### Township Form TA-1 (Revised 2004)

# **SCHEDULE A**

# **Application for Township Assistance**

PHONE NUMBER	AP	PLICATION	DATE	A	PPLIC/	T NOIT	IME	NOIE: SOC	CAS	E NUM	
( ) -		1	1			•		□ AM □ PM			
AREA ###-####	MN	M DD	YY		нн :	MM (	(total:	)	offic	e use o	nly
Applicant's Full Name						Socia	l Secu	rity #	Dat	e of Bir	th
				□ m	1	-	J	-		, ,	
LAST	FIRST	Ta .	MI			0	ptiona	1	MM	DD	YY
Other Adult's Full Name						Social	Secu	rity #	Dat	e of Bir	th
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LAST 1	FIRST		MI				iona		MM	DD	YY
Other Adult's Full Name							cu	rity #	Date	e of Bir	th
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LAST			n A	P	1				MM	DD	YY
<b>Current Address</b>		20	(IV)					toda rockobs			
		יע								Mo Yea	nths irs
Street Address / P.O. Box		А	pt. #		City,	State		Zip	Н	ow Lon	g
Previous Address			J								
	0	*				6			_	Mo	nths rs
Street Address / P.O. Box	-120 - 1	A	pt. #		City,	State		Zip	Н	ow Long	g
QUESTION	APPLI	CANT	***	OTI	HER AI	DULT		OT	HER AD	ULT	
What is your housing status?	□ Óv	vn			Own	3			Own		
	The second second	ying			Buying	g		ū	Buying		
		nting			Rentin	g			Renting		
	☐ Ho	meless			Homel	ess			Homele	ess	
8	☐ Oti	her			Other				Other		
What is your marital status?	☐ Ma	urried			Marrie	d		ם	Married	1	
	☐ Sir	igle			Single				Single		
		vorced			Divorc	ed			Divorce	ď	
		parated			Separa				Separat		
<u> </u>	□ Wi	dowed			Widow	ed			Widowe	ed .	

This office does not discriminate on the basis of race, color, national origin, sex, religion, age or handicap status. Anyone needing special aid, readers or interpreters, please notify us at least 48 hours in advance.

In the following table, list ALL persons living within this household. For EACH person check \( \sqrt{\text{the relationship}} \) to the applicant and \( \text{circle} \) ALL income sources for that person. Signature, affirming income, required of all household members eighteen (18) and older.

Person's Name	Relationship	2	Income Source	Amount (monthly)
Print Signature	☐ Yourself	Date of Birth  Social Sec. # (optional)	No Income Wage Social Security AFDO Unemployment Pensi- Veteran's Suppo Insurance Gifts Strike Benefits Other	on
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	Date of Birth  Social Sec. # (optional)	No Income Wages Social Security AFDO Unemployment Pensio Veteran's Suppo Insurance Gifts Strike Benefits Other	on
Print Signature	Child Spore	JPLE	ial Security inployment in's insurance Strike Benefits  Wages AFDC Pension Suppo	n
Print Signature	Relative Room Mate Other Adult	Date of Birth  Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits  Wages AFDC Pension Gifts Other	n
Print Signature	Child Spouse Relative Room Mate Other Adult	Date of Birth  Social Sec. # (optional)	No Income Wages Social Security AFDC Unemployment Pensio Veteran's Suppo Insurance Gifts Strike Benefits Other	n
Print Signature	Child Spouse Relative Room Mate Other Adult	Date of Birth  Social Sec. # (optional)	No Income Wages Social Security Unemployment Veteran's Suppor Insurance Gifts Strike Benefits Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	Date of Birth  Social Sec. #	No Income Wages Social Security AFDC Unemployment Veteran's Suppor Insurance Gifts Strike Benefits Other	

