

Application for Township Assistance COVID-19

Application Date: _____

Applicant's Full Name: _____ Male Female

Phone #: _____ Email Address: _____

Social Security #: _____ Date of Birth (MM/DD/YY): _____

Street Address: _____ City, State: _____ Zip: _____

How long have you lived at your current address: _____ months _____ years

What is your housing status? Own Rent Homeless

Please list all people living in your household. For each person, select the relationship to the applicant and all income sources.

Name	Relationship*	Income Source	Monthly Amt	Date of Birth
	Yourself	<input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages	\$	
		<input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages	\$	
		<input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages	\$	
		<input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages	\$	
		<input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages	\$	
		<input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages	\$	

*Relationship: yourself, spouse, child, roommate, other

Income status: wages stopped waiting on income receiving income no income

Employment status: working laid off on never worked quit fired leave

Do you have investment holdings (stocks, bonds, CDs, IRAs)? yes no

Do you have a checking account? yes no Do you have a savings account? yes no

	Applicant	Other Adult	Other Adult
Current/Recent Employer			
Start Date – End Date			
Reason for leaving			

Is everyone in the household a US citizen: yes no

List other public assistance*: _____

*subsidized housing, utility allotment, EAP utility assistance

Please list assistance needed. _____

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 operate 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 you have applied for assistance from the Division of Disability, Aging, and Rehabilitative Services as stated under IC 12-20-16-3. IC 12-20-6-5 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 trustee shall require those able to work to seek employment and the trustee shall refuse any aid until the trustee is satisfied that the persons claiming help are endeavoring to find work for themselves. IC 12-20-11-1 requires a recipient or other adult member of the household, with certain exceptions, to do work needed to be done within the county or an adjoining township in any other county for any governmental unit having jurisdiction in those townships.

I HAVE READ THE ABOVE NOTICE OF PUBLIC LAW.

_____ Signature of Applicant	_____ Signature of Other Adult	_____ Signature of Other Adult
Are you willing to work for the township and actively seek employment as a condition of receiving trustee assistance?		
Applicant: YES NO	Other Adult: Yes No	Other Adult: Yes No
If not, explain why not: _____		

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 information to _____, the investigator of township assistance for _____ Township _____ County, Indiana:

Information that will verify my:

1. Countable income.
2. Countable assets.
3. Wasted resources.
4. Relatives capable of providing assistance.
5. Past or present employment.
6. Pending claims or causes of action.
7. A medical condition if relevant to work or workfare requirements.
8. Any other information required by law.

This information may be used only in connection with:

- (1) My township assistance application from _____ Township _____ County, IN.
- (2) My application for public assistance from the Division of Family and Children county offices and the Office of Medicaid Policy and Planning.
- (3) Others (if any).

Signature of Applicant

Signature of Other Adult

Signature of Other Adult

Date Signed

Date Signed

Date Signed

This consent form expires 180 days after the date of signing.

ACKNOWLEDGMENT AND PLEDGE OF CONFIDENTIALITY BY THE TOWNSHIP

The undersigned township trustee or employee acknowledges that he/she may, in the course of employment, have access to certain personal information and that such information is to be treated as confidential, and is to be released and exchanged only with agencies related to the undersigned employment by the township in reviewing and investigating this application or as otherwise provided by law.

Trustee or Employee

Date Signed