ____________________

Print Name Signature

Dated: ____________

Charles A Lutzow Jr., Supervisor
3702 U.S. Highway 14 Crystal Lake, IL 60014
(847) 639-2700 Fax (847) 639-4529

APPLICATION FOR EMERGENCY ASSISTANCE

NAME:______________________________ **DATE:**________________

ADDRESS:____

PHONE:__________________ **S.S.#**________________________

Emergency Assistance is financial assistance to alleviate a life-threatening circumstance or meet an expense which jeopardizes employment. You can receive Emergency Assistance only once a year.

YOU CANNOT BE ELIGIBLE FOR AND RECEIVE EMERGENCY ASSISTANCE AND GENERAL ASSISTANCE AT THE SAME TIME. You may apply for either General Assistance, Emergency Assistance or both, however, you cannot be approved for both.

I am requesting emergency assistance on behalf of myself and the following people who reside with me.

Name	Age	Date of Birth	Relationship

NOTICE OF BENEFITS AVAILABLE
UNDER THE EMERGENCY ASSISTANCE PROGRAM

Emergency Assistance provides financial aid to alleviate a life-threatening circumstance or to assist in attaining self-sufficiency. Assistance up to the amount of the Township's payment level is disbursed by means of vendor payments, that is, a provider of goods and services is paid directly by the Township. Township personnel will tell you what the Township's payment level is. You may receive Emergency Assistance only once in any twelve (12) month consecutive period.

You may receive Emergency Assistance even though you have applied for and been approved to receive Categorical Assistance as long as you have not yet received any Categorical Assistance. However, if you are currently receiving General Assistance or Categorical Assistance (AABD, AFDC, MANG, SSI, Medicaid and Refugee and Repatriation Assistance) you may not receive Emergency Assistance.

A life-threatening circumstance is a condition which poses a peril to health or well-being because of a need for or the jeopardizing of the availability of shelter, food, utility service, medication, transportation or other necessity. If you are eligible, the Township will provide Emergency Assistance up to the amount of its payment level to alleviate a life-threatening circumstance involving a need for assistance for shelter, food, utility expenses, medication, transportation or other necessity.

Self-sufficiency means the financial capacity to pay work related expenses necessary to obtain or maintain employment. Work related expenses may include uniform or other required clothing costs and necessary safety equipment. If you are eligible, the Township will provide Emergency Assistance up to the amount of its payment level to assist you in paying expenses necessary for you to get or keep your job.

In addition to providing financial aid, the Township may also refer you to other agencies and programs or for other services to aid you in alleviating a life-threatening circumstance or assist you in attaining self-sufficiency.

I have read and understand the foregoing information.

Date:________________ Signature____________________________

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

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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 any 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: Pamela Gavers Date: ____________

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
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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: Pamela Gavers Date: ____________

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Charles A. Lutzow Jr., Supervisor

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CONSENT TO RELEASE OF INFORMATION

TO: (Name of entity or person to whom consent is directed)

____

____

____

____

____

FROM: ______________________________

____

____

____

____

You are hereby authorized and directed to release to or permit the examination and the copying or reproduction in any manner, whether mechanical, photographic or otherwise, by the Supervisor of General Assistance and the personnel of the General Assistance Office (GAO) named above of any and all such information as may be requested by the aforesaid Supervisor or GAO personnel.

You are further authorized and directed to furnish as requested oral and written reports to the aforesaid Supervisor and GAO personnel.

You are further authorized and directed to transmit by any method, including the United States Postal Service, fax and Internet, copies of such documents as may be requested by the aforesaid Supervisor and GAO personnel.

I hereby revoke any previously dated Consent to Release of Information.

Signature: ____________________ Date: __________

Witness: Pamela Gavers Date: __________

Please print the following:

Name of Witness: Pamela Gavers

Address: Algonquin Township
3702 U.S. Highway 14
Crystal Lake, IL 60014

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

3702 U.S. Highway 14
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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: Pamela Gavers Date: __________

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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 ALGONQUIN 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 **10** employment applications every month. You will be required to fill out a Job Search Form including the company phone number.

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**

RECIPIENTS: Failure to do so will result in **THE CANCELLATION 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: ____

____

____

____

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

3702 U.S. Highway 14
Crystal Lake, IL 60014

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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), ALGONQUIN 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 ALGONQUIN 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.