Total adults in the hous Total of ALL persons li							n in th	e house	hold:		2
Total GROSS income re							: \$	***************************************			
Does anyone live in this If YES, who and how o			•			ann vara user varanta i•on = va		ES	NO	)	
List all motorized vehic	les c	owned by A	NY per	son in	thi	s housel	nold:			<del></del>	
Type:		(Car / Tru	ck / Boa	at / M	otor	cycle)	Year:		_ Ma	ke:	
Type: (Car / Truck / Box				at / M	otor	cycle)	Year:		Ma	ke:	
					Year:		_ Ma	ke:			
QUESTION		APPLICA	NT			OTHE	R ADU	LT		OTHER	ADULT
.ii				Name:	-			N	Name:		
What is your income status		A STATE OF THE PARTY OF THE PAR	The state of the s			Wages	G,			Wages St	
******		Waiting or				12.		Same A		Waiting o	n Income
		Receiving No Income				_1			u	Receiving No Incom	
What is your employment		No Income	e Calendaria		A	91	7			Currently	working
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answers require						Fired: *				Fired: *	
cplanation below		يبر				Sick lea				Sick leave	
		Maternity	leave			Matern		е		Maternity	leave
		On strike				On stril			1	On strike	
	Ц	Trying to f			<u>u</u>	Trying	<del></del>		0	Trying to	find worl
		OTHE	R FINA		LI						
D 1 1'C 1	•		Appl					Adult			Adult
Do you have life insurance			Yes	No			Yes	No		Yes	No
Do you have another type	V. (1.8)	and the second of the second s	Yes	No			Yes	No		Yes	No
Do you have any investme (Stocks, Bonds, CD's			Yes	No			Yes	No		Yes	No
Do you have any cash on			Yes	No			Yes	No		Yes	No
IF YES, give amount	Hanc	1.	162	110			4	140		¢ 168	110
Do you have a checking a	ccon	int?	Yes	No			Yes	No	2005	Yes	No
Do you have a savings acc	COUNT	t?	Yes	No			Yes	No		Yes	No
IF YES, give name of ea				• 10	-		400	- 10		103	1.0
& current balance				21.18 //						950	
Does anyone in the housel	hold	have any cl	aims, inc	cludin	g lav	wsuits, a	gainst a	person	, insur	ance comp	oany,
employer or government a					-		-				
If yes, explain:	35	200	200 0000	- adde-1	0.5					7280000	

	PROPEI	RTY OWNERSHIP		
Name of mortgage of Amount of mortgage	operty? Application Application Yes  ompany:  payment: Approxim	No Yes		
	REN'	TAL HISTORY		3.
Name of apartment of Address of complex Phone number of complex What date did you may be anyone in the house	the lease: Co-lessed complex or landlord: mplex or landlord: move into this rental unit: _ sehold related to the landlord uded? YES NO If yes, the landlord in the landlord uded? YES NO If yes, the landlord in the landlord	Monthly rd? YES NO If yes which one?	rent amount:	
				Other Adult
2nd most recent emplo Date you started work	there:  there:  ow:  oyer:  there:  there:			Name
	MILIT	ARY SERVICE		
Serial Number: Enlistment Date: Branch of Service: Discharge Date:	Applicant	Other Adul		Other Adult
	Cľ	TIZENSHIP	1	
Is everyone in the hou If no, please explain so		S NO		

		FAM	ILY INFORMATION			
Applicant	's Maiden Name	(if married):				
			rs, sisters, grandparents, Phone	aunts, uncles)	including "ste	they helped
2 32.		С	HILD SUPPORT		*	
If not will If NO, exp Are you re	re minor children you go to court plain: eceiving child su address of child(r	to get support?	ild support ordered for	1	urt?	YES NO
enters or	friends whom into the whom how much & v	o. already l	isted on this form?  OF ALL HOUSEHOLI	YES NO		-service
Amount of Debt	Date Purchased	Name of Creditor	Items Purchased	Value	Amount paid	Last Pay Date
						***************************************
						***************************************
			TATAL STATE OF THE			

## **EXPENSE INFORMATION**

	Paid To	Date Paid	Amount	Paid To	Date Paid
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		-2-			
		SAN	- NI		
		AAA	NPL		
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OTHER PUBLIC ASSISTANCE										
	Are you rec	eiving (	or have you ap	plied for the fol	lowing:					
APPLICANT ·										
	Subsidized Sec. 8, HUD, or other public housing: YES NO Date Applied://									
Utility Allotment		NO								
Food Stamps		10								
AFDC Welfare	YES N	OV								
Other Trustee Office	YES N	VO.	Date Applied:		J	Amount:				
Social Security (any type)	YES N	40	Date Applied:	/	J	Amount:				
V.A. Benefits (any time)	YES N	OV	Date Applied:		<i>J</i>	Amount:				
EAP Utility Assistance	YES N									
FEMA Funds	YES N									
Unemployment Benefits	YES N					Amount:				
Grants / Loans			400,1000			Amount:				
Any other type of help						Amount:				
			SOUTHD ADI	TE CEN						
C Latitle 3 Cas R JUID and	o salatia		OTHER ADU			F 7				
Subsidized Sec. 8, HUD, or o			Date A- "	Date Appli-		/ / Amount:				
Utility Allotment										
Food Stamps	* P			PLE	A	Amount:				
AFDC Welfare				コレト	A —	Amount:				
Other Trustee Office			/ IV/I I			Amount:				
Social Security (any type)		T	JIAI			Amount:				
V.A. Benefits (any time)						Amount:				
EAP Utility Assistance						Amount:				
FEMA Funds						Amount:				
Unemployment Benefits						Amount:				
Grants / Loans						Amount:				
Any other type of help	YES N	10	Date Applied:		<i>J</i>	Amount:				
			THER ADU	п <b>т</b>						
Subsidized Sec. 8, HUD, or o	ther nublic 1	177			·	11				
Utility Allotment						Amount:				
Food Stamps						Amount:				
AFDC Welfare						Amount:				
Other Trustee Office	The second second second					Amount:				
Social Security (any type)						Amount:				
V.A. Benefits (any time)						Amount:				
EAP Utility Assistance						Amount:				
FEMA Funds						Amount:				
Unemployment Benefits						Amount:				
Grants / Loans						Amount:				
Any other type of help		IO :	Date Applied:		1	Amount:				
Any other type of help	YES N	U .	Date Applied.		<i></i>	Alliount.				
Has anyone in the household	haan tarmin	ated fro	m refused or	had AFDC pay	ments red	uced? YES NO				
CONTRACTOR OF CO				nau Arbe pay	IIICIIIS ICG	uceu: 1155 140				
If YES, why?						Maria Con				
Has anyone in the household						YES NO				
If YES, when and where?										

