City of Champaign Township
Andrew J. Quarnstrom, Supervisor
53 E. Logan St.
Champaign, IL 61820
Phone 217-403-6120 FAX 217-403-6125

Please submit the following (circled) items of documentation in order to complete the eligibility process: **ONLY ORIGINAL COPIES ARE ACCEPTED.....NO XEROX COPIES WILL BE ACCEPTED**

- **Proof of Residency within the limits of the City of Champaign, IL (Certification of Address) MUST BE NOTARIZED**
- **Proof of Inability to Work – A physician, physician assistant, or a nurse practitioner must complete, sign & date using their company stamp on the Certification of Medical Status Form included in the application package**
- **Illinois Driver's License or State ID – Social Security Card – Birth Certificate**
- **Proof of SSI/SSD Application Documentation with Date Filed**
  - **Proof of SSI/SSD Denial Letter Documentation with Date Filed**
  - **Proof of SSI/SSD Appeal Letter Documentation with Date Filed**
  - **Proof of Request for Reconsideration of Application with Date Filed**
  - **Proof of Request for Hearing before Administrative Law Judge (ADJ) w/ date**
- **Proof of IDSH Food Stamp Benefits with Date from Caseworker**
- **Proof of State of Illinois Health Care & Family Services Medical Card**
- **Proof of Application for Affordable Health Care Act with Date**
- **UI Finding/Payment Detail History from the IDES Office**
  - **1307 N. Mattis Ave. – PO Box 3369, Champaign, I L61821**
- **Proof of Charges from Parole or Probation Officer (included in application package) completed and signed by Parole/Probation Officer w/Date**
- **Proof of any additional income within the past month**

State of Illinois
Department of Human Services

1(Permanent)

APPLICATION FOR GENERAL ASSISTANCE

City or Township: City of Champaign Township

County: Champaign

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 First Middle Last	Date of Birth Month Day Year	Birthplace City State	Relationship	Illinois Department of Employment Security Registration Number	Social Security Number
			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 First Middle Last	Age	Relationship	Present Means of Support	Amount Paid Monthly for Board, Lodging, or Share of Household Expenses

2. Why do you need assistance?

State of Illinois
Department of Human Services

1(Permanent)

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

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 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: _____

City of Champaign Township
Andrew J. Quarnstrom, Supervisor
53 E. Logan St.
Champaign, IL 61820
Phone: 217-403-6120 Fax: 217-403-6125

Are you Eligible for General Assistance/Transitional Assistance

Name: _____ SS#: _____
Birth Date: _____ Telephone No._____

Please answer the following questions: (Yes or No)

_____ Do you live **outside** of the City of Champaign?

_____ Do you currently receive **a Cash Grant from IDHS?**

_____ Have you been **Denied a Cash Grant from IDHS due to failure to cooperate** with that agency?

_____ **Have you had an IDHS case Termination because you have reached the lifetime limit?**

_____ Do you receive **SSI or SSD (Disability)?**

_____ Do you receive **Social Security benefits in excess of $250.00 per month, other than SSI?**

_____ Have you had your **SSI cancelled due to your failure to cooperate** with the agency**?**

_____ Are you **receiving or eligible to receive Unemployment Compensation Benefits**?

_____ Do you have an **active felony warrant for your arrest?**

_____ Are you are in **violation of parole or probation in the State of Illinois?**

_____ Do you have a **State Class X or Class 1 Felony Drug** conviction or Federal law equivalent?

_____ **Have you ever been convicted of a felony under the Illinois Controlled Substances Act or the Cannabis Control Act or comparable federal criminal law which has an element the possession, use or distribution of a controlled substance?**

_____ Do you have children under the age of 18 in the household?

_____ Are you pregnant?

If you answered YES to any of the following questions, then you are ineligible for General Assistance-Transitional Assistance.

CITY OF CHAMPAIGN TOWNSHIP
GENERAL ASSISTANCE-TRANSITIONAL ASSISTANCE OFFICE

Andrew J. Quarnstrom, Supervisor
53 E. Logan St., Champaign, IL 61820
Office (217) 403-6120 Fax 403-6125

CERTIFICATION OF ADDRESS

TO THE APPLICANT: If you do not have a lease, you must have the person you are residing with provide proof of your residency by completing this form.

TO THE LAND OWNER: The person listed below has applied for General Assistance-Transitional Assistance and has indicated that she or he resides with/or rents from you. All General Assistance-Transitional Assistance applicants must provide written verification by the land owner of record (as recorded at the assessor's office) of the applicant's current address.

