RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

APPLICATION FOR GENERAL ASSISTANCE

PRIMARY CONTACT INFORMATION

Applicant Name: _____ SSN: _____ ☐ Adult

Other Names or Spellings: _____ Relationship: _____

IDES Reg #: _____ Birthdate: _____ Birthplace: _____

Home Phone: _____ Work Phone: _____ _____

Email Address: _____

Application Date: _____ Case ID #: _____

Need for Assistance: _____

PRESENT ADDRESS INFORMATION

Address 1: _____

Address 2: _____ Address 3: _____

City: _____ State: _____ Zip: _____

Date Moved In: _____ in Township Since: _____ in County Since: _____ in State Since: _____

Residence Status: _____ Amt/Mo: _____ Landlord: _____

Landlord Relation: _____ Landlord Address: _____

PREVIOUS ADDRESS INFORMATION

Address	City	State	Zip	Date Moved In

MARITAL STATUS

Marital Status: _____ Spouse: _____

Married On: _____ Location of Marriage: _____

Reason for Separation: _____ Spouse Address: _____

ASSISTANCE UNIT MEMBERS

Name	Birth Date	Birth Place	Relationship	IDES Reg #	SSN

NON-ASSISTANCE UNIT MEMBERS

Name	Age	Relationship	Means of Support	Monthly Amount Paid for Expenses

MILITARY INFORMATION

Family Member	Branch	Serial #	Enlisted	Discharged	Recv Comp?	Recv Pension?

PRESENT EARNED INCOME INFORMATION

Person Receiving	Source	Employer or Description of Resource	Monthly Amount

PUBLIC ASSISTANCE AND RELATED PUBLIC BENEFITS

Person Receiving	Source	Amount

PRESENT UNEARNED INCOME INFORMATION

Person Receiving	Source	Description of Resource	Monthly Amount

PRESENT ASSET INFORMATION

Person Receiving	Source	Description of Resource	Amount

MEDICAL INSURANCE BENEFIT INFORMATION

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 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: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
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22013 Governors Highway
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Phone: (708) 748-6722

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: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
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Phone: (708) 748-6722

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: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
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Phone: (708) 748-6722

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.

Signature: _____ Date: _____

STATE OF ILLINOIS)
) ss.
COUNTY OF _____)

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_____

Notary Public: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

CONSENT TO RELEASE OF INFORMATION

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

Rich Township General Assistance Department

22013 Governors Highway

Richton Park, IL 60471

Phone: 708-748-6722

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.

Effective Dates: _____ to _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Please print the following:

Name of Witness: _____

Address: Rich Township

22013 Governors Highway

Richton Park, IL 60471

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

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: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
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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 RICH 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: _____

_____

_____

_____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

JOB SEARCH FORM

CLIENT: _____ **DATE ISSUED:** _____

EMPLOYER: The bearer of this form is responsible for conducting an active search for employment. To verify this, we are asking for your cooperation by signing or stamping in the column indicated below.

DATE	COMPANY	ADDRESS & PHONE	POSITION AVAILABLE	SIGNATURE/STAMP

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

Client Signature: _____

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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), RICH 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 RICH 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 or 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
RICH 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:

RICH TOWNSHIP
22013 Governors Highway
Richton Park, IL 60471
(708) 748-6722

I have received a copy of the RICH TOWNSHIP Notice of Privacy Practices on _____ (Date).

Signature: _____ Date: _____

Please print your name: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

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. Hence, you may not receive the maximum permissible amount if you have any income.
- 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 disbursing orders will be issued totaling the amount of your grant. The disbursing orders may only be used to obtain allowable basic maintenance needs.

MEDICAL ASSISTANCE

- If approved for GA, you are entitled to have certain medical care paid for unless you are denied medial 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: _____

FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Case #: _____

Notice of Benefits Given On: _____

Notice of Benefits Given By: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

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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

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

GENERAL ASSISTANCE OFFICE

Issued By: _____ Date: _____

(NEXT PAGE)

NOTICE ABOUT THE DECISION BY THE GENERAL ASSSISTANCE 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

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

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.