### READ CAREFULLY\* NOTICE OF PUBLIC LAW

Indiana Code 12-20-6-9 requires the township trustee to investigate my circumstances, and the cause of my condition. I understand that I am required to cooperate in such investigation. I understand that Indiana Code 12-20-6-8 requires the trustee to notify me of the action taken (approval, denial, pending) on my case within 72 hours (excluding weekends and legal holidays) and that the trustee must retain a copy of each application whether or not relief is granted.

Indiana Code 12-20-16-2 prohibits the Trustee from providing medical assistance if the applicant could qualify for that assistance under the Hospital Care for the Indigent Program (IC 12-16). The township may not provide assistance for payment for more than 30 days of heating fuel or electric services assistance unless the applicant has applied for assistance as stated under IC 12-20-16-3. IC 12-20-16-5 provides that applicants, or a member of the applicant's household, granted emergency township assistance, file an application with the appropriate government agency. If the applicant, or a member of the applicant's household, failed to file within fifteen (15) working days, no further Trustee assistance may be granted for sixty (60) days following emergency Trustee assistance granted.

Applicants for food assistance may not be provided food assistance for more than thirty (30) days unless an application for food stamps is filed with the Division of Family and Children. IC 12-20-10-1 provides that if applicants applying for aid are in good health, or if any member of their household are so, the to seek

employment and the trustee shall refuse any aid until the trustee

to find work for themselves. IC 12-20-11-1

exceptions, to do work needed governmental unit having jurisdiSAMPL

claiming help are endeavoring f the household, with certain in any other county for any

I HAVE READ THE ABOVE N

Signature of Applicant				Signature	of Other A	Adult	Signature of Other Adult		
Are you wil	ling to v	vork for th	e township and act	ively se	ek employ	ment as a condition	of rece	iving trustee assistance	
44.44.5			Other Adult:	YES	NO	Other Adult:	YES	NO	
If no, explai	n why r	iot:		· · · · · · · · · · · · · · · · · · ·					

### Affidavit

I certify and affirm under penalties of perjury that the information I have given on this application is true and correct to the best of my knowledge and belief in every respect as to myself and member of my family and household, and that I have not withheld any information on matters bearing upon the eligibility and need for relief from myself and members of my family and household, and that I and the members of my family and household have no other means of support than those stated in this application. I also certify that I have not been convicted under IC 35-43-5-7 (Welfare Fraud) and am eligible to receive township assistance.

Signature of Applicant

Signature of Other Adult

Signature of Other Adult

Note: All household members eighteen and older must sign where indicated for application to be complete.

# CONSENT TO THE DISCLOSURE OF INFORMATION TO THE TOWNSHIP TRUSTEE

I,	, Case Number	, residing at
		, Indiana, consent to
the disclosure of the following informa	tion to	, the investigator of
township assistance for	Township	County, Indiana:
Information that will verify m	ıy:	
1. Countable income.		
2. Countable assets.		# **
3. Wasted resources.		9 000
4. Relatives capable o	f providing assistance.	
5. Past or present emp	oloyment,	\\
6. Pending claims or o	causes of act	
7. A medical condition		
8. Any ot	ANNU	
This information may be use	SAMPLE Town	
(1) My township assistance a	Town	shipCounty, IN.
(2) My application for public a		ildren county offices and the Office of
	on the Division of Family and Chi	nation country offices and the office of
Medicaid Policy and Planning.		
(3) Others (if any).	** g	
Signature of Applicant	Signature of Other Adult	Signature of Other Adult
Date Signed	Date Signed	Date Signed
This conse	nt form expires 180 days after the date o	of signing.
ACKNOWLEDGMENT AN	ND PLEDGE OF CONFIDENTIAL	ITY BY THE TOWNSHIP
The undersigned township trustee or elaccess to certain personal information a and exchanged only with agencies related this application or as otherwise provide	nd that such information is to be treated to the undersigned employment by the	ed as confidential, and is to be released
Trustee or Employee		Date Signed