Please complete the form below. YOU MUST SIGN THE FORM AND HAVE YOUR SIGNATURE NOTARIZED BY A NOTARY PUBLIC. Notary services are available at the township office free of charge. The Urbana Free Library and local banks and also offer notary service.

I, _____ certify that _____
(Land Owner or Tenant) *(Applicant)*

has resided at _____
(Street Address) *(City, State, Zip Code)*

since _____ and pays $ _____ a month for rent. I understand that falsifying any information regarding the applicant's address will jeopardize the applicant's eligibility and could result in several penalties.

Please check the appropriate statement:

_____ I verify that I am the owner of record for the above listed address.

_____ I am not the owner of the property at the address listed above.

_____
Land Owner's or Tenant's Signature

_____
(Street Address) *(City, State, Zip Code)* *(Phone)*

_____ _____
Date *Notary Public*

Shared server: f:\Caseworker\GAForms\certification of address

CITY OF CHAMPAIGN TOWNSHIP
General Assistance-Transitional Assistance Office
53 E. Logan St.
Champaign, IL 61820
Phone: (217) 403-6120 Fax: (217) 403-6125
Andrew J. Quarnstrom, Supervisor

CERTIFICATION OF MEDICAL STATUS

Date of Request:
Address:
Social Security #

Name:
Date of Birth:
Client Case Number:

PURPOSE: This form documents the current and ongoing medical status of the applicant (patient) identified above for the purpose of qualifying and recertifying for General Assistance-Transitional Assistance benefits. It does not constitute as a finding of disability. ***The law defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment (s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.*** To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other full-time job in the national economy. **This form must be completed by the patient's physician, physician assistant or advanced nurse practitioner who has diagnosed the patient.**

PROVIDER CERTIFICATION:

Has this patient been in care with your clinic/practice within the last 6 months? [ ] Yes [ ] No

___ **Based upon my medical evaluation, I have diagnosed the patient listed above with the chronic medical condition (s) indicated below and I certify that the patient is in need of ongoing treatment including prescription drugs, chemotherapy or radiation for this condition (s):**

____ Cancer patient requiring chemotherapy - except non-melanoma skin cancer
____ Terminally ill (see definition on reverse side)
____ Heart Disease - Cardiac failure/coronary artery disease, bypass or stents
____ Kidney Problems (failing or on dialysis)
____ Cystic Fibrosis
____ Spinal Cord injuries
____ Chronic Diabetes or Diabetes Insipidus or Diabetes Mellitus Types 1 & 2
____ Chronic seizure disorder
____ Chronic mental illness (see definition on reverse side)
____ Bipolar Disorder
____ Chronic hypertension
____ Multiple Sclerosis
____ Other (Specify)

Diagnosis_____

___ **I certify that I have examined the patient named above and this patient does NOT require prescription drugs, chemotherapy or radiation for their chronic condition or illness.**

B. Treatment Discontinued

[ ] Is non-compliant with appointments
[ ] Is non-compliant with medication
[ ] Other _____
[ ] Has relocated out of town
[ ] Has transferred medical care

DEFINITIONS
Acute and Chronic Medical Conditions

The following definitions are offered as guidance in making a medical determination of whether the individual listed on the reverse side of this form presents "chronic mental illness" or is "terminally ill." These definitions are only guidelines and are not intended to replace your professional medical judgment in a specific case. These definitions do generally reflect the conditions for which the GA-TA Program is intended:

What is a "Medically Determinable Impairment"?
A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings-not only by the individual's statement of symptoms.

Chronic Mental Illness: An individual with "chronic mental illness" suffers from a very serious mental illness and exhibits significant deficiencies in functioning. A chronic mental illness is more than a severe emotional disturbance, and is marked by the presence of (1) a psychosis of some kind, (2) a mental disorder that is marked by a loss of contact with reality, and (3) by a deterioration in personality and social functioning. A determination of chronic mental illness means that the individual shows involvement generally consistent with the following Medicaid definition of "chronically mentally ill adult" in 7 AAC 43.1990(10):
"chronically mentally ill adult" means an individual 21* years of age or older (1) who has been diagnosed as having a schizophrenic, major affective, or paranoid disorder, or other severe mental disorder with a documented history of persistent psychotic symptoms not caused by substance abuse; **and** (2) whose role functioning is impaired in at least two of the following three ways:

(A) inability to function independently in the role of worker, student, or homemaker;
(B) inability to engage independently in personal care or community living activities; or
(C) inability to exhibit appropriate social behavior, resulting in intervention by the mental health system or judicial system.

Terminally Ill: Reference Medicare and Medicaid definition used for hospice care:
"Terminally Ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (42 C.F.R. 418.3)
By signing, I certify that this patient is unable to work due to a psychological or physical disability. PLEASE USE YOUR COMPANY STAMP OR SEAL on the back of this form to validate that this form has been completed at your location.

