City of Champaign Township
Kyle Patterson, Supervisor
53 E. Logan St.
Champaign, IL 61820
Phone: 217-403-6120

# Are you Eligible for General Transitional Assistance

**Please answer the following questions: (Yes or No)**

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

_____ Are you **currently** employed?

_____ Are you **currently seeking** employment?

_____ 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)?**

_____ 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 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?

**City of Champaign Township**
**Kyle Patterson, Supervisor**
**53 E. Logan St.**
**Champaign, IL 61820**
**Phone 217-403-6120**

Please submit the following items of documentation (all must be dated in the past 30 days): **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 or a Lease) 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 with current City of Champaign Address**
- **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 from the IDES Office – (*mailed to the applicant, takes about a week. If UI Finding is more than 30 days old a Payment History Detail must accompany the Finding.)**
  - **You can do this online yourself, or if you need the case manager's assistance in doing so, you will need to schedule an appointment to get that done.**

- **Proof of Charges from Parole or Probation Officer (included in application package) completed and signed by Parole/Probation Officer w/Date**

- ***THIS LIST IS BY NO MEANS ALL-INCLUSIVE* TOWNSHIP STAFF MAY REQUIRE ADDITIONAL DOCUMENTATION RELATED TO THE ASSISTANCE APPLICATION* ANY ADDITIONAL DOCUMENTATION REQUESTED MUST BE GIVEN TO TOWNSHIP STAFF IN ORDER TO PROCESS AN APPLICATION FOR ASSISTANCE* EXAMPLES OF DOCUMENTATION TO BE REQUESTED INCLUDE BUT ARE NOT LIMITED TO:**
    - **Documentation showing any type of rent assistance received, for example:**
        - **From Rosecrance**
        - **From Champaign County Housing Authority**
        - **RPC's Shelter Plus Care Program or,**
        - **If a family member/friend assists with rent and utilities**
            - **A notarized letter stating that they will be required**
            - **Documentation on how power bill will be paid**
            - **Documentation on how water bill will be paid**
    - **Additional documentation from IDES and,**
    - **Any other documentation deemed necessary by the Township Case Manager or Township Supervisor**
- ***FAILURE TO PROVIDE REQUESTED DOCUMENTATION WILL RESULT IN THE APPLICATION BEING CONSIDERED INCOMPLETE, AND WILL NOT BE PROCESSED FURTHER UNTIL REQUESTED DOCUMENTATION HAS BEEN RECEIVED***

# APPLICATION FOR GENERAL TRANSITIONAL ASSISTANCE

Township: City of Champaign Township
County: Champaign

Date Issued: _____
Date Returned: _____

1. General Information:

Last Name: _____ First Name: _____ M: _____

Date of Birth: _____ Social Security Number: _____ Birthplace: _____

Other Names/Spellings: _____

Primary Contact Number: _____

Email Address: _____

Current Address: _____, IL Zip: _____

Date of Move-In: _____ Monthly Rent: $_____

Previous Two Addresses (including city, state and Zip code):

Address 1: _____ Date Moved In: _____

Address 2: _____ Date Moved In: _____

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

First Name: _____ M: _____ Last Name: _____

Date of Birth: _____ Relationship to Applicant: _____

How do they support you? _____

First Name: _____ M: _____ Last Name: _____

Date of Birth: _____ Relationship to Applicant: _____

How do they support you? _____

2. Why are you seeking assistance?

_____

_____

_____

_____

_____

CITY OF CHAMPAIGN TOWNSHIP

# APPLICATION FOR GENERAL TRANSITIONAL ASSISTANCE

3. Personal Information

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

If married, date of Marriage: _____

If separated, state the reason: _____

_____

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

_____

Living Arrangements: Rent: ____ Own: ____ Living with Someone: ____ Homeless: ____ Shelter: _____

Military Service: Do you or your spouse have current or previous military service? Yes: ___ No: ____

If "Yes" who has current or previous military service? _____

If you or your spouse have current or previous military service, are either of you receiving any income from such service? Yes: ____ No: ____

Past Employment: List your last employer and one longest term employer.

Name and Address (include City & State) of Employer: _____

_____

_____

Hours Worked Weekly: _____ Hourly Wage: _____ Start Date: _____ End Date: _____

Reason for Leaving: _____

_____

Name and Address (include City & State) of Employer: _____

_____

_____

Hours Worked Weekly: _____ Hourly Wage: _____ Start Date: _____ End Date: _____

Reason for Leaving: _____

_____

CITY OF CHAMPAIGN TOWNSHIP

# APPLICATION FOR GENERAL TRANSITIONAL ASSISTANCE

Are you receiving from any of these Public Assistance Benefits? If yes, check all that apply.