## (THIS PAGE FOR TOWNSHIP USE ONLY)

### WORK ORDER:

Given \_\_\_\_\_ Amount \_\_\_\_\_ Completed \_\_\_\_

	STATISTICAL SUMMARY OF THIS APPLICATION								
Date	# Recipients Rec'd. Benefit	Utility \$ Benefits	Housing \$ Benefits	Food \$ Benefits	Health Care \$ Benefits	Other	Total \$ Benefits		

Training Program Referral	Referrals	Workfare Hours	Time Spent on Application
9			
	· ·	e 9 = =	

CASE RECORD OF INVESTIGATION



# APPLICATION FOR ADDITIONAL OR CONTINUING TOWNSHIP ASSISTANCE Please do not write in this DATE: NAME: \_\_\_\_\_ PHONE: \_ column. ADDRESS: CASE NO. Number of persons living at your address: Since your application with the trustee's office dated \_\_\_\_\_\_ has your income, resources or household size changed? YES \_\_\_\_\_ NO \_\_\_\_ Are you or anyone else in the household working? YES \_\_\_\_\_ NO \_\_\_\_ Are you or any member of your household under a doctor's care? YES \_\_\_\_\_ NO \_\_\_\_ Have you / they applied for disability? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, what is the status of the case? \_\_\_\_\_\_ SINCE THE DATE OF YOUR MOST RECENT APPLICATION: Have you applied for AFDC? YES NO If receiving, give amount \_\_\_\_\_ Have you applied for Food Stamps? Have you applied for Unemployment? Have you applied for Energy Assistance? YES NO If receiving, give amount YES NO If receiving, give amount YES NO If receiving, give amount YES NO If receiving amount Have you applied for / received assistance from any other source? Yes, explain: SAMPLE What has been the household's: Total Income: \$\_ TODAY I AM REQUESTING ASS REQUESTED **ACTION INCOME AND EXPENSES INCOME** is any source of benefit to you, or any member of your household, whether money or payment assistance. This includes: work income, AFDC, housing assistance, odd job money, sick pay, relative or church assistance, EAP/Project Safe payments, Worker's Compensation, Social Security benefits, unemployment, child support, vacation pay, tax returns, bartered goods, etc. **EXPENSE** is any bill you have <u>already</u> paid or anything on which you used the above income. LIST ALL MONEY, INCOME, BENEFITS RECEIVED BY ANYONE AMOUNT VERIFIED RECEIVED **AMOUNT** IN YOUR HOUSEHOLD IN THE PAST THIRTY (30) DAYS: Date Received: Received from: SCHEDULE B

Page 2 - Form TA-1B  LIST ALL PURCHASES, E YOUR HOUSEHOLD IN TH	XPENSES, OR HE PAST THIRT	BILLS PAID E TY (30) DAYS:	Y YOU OR MEMBERS OF	Please do not write in this column.
Paid for:	Date Paid:	Paid to:	AMOUNT PAID OU	
Rent / Mortgage	Dule I that.	F 414 10:	PAID OC	VERIFIED
Electric service		//		
Gas service				
Water service				
Sewer service				
Phone payment				
Food purchased				
Babysitting / Childcare				
Transportation costs				
Medical expenses	<del></del>			
Insurance payment (state type)		7.11.11.11.11.11.11.11.11.11.11.11.11.11		
Household items (specify)			-	
Loans / Charge payments			· · · · · · · · · · · · · · · · · · ·	
Other monthly cost (specify)		119 11 12		
Cable television				
Other (specify) Other (specify)		$M_{II}$		
Expenses OWED (not paid Rent / Mortgage amount: Utilities (type and amount owed. Other bills (specify type and amou		MP		
affirm under the penalties of perj knowledge and belief in every resp request for assistance other than wing upon the eligibility and need for my family and household have no victed under IC 35-43-5-7 (Welfar	occt as to myself ar that has been stated or relief from myse other means of sup	nd members of my lon this form; and elf and members opport than those st	on this application is true and contain the family and household and has not that I have not withheld any information from family and household, and that in this application. I also certain the face of the face	ot changed since my last rmation on matters bear- nat I and the members of
Applicant Signature	I	Date	Other Adult in Household	Date

For Township to Fill Out

### REIMBURSEMENT AUTHORIZATION

70, 70	mismp to 1 iii Out
Township	County
ADAMS	ALLEN
Townshi	p's Mailing Address
Client's Name	Date of SSI Application
Client's Phone #	Township Caseworker

#### AUTHORIZATION FOR REIMBURSEMENT OF INTERIM ASSISTANCE

Name:		Social Security Number:	
Address:	C'. T. /Z'. C. l		

City/Town/Zip Code

Print or Type

The term "state" means the State of Indiana Family and Social Services Administration.

