



APPLICATION FOR GENERAL ASSISTANCE

City or Township: _____ Date Issued: _____
 County: _____ 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?



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 service? 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	Description	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



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 _____ Date: _____ Spouse _____ Date: _____
Signature: _____ Signature: _____

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: _____

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE

Randolph J. Funk, Supervisor

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

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

NOTICE OF OBLIGATION TO PROVIDE ASSISTANCE

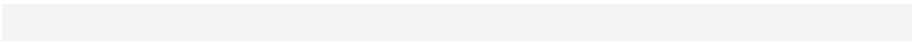
To: (General Assistance Office obligated to provide assistance)

Regarding:

The undersigned, _____, a duly authorized representative of the aforesaid General Assistance Office sending Notice (hereinafter referred to as the "GAO"), hereby notifies you as follows:

1. The aforementioned Applicant/Recipient has applied to the GAO for General Assistance ("GA") and it appears that the Applicant/Recipient is eligible for GA.
2. GA in the amount of \$ _____ has already been provided to the Applicant/Recipient because of immediate need.
3. The aforementioned Applicant/Recipient has not resided in the geographical area served by the GAO for six (6) continuous months and to the GAO's knowledge and belief the last governmental unit in which the Applicant/Recipient resided for six (6) continuous months was your governmental unit. (A copy of the Applicant/Recipient's Application for General Assistance accompanies the Notice.)
4. Pursuant to the provisions of Section 5/6-1.1 of the Illinois Public Aid Code (305 ILCS 5/6-1.1), you are hereby notified that your governmental unit is obligated to provide GA to the Applicant/Recipient until the Applicant/Recipient has resided in the geographical area served by the GAO for six (6) continuous months and demand is hereby made upon you to provide such GA.
5. You are hereby further notified that unless we hear from you within five (5) business days of the date of this Notice, we shall presume that you will not provide such GA and we shall provide GA to the Applicant/Recipient. If we provide such GA to the Applicant/Recipient, we shall charge your governmental unit with the total amount of GA provided to the Applicant/Recipient, including financial and medical assistance, until the Applicant/Recipient has resided in the geographical area served by the GAO for six (6) continuous months.

Issued By: _____ Date: _____



Case Name: _____

Case #: _____

Date of Mailing Notice: _____

Notice Sent By: _____

Notice Sent To: _____

Date and Response From Other Unit: _____

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE
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AGREEMENT TO REPAY

I, _____, hereby agree that if my pending application for Supplemental Security Income (SSI) is ultimately approved I shall repay the General Assistance Office (GAO) the amount of General Assistance provided to me for basic maintenance needs during the time my application for Supplemental Security Income was pending (including appeals) with the Social Security Administration.

If my first Supplemental Security Income checks (lump sum payments for payment back through the date of my application) are received by me, I will endorse and surrender them immediately to the GAO. In the event my first Supplemental Security Income lump sum payment checks are insufficient to reimburse the GAO for the General Assistance provided to me for basic maintenance needs while my Supplemental Security Income application was pending, I agree to endorse and surrender to the GAO subsequent Supplemental Security Income checks received until full recovery is accomplished.

Before me, a Notary Public in and for the County and State aforesaid, appeared _____, personally known to me to be the same person who executed the foregoing Agreement to Repay, and acknowledged that (he/she) executed and delivered the said Agreement to Repay as (his/her) free and voluntary act and deed, for the uses and purposes set forth therein.

Given under my hand and notarial seal this _____ day of _____, 20 _____

Signature: _____ Date: _____

STATE OF ILLINOIS)
) ss.
COUNTY OF _____)

Notary Public: _____

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APPLICATION FOR EMERGENCY ASSISTANCE

NAME: _____ DATE: _____
ADDRESS: _____
PHONE: _____ SSN: _____

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 in any twelve (12) month period.

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 period.

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.

Signature: _____ Date: _____

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**NOTICE OF RIGHTS AND RESPONSIBILITIES OF
EMERGENCY ASSISTANCE APPLICANTS AND RECIPIENTS**

As an applicant for or recipient of Emergency Assistance you have certain rights and responsibilities.