(NEXT PAGE)

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

ALGONQUIN 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:

ALGONQUIN TOWNSHIP
3702 U.S. Highway 14
Crystal Lake, IL 60014
(847) 639-2700

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

Signature: ______________________________ Date: ____________

Please print your name: ____________________________________

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

3702 U.S. Highway 14
Crystal Lake, IL 60014

Phone: (847) 639-2700
Fax: (847) 639-4529

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.

____

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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.

____

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____

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.

(NEXT PAGE)

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 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.

____

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____

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: ____________

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
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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 Available 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: Pamela Gavers

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

3702 U.S. Highway 14
Crystal Lake, IL 60014

Phone: (847) 639-2700
Fax: (847) 639-4529

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: Pamela Gavers

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, ______________________________, SSN ______________, hereby authorize (medical provider) ____ to disclose protected health information related to services provided in connection with my medical treatment.

This medical information may be disclosed to personnel within the ALGONQUIN TOWNSHIP Supervisor's Office and other individuals, specifically, ____________________________, assisting me with this request.

Description of the information to be used or disclosed:

Indicate the reason for the release or request of information:

[ ] At the request of the individual or personal representative.

[ ] Other:

I understand that if I refuse to sign this authorization, the above described health information will not be disclosed except as provided by law.

I understand that:

- Eligibility for General Assistance may be affected if I do not sign this form.
- I may revoke this authorization at any time by written notification to the entity listed above. My revocation will have no effect on information that has been released under this authorization prior to receipt of my intent to revoke such authorization.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I am entitled to a copy of this authorization upon signature.

This authorization expires on: _____________________

Signature: ________________________________ Date: ____________

Witness: Pamela Gavers Date: ____________

If a personal representative executes this form, that representative warrants that he or she has the authority to sign this form on the basis of ____

____
(Parent, Guardian, Power of Attorney, or other Authorized Representative)

Signature: ________________________________ Date: ____________

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

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Crystal Lake, IL 60014 | Fax: (847) 639-4529

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 ten (10) 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 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.

(NEXT PAGE)

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: Pamela Gavers

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
Charles A. Lutzow Jr., Supervisor

3702 U.S. Highway 14
Crystal Lake, IL 60014

Phone: (847) 639-2700
Fax: (847) 639-4529

NOTICE OF DETERMINATION OF OBLIGATION TO PARTICIPATE IN COMMUNITY WORK PROGRAM

Date: ____________

To: ____

____

____

____

____

[ ] It has been determined that you are required to participate in the Community Work Program

- [ ] Job Search, Training and Work Program
- [ ] Workfare
- [ ] Special Service Referrals
  - [ ] Attend mental health evaluation/treatment
  - [ ] Attend substance abuse evaluation/treatment
  - [ ] Other
- [ ] With the following work or training restrictions:

[ ] It has been determined that you are not required to participate in the Community Work Program

This decision conforms with section(s) ______________ of the General Assistance Office's General Assistance Handbook.

GENERAL ASSISTANCE OFFICE

Issued By: Pamela Gavers ______________________ Date: ____________

(NEXT PAGE)

NOTICE ABOUT THE DECISION BY THE GENERAL ASSSISTANCE OFFICE

This decision will be changed if you can show that it is wrong. You may meet with a representative of the General Assistance Office to question this decision. This meeting would be informal and you would have the opportunity to show why this decision is wrong. Whether or not you meet with a representative of the General Assistance Office, you still have the right to appeal the General Assistance Office's decision and be given a fair hearing.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

At any time within 60 calendar days of the date of this Notice you have the right to appeal this decision and be given a fair hearing. Your appeal request must be in writing and filed with the General Assistance Office or the County Public Aid Committee. You may represent yourself at the fair hearing or be represented by a person of your choice, such as a lawyer, relative or friend. The General Assistance Office will provide you with an appeal form and will help you fill it out if you wish.

YOU SHOULD CONTACT THE GENERAL ASSISTANCE OFFICE IMMEDIATELY IF YOU DO NOT UNDERSTAND OR HAVE QUESTIONS ABOUT THIS NOTICE