#### How can the state use this form when blocks for initial claims and posteligibility cases are part of the form?

The state can use this form for one case situation at a time, either an initial claim or a posteligibilty case. If both blocks are checked the form is not valid. You and the state must sign and date a new form with only one block checked.

#### What kind of state payment qualifies for reimbursement by SSA?

SSA can reimburse a state for a payment that is paid only from state or local funds. The state cannot be reimbursed for payments made wholly or partially from Federal Funds.

#### How does SSA determine how much of my SSI money to pay the state?

SSA decides the amount of payment based on two considerations. First, SSA looks at the amount of money claimed by the state, and second, SSA looks at the amount of your retroactive SSI money available to pay the state. SSA can reimburse the state for a payment made in a month only when you receive a state payment and an SSI payment for the same month. SSA will not pay the state more money than you have for the SSI retroactive period.

#### What actions am I authorizing when I sign this authorization and I check the "Initial Claim Only" block?

#### X Initial Claim Only

You are authorizing the Commissioner of the Social Security Administration (SSA) to reimburse the state for some or all of the money the state gives you. This money helps you while SSA decides if you are eligible to receive SSI benefits. If you become eligible, SSA pays the State from the retroactive SSI benefits due to you. The reimbursement covers the time from the first month you are eligible to receive SSI benefits through the first month your monthly SSI benefit begins.

If the state cannot stop the last payment made to you, SSA can reimburse the state for this additional payment amount.

### How long is this authorization effective for the state and me if I checked the "Initial Claims Only" block?

This authorization is in effect for you and the state for twelve (12) months. The 12 months begin with the date SSA receives the authorization from the state and end 12 months later. You and a state representative must sign and date the authorization for the authorization to be valid.

SSA must receive the form within 30 calendar days of the date you signed the authorization. If the form is late, SSA will not accept the form as a valid authorization. SSA will not pay any of your retroactive SSI benefits to the state. SSA will send you any SSI money that may be due you, based on SSA's regular payment rules.

# Can the authorization stay effective longer than the 12-month period? Can the authorization end before or after the 12-month period ends?

The authorization can stay effective longer than the 12-month period, if you

- apply for SSI benefits before the state has the authorization form, or
  - apply within the 12-month period the authorization is effective, or
- file a valid appeal of SSA's determination on your initial claim.

The period of the authorization can end before the 12-month period ends, or end after the 12-month period ends when any of these actions take place:

Schedule C

- · SSA makes the first SSI Payment on your initial claim; or
- SSA makes a final determination on your claim; or
  - the state and you agree to terminate this authorization.

The authorization period will end with the day of the month any of these actions take place.

#### Can SSA use this authorization form to protect my filing date for SSI benefits?

SSA Field Office

Copies to: Client

SSA can use this form to protect your filing date if you checked the "Initial Claims Only" block. When you sign this form, you are saying that you have the intention of filing for SSI benefits if you have not already applied for benefits.

You have sixty (60) days from the date the state receives this form to file for SSI benefits. Your eligibility to receive SSI benefits can be as early as the date you sign this authorization if you file within 60-day time period. If you file for SSI benefits after the 60-day time period, this form will not protect your filing date. Your filing date will be later than the date you sign this form.

What actions am I authorizing when I sign this authorization and I check the "Posteligibility Case Only" block? **Posteligibilty Case Only** You are authorizing the Commissioner of the Social Security Administration (SSA) to reimburse the state for some or all of the money the state gives you. This money helps you while SSA decides if your SSI benefits can be reinstated after being terminated or suspended. If your SSI benefits resume, SSA pays the state from the retroactive SSI benefits due you. The reimbursement covers the time from the day of the month the reinstatement is effective through the first month your monthly SSI benefit resumes. If the state cannot stop the last payment made to you, SSA can reimburse the state for this additional payment amount. How long is this authorization effective for the state and me if I checked the "Posteligibility Case Only" block? This authorization is in effect for you and the state for twelve (12) months. The 12 months begin with the date SSA receives the authorization from the state and end 12 months later. You and a state representative must sign and date the authorization for the authorization to be valid. SSA must receive the form within 30 calendar days of the date you signed the authorization. If the form is late, SSA will not accept the form as a valid authorization. SSA will not pay any of your retroactive SSI benefits to the state. SSA will send you any SSI money that may be due you, based on SSA's regular payment rules. Can the authorization stay effective longer than the 12-month period? Can the authorization end before or after the 12-month period ends? The authorization can stay effective longer than the 12-month period, if you file a valid appeal. You must file your appeal within the time frame SSA requires. What rights and appeals are available to me under this authorization. The State is required to: 1. Give me written notice explaining: \* How much SSA repaid the State for interim assistance it gave to me; \* That I will have an opportunity for a hearing with the State if I disagree with its actions regarding repayment of interim assistance or any action it took regarding this authorization. Date Signature of Recipient GR Code <u>15480</u> Date Signature of State or Township Representative