TANF: _____ SNAP: _____ RSDI: _____ AABD: _____ GENERAL ASSISTANCE: _____ OTHER: _____

Are you receiving cash from any of these sources? If yes, check all that apply.

Unemployment Benefits: _____ Worker's Compensation: _____ Alimony/Child Support: _____

Friends/Relatives: _____

Do you have any bank accounts or savings accounts? Yes: _____ No: _____

If you answered yes, which kind of account? _____

Do you have any vehicles? Yes: _____ No: _____ How many vehicles? _____

List of all vehicles:

Year: _____ Make: _____ Model: _____

Year: _____ Make: _____ Model: _____

Year: _____ Make: _____ Model: _____

Year: _____ Make: _____ Model: _____

Medical Information:

Please, tell me the name, phone number, and address to your physician/s:

_____

_____

List your insurance:

Name of Company: _____ Type of Coverage: _____

CITY OF CHAMPAIGN TOWNSHIP

# APPLICATION FOR GENERAL TRANSITIONAL ASSISTANCE

I understand that if I want someone else to apply for General Transitional 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 Transitional 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 Transitional 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.

I agree to notify the Case Manager of General Transitional 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 Case Manager of General Transitional 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 an application for General Transitional 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
Kyle Patterson, Supervisor
53 E. Logan St.
Champaign, IL 61820
Phone: 217-403-6120

# Statement of Support

Name: _____

Address: _____

Date: _____

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

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

## Consent to Release Information

Date:_____ Name:_____ DOB: _____

I, the above named, give permission for staff members at the City of Champaign Township to contact, obtain, and share information with the following organizations:
(Please strike through any organization you do not want contacted).

| | |
|---|---|
| Regional Planning Commission | Daily Bread Soup Kitchen |
| Housing Authority of Champaign County | Salt and Light |
| Champaign-Urbana Tenant Union | Phoenix House/CU at Home |
| Rosecrance | Habitat for Humanity |
| PACE: Center for Independent Living | Department of Human Services |
| First Followers | Courage Connection |
| Salvation Army | Restoration Urban Ministries |
| Cunningham Children's Home | OSF Hospital |
| City of Champaign Township | Empty Tomb |
| Cunningham Township | Francis Nelson |
| Champaign County Health Care Consumers | Carle Foundation Hospital |
| Land of Lincoln Legal Aid | Social Security Administration |
| Landlord Name: | |
| Other: | |

*By signing this release form, you are giving the City of Champaign Township permission to assist you with advocacy, obtaining information, and/or communicating with others involved in your case. We will work closely with you to ensure that you approve of our actions on your behalf. You can also withdraw this agreement at any time by contacting us. This consent expires one year after the date it is signed. Thank you!*

Signature:_____ Date: _____

Witness:_____ Date: _____

**CITY OF CHAMPAIGN TOWNSHIP**
**GENERAL TRANSITIONAL ASSISTANCE OFFICE**

Kyle Patterson, Supervisor
53 E. Logan St., Champaign, IL 61820
Office (217) 403-6120

# 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 LANDOWNER: The person listed below has applied for General Transitional Assistance and has indicated that she or he resides with/or rents from you. All General Transitional Assistance applicants must provide written verification by the landowner 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 IN FRONT OF A NOTARY AND HAVE YOUR SIGNATURE NOTARIZED BY A NOTARY PUBLIC. Notary services are available at the Urbana Free Library, The UPS Store, and local banks also offer notary services.

I, _____ certify that _____
*(Landowner 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 Transitional Assistance Office**
**53 E. Logan St.**
**Champaign, IL 61820**
**Phone: (217) 403-6120**
***Kyle Patterson, Supervisor***

# ***CERTIFICATION OF MEDICAL STATUS***

**Date of Request:** **Name:**
**Address:** **Date of Birth:**
**Social Security #**

***PURPOSE:*** This form documents the current and ongoing medical status of the applicant (patient) identified above for the purpose of qualifying and re-certifying for General 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 ongo-ing 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 [ ] Has relocated out of town
[ ] Is non-compliant with medication [ ] Has transferred medical care
[ ] Other _____

**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. **"Chronically mentally ill adult"** means an individual 18 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 BELOW 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: _____

**STAMP HERE**

City of Champaign Township
Kyle Patterson, Supervisor
53 E. Logan St.
Champaign, IL 61820
Phone: (217) 403-6120

# Request For Information
# Parole Officer or Probation Officer

Date: _____

To: _____

Applicant Name:_____ IDOC#:_____

**In order to determine eligibility for General Transitional 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 _____

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 #