RIGHTS

- You have a right to file a written application for Emergency Assistance and to be assisted in completing an application. You may obtain an application at the General Assistance Office or request one by telephone or mail.
- You have a right to voluntarily withdraw any application for Emergency Assistance you file.
- If the General Assistance Office has an Emergency Assistance Handbook, you have a right to read and ask questions about it.
- You have a right not to be discriminated against because of race, religion, color, sex, sexual preference, national origin, age, handicap status or political affiliation.
- You have a right to have the information you provide kept confidential unless disclosure is required to determine your eligibility or is otherwise required or permitted by law.
- You have a right to written notice of the benefits available under the Emergency Assistance Program.
- You have a right to be treated with respect and in a courteous and considerate manner. If you have not been treated this way, you have a right to complain to the Supervisor. Nothing can be done to you because you complain.
- You have a right to freedom of choice as to where you obtain the goods and services for which the General Assistance Office will pay, however, if the General Assistance Office has an arrangement with a specific vendor to provide goods and services the General Assistance Office may refuse to pay other vendors for such goods and services. In addition, the General Assistance Office has no control over whether any vendor will furnish you with goods and services in exchange for payment by the General Assistance Office.
- You have the right to ask questions about your application and inspect, in the presence of personnel of the General Assistance Office, your case file during regular office hours. You also have a right to request copies of what is contained in your case file. However, certain information may have been provided to the General Assistance Office on the condition that the information or its source would not be revealed to you or is privileged from such disclosure. In such cases the General Assistance Office has a right to remove such information from your case file before you see it, however, if that happens you will be told that information has been removed.
- You have a right to be referred to other agencies for benefits and for other programs which may assist you.
- A decision must be made on your application for Emergency Assistance within 30 days. You have a right to written notice of this decision. If your income or assets result in a denial of your application, you have a right to a written notice indicating how your income or assets make you ineligible for Emergency Assistance.
- You have a right to voluntarily repay any Emergency Assistance provided to you.

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RESPONSIBILITIES

- You must fill out a written application for Emergency Assistance which must contain, at the very least, your name, mailing address and signature. An application containing your name, mailing address and signature requires the General Assistance Office to make a decision on your application, however, an application with only this information would not provide sufficient information to approve your application.
- You must keep all scheduled appointments at the General Assistance Office.
- You must provide information needed for a determination of your eligibility for Emergency Assistance.
- You must assist the General Assistance Office in securing and verifying information needed for a determination of your eligibility for Emergency Assistance.
- You must consent to the release by other agencies and persons of information to the General Assistance Office necessary for a determination of your eligibility for Emergency Assistance. You must sign any consent required by the General Assistance Office to obtain necessary information.
- You must report to the General Assistance Office with 5 calendar days of occurrence any change in your circumstances, such as a change in income or the acquisition of property, which might affect your eligibility for Emergency Assistance.
- You must utilize all resources (e.g., relatives, food pantries, community and charitable organizations) which might help alleviate your present needs.
- You must apply for any benefit (e.g., unemployment compensation, worker's compensation, Food Stamps) which might help alleviate your present needs.
- You must accept and follow-up in good faith any referral by the General Assistance Office to any other agency.

IF YOU FAIL OR REFUSE TO SATISFY ANY OF THESE RESPONSIBILITIES, YOUR APPLICATION FOR EMERGENCY ASSISTANCE MAY BE DENIED.

I acknowledge receiving a copy of the foregoing Notice of Rights and Responsibilities of Emergency Assistance Applicants and Recipients consisting of (2) pages this _____ day of _____, 20 ____.

Signature: _____

Case Name: _____

Case #: _____

Notice of Rights Given On: _____

Notice of Rights Given By: _____

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**AGREEMENT TO COOPERATE WITH
SPECIAL SERVICE REFERRALS**

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

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

Signature: _____ Date: _____

Address: _____

Phone: _____

Witness: _____ Date: _____

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE

Randolph J. Funk, Supervisor

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**AGREEMENT TO PARTICIPATE
IN THE COMMUNITY WORK PROGRAM**

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

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

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

I am signing this Agreement freely and voluntarily.