ITA State Office

Original: Township Client File

Approved by the		

OFFICE OF THE TOWNSHIP TRUSTEE

Name:		Last,	First	MI				
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## 1125 Hartzell Street New Haven, Indiana 46774

# Adams Township Trustee

Denita L. Washington, Trustee

(260) 749-4162 Phone (260) 749-6086 Fax

info@adamstownship.org

# **EMPLOYMENT RECORD**

Company/Employer Name Em	pployer Address Employer Phone
Please provide the following employment information t regarding:	to the Adams Township Trustee as soon as possible
Employee Name Case Number Employee	loyee Address Social Security #
If No Longer Employed: (Inc. most recent temp assignment)  Start Date:  Last date worked:  Date of Last Paycheck:  # of hours per week:  Position:  Reason no longer working (circle all that apply): Quit / Fired / Temp Job Term Ended Lay off – Perm. Lay off – Temp.  Fired from Temp Employer  If employee quit, was there work available, had he or she continued employment? Y N	If Currently Employed / New Hire:  Start Date:  Date of Next or First Paycheck:  # of hours per week:  Circle one: Temporary / Permanent  How often paid:  Day of week employee is paid:  Rate of pay:  Comments:
If employee was fired, please give the reason*:  Record Satisfactory? Y N Chance for re-employment? Y N	☐ If checked, please also fax the pay history for this employee, listing the pay dates, gross, and net amounts for the past months.
*NOTE: Employers are allowed to release this information to governmental agencies for the purposes of determining eligibility for public assistance. (example: attendance, policy violation, etc.)	Signature of person completing Date this form

Job Applications Log Sheet

Name:		Week	as of the section of	Due Date:	
Name of Company	How did you apply? (in person, on- line, kiosk)	Street Address or Website Address	Phone number and fax number, if applicable	Company Representative or User Name, Password, and Confirmation #	Date Applied
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# Adams Township Trustee

Committed to Community through Service and Accountability

Denita L. Washington, Trustee

1125 Hartzell Street New Haven, IN 46774

(260) 749-4162 Assistance (260) 749-6086 Fax info@adamstownship.org

# **INCOME GUIDELINES**

# Effective JULY 1, 2022

# Income Guidelines Based on 115% of 2022 Federal Poverty Level

PERSONS IN HOUSEHOLD	MONTHLY GROSS INCOME
1	\$ 1,302
2	<b>\$ 1,755</b>
3	\$ 2,207
4	\$ 2,659
5	\$ 3,112
6	<b>\$ 3,564</b>
7	\$ 4,106
8	\$ 4,469

For each additional person – add \$452

# **HOUSEHOLD BUDGET**

Date	Expenditures	Amount	Resources of Income	Gross	Net
	Food Stamps		TANF		
	Food & Paper Products/Cash		Social Security (S.S.D.)		
	Paper Products Only Cash		Child Support		
	Rent-Own-Payment		S.S.I.		
	Rental Deposit		Earnings		
	Gas / Gas Deposit		Checking Account		
	Electric / Electric Deposit		Savings Account		
	Water / Water Deposit		Pensions		
	Fuel Oil		Unemployment Compensation		
	Telephone (Basic Service)		Roomer / Boarders		
	Insurance (Life, Med, Auto)		Utility Allowance (FWHA)		
	RX's / Medical (Receipts) Bills		Settlements		
······································	Clothing (Receipts)		Loans		
	Transportation (Medical / Work)		Gift		
***************************************	Car Repairs (Medical / Work)		Sick Benefits		
	Bus		Federal Tax Refund		
	Day Care (\$45/wk, work only) Babysitter (\$1.00/hr., work only)		State Tax Refund		
	Support Payment (out of household)		Other		
	Automobile Payments (work only)				
	Other (Emergencies)				
	9		a		
	TOTAL		TOTAL		

# FOOD AND PAPER PRODUCTS MONTHLY ALLOTMENT SCHEDULE

HOUSEHOLD	FOOD	PAPER PRODUCTS	TOTALS:
SIZE	ALLOTMENT	ALLOTMENT	FOOD & PAPER PRODUCTS
1	130.00	50.00	180.00
2	205.00	60.00	265.00
3	215.00	70.00	285.00
4	225.00	80.00	305.00
5	235.00	90.00	325.00
. 6	245.00	100.00	345.00
7	255.00	110.00	365.00
8	265.00	120.00	385.00
9	275.00	130.00	405.00
10	285.00	140.00	425.00

Two vouchers a month may be issued to assist clients with food allotment. Divide the amount for monthly food allotment by two (2) to get the amount for issuing two vouchers a month.