GENERAL ASSISTANCE OFFICE

Issued By: _____ Date: _____

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FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Case #: _____

Date of Mailing Notice: _____

Notice Sent By: _____

Notice Sent To: _____

Date and Response From Other Unit: _____

_____

_____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

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

(NEXT PAGE)

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: _____

FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Case #: _____

Notice of Rights Given On: _____

Notice of Rights Given By: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

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: _____

FOR USE OF GENERAL ASSISTANCE OFFICE ONLY

Case Name: _____

Notice of Rights Given On: _____

Notice of Rights Given By: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

MEDICAL RESOURCE INQUIRY

Applicant/Recipient: _____ Date: _____

You must provide information to the General Assistance Office about any medical insurance or other medical benefits that covers you and the persons listed in your Application for General Assistance. If you do not provide this information, neither you nor anyone else listed in your Application will receive medical assistance.

Answer **all** of the questions below. This inquiry should be submitted to the General Assistance Office together with all documents and information you have regarding medical insurance or other medical benefits.

1. Did either you or your spouse work during the last 3 months at a job in which you were covered by group health insurance? **[ ] Yes [ ] No**

If yes, you must provide (a) the Social Security Number(s) of the employed person(s), (b) the health group ID card, (c) the name and address of the employer, and (d) the name and address of the insurance company.

_____

_____

_____

2. Do you or your spouse have insurance as a member of any union? **[ ] Yes [ ] No**

If yes, you must provide (a) the Social Security Number(s) of the union member(s), (b) the union and health group ID cards, (c) the name, address and local number of the union, and (d) the name and address of the insurance company.

_____

_____

_____

3. Does your application include a child(ren) who has a parent not living with you and, if so, does the absent parent have medical insurance covering either you or the child(ren)? **[ ] Yes [ ] No**

If yes, you must provide (a) the Social Security Number of the absent parent, (b) the health group ID cards covering you and the child(ren), (c) the name and address of the absent parent's employer, (d) the name, address and local number of the absent parent's union, if any, and (e) the name and address of the insurance company.

(NEXT PAGE)

4. If you are under 19 (or under 23 and a full-time student), do either of your parents include you in their group health insurance? **[ ] Yes [ ] No**

If yes, you must provide (a) your parents' names and Social Security Numbers (b) the health group ID cards covering you, (c) the name and address of your parents' employer(s), (d) the name, address and local number of your parents' union, if any and (e) the name and address of the insurance company.

5. Is anyone in your home covered by school insurance? **[ ] Yes [ ] No**

If yes, you must provide (a) the name and address of the school, and (b) the name and address of the insurance company.

6. Are you, your spouse, your parents or your child's other parent in the military or a military veteran?
[ ] Yes [ ] No

If yes, you must provide a name and address of the military member or veteran.

7. Do you or does anyone else pay for an individual health insurance policy (including an indemnity or income protection policy which pays a certain amount per day such as an AARP policy) for you or anyone in your home? **[ ] Yes [ ] No**

If yes, you must provide (a) the name, birthdate and Social Security Number of the person named as the policyholder, (b) the name and address of the insurance company, and (c) the policy number.

(NEXT PAGE)

8. If you or your spouse are retired, do you have health insurance coverage as a retiree or as a dependent or a survivor of a retiree? **[ ] Yes [ ] No**

If yes, you must provide (a) the Social Security Number of the retiree, (b) the health group ID cards covering you, (c) the name and address of the employer(s), (d) the name, address and local number of the union, if any, and (d) the name and address of the insurance company.

_____

_____

_____

9. Have you or has anyone in your household had a hospital or doctor bill paid by insurance in the past year? **[ ] Yes [ ] No**

If yes, you must provide (a) the name and address of the insurance company, and (b) the policy number.

_____

_____

_____

10. Do you have any other resource for the payment of your medical bills other than as mentioned above? **[ ] Yes [ ] No**

If yes, please specify and explain:

_____

_____

_____

Signature: _____ Date: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

REFERRAL FORM

Agency: Rich Township General Assistance Department

22013 Governors Highway

Richton Park, IL 60471

Phone: 708-748-6722 Fax: 708-228-5523

Regarding: _____

The aforementioned client is being referred to your office by the General Assistance Office to apply for or obtain information with regard to potential benefits. Please complete this Referral Form and return to the aforementioned General Assistance Office to advise it of the status of the client with regard to such benefits. Thank you for taking the time to complete and return this Referral Form.