Signature: _____ Date: _____

Address: _____

Phone: _____

Witness: _____ Date: _____

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE

Randolph J. Funk, Supervisor

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

Phone: (847) 639-2700
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CONSENT TO RELEASE OF INFORMATION

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

FROM: (Name of person authorizing release of information)

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 Signature: _____ Date: _____

Please print the following:

Name of Witness: _____

Address: Algonquin Township

3702 U.S. Highway 14

Crystal Lake, IL 60014

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE

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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: _____

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: _____

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Randolph J. Funk, Supervisor

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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.

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Payment: While the Township generally does not engage in billing, the Township is permitted to use 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

Randolph J. Funk, Supervisor

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

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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. However, you may not receive the maximum amounts if you have any income or if you do not have a sufficient need for a certain basic maintenance need.
- 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 you will be issued disbursing orders totaling the amount of your grant. The disbursing orders may only be used to obtain the basic maintenance needs for which you have been approved.

MEDICAL ASSISTANCE

- If approved for GA, you are entitled to have certain medical care paid for unless you are denied medical assistance for a specific reason. Medical assistance is disbursed by direct vendor payment; that is, the General Assistance Office pays the medical provider.
- The General Assistance Office only pays for necessary and essential medical services. Preventive care is not considered essential. If you have any questions about what types of medical services can be paid for, you should ask personnel of the General Assistance Office.
- Unless an emergency exists, you must receive prior approval from the General Assistance Office for medical care, otherwise the General Assistance Office may refuse to pay for such care. You should contact a representative of the General Assistance Office during reasonable hours with a specific request to have medical care authorized.

I acknowledge receiving a copy of this Notice of Benefits this _____ day of _____, 20 ____.

Signature: _____



Case Name: _____

Case #: _____

Notice of Benefits Given On: _____

Notice of Benefits Given By: _____

ALGONQUIN TOWNSHIP GENERAL ASSISTANCE OFFICE

Randolph J. Funk, 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**.

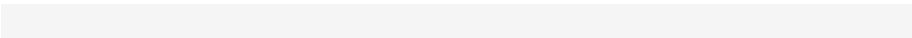
- You have the right to apply for GA at any time. Application must be in writing and must contain at least your name, mailing address and signature. Should you desire, you may get help in filling out the application form. Your application must be submitted to the General Assistance Office, however, you 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: _____



Case Name: _____

Notice of Rights Given On: _____

Notice of Rights Given By: Pamela Gavers _____

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**NOTICE OF RIGHTS AND RESPONSIBILITIES OF
COMMUNITY WORK PROGRAM PARTICIPANTS**

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

RIGHTS

1. To be notified of a work or training assignment at least 24 hours in advance of the time the work or training assignment is scheduled to begin.
2. To be required to work no more than 8 hours a day and 40 hours a week.
3. To be required to work only enough hours as are sufficient to offset the amount of your monthly General Assistance benefits, based on the prevailing minimum wage.
4. Not to be required to perform work or engage in training involving a substantial threat to your health or safety.
5. To be paid by a sponsor at no less than the prevailing minimum wage if you work for a sponsor more than 8 hours a day, 40 hours a week or beyond the hours you are required to work by the General Assistance Office.
6. To be provided with proper and safe clothing and equipment to perform any work or engage in any training.
7. To be treated like a regular employee or trainee.
8. Not to be discriminated against because of your race, religious beliefs, color, sex, marital status, sexual preference, national origin, age, handicap or political affiliation.
9. To appeal any action, inaction or decision of the General Assistance Office with regard to your participation in the Community Work Program.

RESPONSIBILITIES

1. To sign an Agreement to Participate in the Community Work Program.
2. To participate in and cooperate with the Community Work Program.
3. To timely keep all Community Work Program appointments and interviews.
4. To accept training and work assignments from the General Assistance Office.
5. To make at least 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

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Office.

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

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

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

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

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

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

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

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

17. To satisfactorily complete all work and training assignments.

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

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

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

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

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

Signature: _____ Date: _____

Case Name: _____

Case #: _____

Notice of Rights Given On: _____

Notice of Rights Given By: _____

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Randolph J. Funk, Supervisor

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**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

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

GENERAL ASSISTANCE OFFICE

Issued By:

Date:

Pamela Gavers _____

NOTICE ABOUT THE DECISION BY THE GENERAL ASSISTANCE 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**

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I certify that I have applied for or interviewed with the above employers on the dates indicated.

Client Signature: _____