## MONTHLY SHELTER ALLOTMENT

All Clients requesting assistance from the Adams Township Trustee Office must apply for affordable shelter at the Fort Wayne Housing Authority and remain in compliance (See schedule N) with Housing Authority requirements. Clients not eligible for Housing Authority must apply and continue to comply with a comparable housing program to find low-cost housing.

Adams Township will consider assisting with shelter at the following monthly rates.

# **HEAT INCLUDED\***

Transitional Housing Boarding House/Sleeping	\$200.00 Rooms	
Efficiency	\$400.00	
One (1) bedroom	\$500.00	\$565.00
Two (2) bedrooms	\$550.00	\$625.00
Three (3) bedrooms	\$600.00	\$685.00
Four (4) bedrooms	\$700.00	\$800.00

<sup>\*</sup>If heat is included in rent, the township will consider paying an additional \$65 for a one bedroom residence, \$75 for a two bedroom residence, \$85 for a 3 bedroom residence and \$100 for a four bedroom residence.

The amount of shelter assistance provided must be the most economical and practical method of relieving the applicant. Adams Township will provide shelter assistance only for the size of the housing unit needed to accommodate the number of persons and family composition of those in the household. To determine the maximum size of the unit necessary for the household, Adams Township will take into consideration the number of persons in the household; the relationship, age and gender of the household members, and any special circumstances that might necessitate a larger unit.

The general standards are:

<b>Household Size</b>	Maximum Unit Size
One person or couple	1 Bedroom
One person or couple Plus one additional occupant	2 Bedroom
One person or couple Plus two additional occupants	3 Bedroom
One person or couple Plus three additional occupants	4 Bedroom

## **MONTHLY MAXIMUM UTILITY ALLOTMENT\***

	ELECTRIC	CITY UTILITY	GAS
Efficiency	\$100.00	\$70.00	\$85.00
One (1) bedroom	\$130.00	\$100.00	\$110.00
Two (2) bedrooms	\$165.00	\$110.00	\$135.00
Three (3) bedrooms	\$180.00	\$120.00	\$165.00
Four (4) bedrooms	\$195.00	\$130.00	\$190.00

For housing units with electric heat only, Adams Township will consider adding the gas allotment to the electric allotment to determine the amount of electric utility assistance.

<sup>\*</sup>Adams Township will provide utility assistance only for the size of the housing unit needed to accommodate the number of persons and family composition of those in the household. To determine the maximum size of the unit necessary for the household, refer to Schedule L, Monthly Shelter Allotment.

# **BURIAL ALLOTMENT**

	<u>INFANT</u>	<u>ADULT</u>
Funeral Home	\$150.00	* \$ 700.00
Cemetery	\$100.00	\$ 700.00
Cremation	\$200.00	\$ 200.00

<sup>\*</sup>Allotment may increase (up to \$800.00 maximum) for larger casket.

# ADAMS TOWNSHIP TRUSTEE OFFICE

# 1125 Hartzell Street New Haven, IN 46774

Case #
Investigator
Date

(260) 749-4162 phone (260) 749-6086 fax info@adamstownship.org

# **Shelter Verification Affidavit**

	has applied for township assis	tance. In order	to determine elig	ibility, please complete
this form and return it to our o	ffice as soon as possible.			
Special Instructions for questions that don't apply	<b>Move-In Assistance:</b> For Quy, simply write in N/A.	2, write in the	expected move i	n date. Also, for
1. Address	2. Move in	e in date:		
3. Rental Rate \$pe	er 4. Is deposit paid	? Y N	5. # of bedroo	ms:
6. Is there a co-signor? Y	N If yes, name(s):			
The state of the s	ehold a relative of the landlo			-
8. Does the tenant receive	Section 8 (Housing)? Y	N If yes, ter	nant's portion \$_	
9. Total amount due as of t	oday's date: \$			
10. Have you filed an evict	ion? Y N			
11. Appliances provided (c	ircle): refrigerator / stove/o	ven / washe	r / dryer / othe	er
12. Utility Information:				For utilities NOT INCLUDED w/rent:
Included in rent: (no additional cost)	Tenant must pay to separate utility co.	Tenant mus directly to la		Check if utility has individual meter.
☐ electric ☐ gas ☐ water ☐ trash ☐ sewer ☐ other ☐ oth	electric gas water trash sewer oer other	electric gas water trash sewer		☐ electric☐ gas☐ water
13. <b>List EVERY member o</b> household that will be movin	of this household (for moveing in).	-in assistance	e, please list eve	ery member of the
				8