(Dr.) Provider Name: (Print) Date: _____

_____

Title:_____ Specialty:_____

Signature: _____

Address: _____

City/State/Zip Code: _____

Phone/Fax: _____

CITY OF CHAMPAIGN TOWNSHIP
GENERAL ASSISTANCE /TRANSITIONAL ASSISTANCE OFFICE

53 E. Logan St., Champaign, IL 61820
Phone (217) 403-6120 Fax (217) 403-6125

GENERAL ASSISTANCE- TRANSITIONAL ASSISTANCE
APPLICATION SUPPLEMENT
(To be submitted with completed application)

Name:_____ Soc. Sec. No. _____

Birth Date: _____ Telephone No _____

1) Have you ever been convicted of/plead guilty to a violation of the Illinois Controlled Substances Act, the Cannabis Control Act, or comparable federal criminal law which has as an element the possession, use or distribution of a controlled substance? ____ Yes _____ No
If yes, please specify the class: _____ Date of conviction: _____

County of conviction: Champaign County_____ Other (specify) _____

2) Have you ever been convicted in federal or state court of having made a fraudulent statement in order to receive assistance (TANF, G.A., OR SOCIAL SECURITY) _____ Yes _____ No

3) Are you in violation of a probation or parole order? _____Yes _____No Are you named in any outstanding felony warrants? _____Yes _____No

4) Please note, which of the following you have applied for, been denied from, terminated from or are currently receiving:

Type of Benefit	Application Date	Denied Date	Termination Date	Date Benefit Last Received	Amount Received
SSI					
SSD					
IDHS Medical					
TANF/AFDC					
Food Stamps					
Worker's Comp., Personal Injury Lawsuit, Employment Disability (Long or Short Term)					
Unemployment Benefits					

I certify under penalty of perjury that the information I have provided on this form is true and complete to the best of my knowledge.

Date: _____ **Signature:** _____

City of Champaign Township
Andrew J. Quarnstrom, Supervisor
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Phone: 217-403-6120 Fax: 217-403-6125

Statement of Support

Name: _____

Address: _____

Date: _____

Please write a brief statement explaining how you have been supporting yourself. Thank you.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CITY OF CHAMPAIGN TOWNSHIP GENERAL ASSISTANCE OFFICE
Andrew J. Quarnstrom, Supervisor

53 E. Logan St.
~~603 S. Randolph St.~~
Champaign, IL 61820

Phone: (217) 403-6120
Fax: (217) 403-6125

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: _____ Date: _____

Please print the following:

Name of Witness: _____

Address: _____

_____

_____

City of Champaign Township
Andrew J. Quarnstrom, Supervisor
53 E. Logan St.
Champaign, IL 61820
Phone: (217) 403-6120 Fax: (217) 403-6125

Request For Information
Parole Officer or Probation Officer

Date: _____

To: _____

Applicant Name:_____ IDOC#:_____

In order to determine eligibility for General Assistance, the City of Champaign Township is requesting the following information.

1. Charge: _____
2. Class:_____
3. Parole/Probation Status: (Please Circle One) Active Discharged None
4. Location of Charge: _____
5. Parole Probation Period:
   From: _____ to _____

(Please Circle Answer)

Has the above person been convicted of a Class X or Class 1 felony under the Illinois Controlled Substance Act? If so, please provide date of conviction?

Yes No Date _____

Has the person been convicted of a lesser charge than a Class X or Class 1 felony under the Illinois Controlled Substance Act or any comparable federal criminal laws?
If so, please provide date of conviction.

Yes No Date _____

If yes to the above question, is the person currently participating or have they completed a treatment program?

Yes No Date _____

Has the person above been convicted of the Cannabis Control Act of any comparable federal crime law? If so, please provide date of conviction.

Yes No Date _____

(TURN PAGE OVER)

Has the above person been convicted of any sexual crime, crime against a child, or violent crime? If yes, are there limitations of housing or work/training site placement?

Yes No Date _____

Has the above person violated any condition of probation or parole? If yes, date of violation:

Yes No Date _____

Is applicant now in compliance?
Yes No

Does the above person have any court order requirements of probation/parole, i.e. treatment, counseling, etc.? If yes, please state requirement and if person is complying? Yes No

_____

_____

****

RELEASE OF INFORMATION

Authorized Given by: (Applicant's Name)

_____

This verification of information was provided by:

_____ _____
Signature of Parole/Probation Officer Print Name Here

_____ _____ _____
Title Date Phone #