### PLEASE COMPLETE PAGE 2

This form must be completed by the owner of the property, unless there is a registered agent legally designated to handle the owner's rental business. Owner information MUST be provided, regardless of who signs the form. The undersigned (owner)\_\_\_\_ \_\_\_\_\_, being duly sworn upon his/her oath, deposes and says: printed name of owner (not agent) (1) He/She is the legal fee simple owner of real property located at \_\_\_\_\_\_ and is legally entitled to collect rent thereon. (2) That said property has been rented to \_\_\_\_\_\_ for \$\_\_\_\_ per month: (3) That the owner/landlord DOES NOT reside at this address; IS NOT related to any household member, or IS related to at least 1 tenant. Describe relationship: to act as agent or owner to (4) That the undersigned (owner) hereby authorizes \_\_\_\_ collect the rent for the above-described property. If box is checked, this client is requesting shelter assistance. The following information is relevant for payment. (1) That owner understands that by accepting a voucher (general purchase order) as payment (whole or partial) for the time period expressed on the voucher; landlord is guaranteeing that the tenant will not be evicted for non-payment for the period covered on the voucher as long as the tenant pays the denied amount that the Township cannot pay. (2) This form does not constitute a contract on the part of either party. It merely sets forth the agreement terms and aids in the determining of the client(s) eligibility. The contract commences upon the signing of the voucher by all parties. (3) All Adams Township vouchers (purchase orders) issued from this office must be signed and returned to Adams Township Trustee office in order to process payment. Payments are mailed every Monday, Tuesday, and Thursday. Signature of Agent For Tax Purposes Printed Name of Agent Signature of Owner/Landlord Telephone Number of Agent Printed Name of Owner/Landlord Upon approval, check is being mailed to the following: Address, (City, State, Zip) of Owner/Landlord Name: Address: Telephone Number of Owner/Landlord Social Security or Federal I.D. Number of Owner/Landlord I do solemnly affirm that the information on page one and two are true and correct to the best of my knowledge and belief. Printed Name of Owner Signature of Registered Owner Date

### **COMPLIANCE WITH OTHER AGENCIES**

It's very important that when you request assistance from Adams Township you also comply with other agencies in our community. Several of them can help in ways that Adams Township cannot. It is a requirement that you comply with the following agencies in order to receive assistance. Following is list of ways to comply with other agencies:

#### FOOD STAMPS/TANF

- Attend all IMPACT classes
- Attend all update meetings
- Attend all recertification appts.
- Complete all job search requirements
- If unable to get food stamps/tanf must provide letter from FSSA stating why

#### **FWHA (SECTION 8 & PUBLIC HOUSING)**

- Everyone must apply
- Update address or name change or household size change
- Attend all orientations / return all paperwork including postcards to FWHA within time frame allowed
- · Report new or changed income
- Attend all recertification appts.
- Once on FWHA, must continue to comply with all rules & regulations governed by the agency
- Do everything required to stay on FWHA
- If denied FWHA, must provide a denial letter with date, reason for denial
- If evicted from FWHA, must provide effective date, reason for eviction

### SOCIAL SECURITY DISABILITY& MEDICAID

- Attend all appointments
- Provide all required documentation to above agencies
- Provide physicians statements every 3 months
- Provide updates from agencies to Adams TWP
- Appeal after each denial & provide proof of doing so
- Securing an attorney after the second Social Security denial sometimes helps to expedite the process

### **COMMUNITY ACTION (Brightpoint)**

- Apply for Energy Assistance Program each year
- Provide all required documentation
- Apply for childcare if applicable

#### CHILD SUPPORT OFFICE

- Must file for support for all children in the household
- Do everything necessary to find the father of the children
- Cooperate with Prosecuting Attorney doing everything necessary to obtain support
- Get paternity tests for all children in the household
- Appear in court

Failure	to com	nly ic	grounds	for	denial	of	Adame	Township	Assistance.

SIGNATURE	DATE	
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### MONTHLY TELEPHONE ALLOTMENT

Adams Township recognizes a telephone as a basic necessity. Clients may spend up to \$45 per month toward the most cost-effective telephone service available, which payment will not be counted as a wasted resource.

Clients who want a telephone must apply for a cell phone through one of the free cell phone programs for low income individuals and must do everything required to receive a free cell phone.

Adams Township will consider paying a maximum of \$45 per month for extra minutes for Clients who have a free cell phone for low-income individuals.