GENERAL ASSISTANCE OFFICE

Issued By: _____ Date: _____

(Please print or type)

Has the client applied at your office for any of the following types of benefits? If so, please check the box that applies and indicate the date of application.

		Date of Application
[ ]	Unemployment compensation	_____
[ ]	TANF	_____
[ ]	SS, SSI, SSDI	_____
[ ]	Food Stamps	_____
[ ]	Expedited Food Stamps	_____
[ ]	Medical Aid No Grant	_____
[ ]	Medicaid	_____
[ ]	Other _____	_____

(NEXT PAGE)

Is the client eligible for or receiving assistance under any of the following programs? If yes, please indicate the amount of assistance and when it did or will commence.

		Date Commenced	Amount
[ ]	Unemployment compensation		
[ ]	TANF		
[ ]	SS, SSI, SSDI		
[ ]	Food Stamps		
[ ]	Expedited Food Stamps		
[ ]	Medical Aid No Grant		
[ ]	Medicaid		
[ ]	Other _____		

Has the client provided your agency with all documentation required to process their application?

[ ] Yes [ ] No If no, what further documentation is needed?

_____

_____

_____

Has the client been denied for any of the above listed benefits?

[ ] Yes [ ] No If yes, what was the type of benefit, date of and reason for the denial?

_____

_____

_____

Agency: _____

By: _____ Date: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, SSN _____, hereby authorize (medical provider) _____ to disclose protected health information related to services provided in connection with my medical treatment.

This medical information may be disclosed to personnel within the RICH TOWNSHIP Supervisor's Office and other individuals, specifically, _____, assisting me with this request.

Description of the information to be used or disclosed:

Indicate the reason for the release or request of information:

[ ] At the request of the individual or personal representative.

[ ] Other:

I understand that if I refuse to sign this authorization, the above described health information will not be disclosed except as provided by law.

I understand that:

- Eligibility for General Assistance may be affected if I do not sign this form.
- I may revoke this authorization at any time by written notification to the entity listed above. My revocation will have no effect on information that has been released under this authorization prior to receipt of my intent to revoke such authorization.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I am entitled to a copy of this authorization upon signature.

This authorization expires on: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

If a personal representative executes this form, that representative warrants that he or she has the authority to sign this form on the basis of _____

_____
(Parent, Guardian, Power of Attorney, or other Authorized Representative)

Signature: _____ Date: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor

22013 Governors Highway
Richton Park, IL 60471

Phone: (708) 748-6722

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), RICH 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 RICH 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.

(NEXT PAGE)

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

RICH TOWNSHIP
22013 Governors Highway
Richton Park, IL 60471
(708) 748-6722

I have received a copy of the RICH TOWNSHIP Notice of Privacy Practices on _____ (Date).

Signature: _____ Date: _____

Please print your name: _____

RICH TOWNSHIP GENERAL ASSISTANCE OFFICE
Calvin Jordan, Supervisor
22013 Governors Highway
Richton Park, IL 60471
Phone: (708) 748-6722

STATEMENT FOR MONTHLY RENT/MORTGAGE

Date: _____

Name: _____

Address: _____

City/St/Zip: _____

Rent/Mortgage Due for the month of: _____

Amount Due: _____

X Recurring monthly payment while the client is eligible for General Assistance.

One time only Emergency Assistance payment.

Name: _____

Address: _____

City/St/Zip: _____

Phone: _____

Landlord Signature: _____

Initials

I declare, under penalties of perjury, that I am the property owner of record. _____

I declare, under penalties of perjury, that I am an authorized agent of the owner. _____

As the landlord, I agree that upon receipt of payment from Rich Township, there will be no eviction/foreclosure proceedings initiated for the above named client for a period of 30 days. _____

Issued By: _____

Rich Township

22013 Governors Highway, Richton Park, IL 60471
(708)748-6722 Fax (708)748-8796

General Assistance Department

Landlord Statement

Date: _____

RE: Clients Name _____
Address _____
City _____

This is to confirm that the above named client is currently residing at said address and is paying

__ rent, __ mortgage, __ assessment fees to you. The monthly amount is $_____.

The above resident has a __ outstanding debt; __ is on time with their rent.

Rich Township will send a payment of $_____ directly to you, on behalf of the above named client. This amount:

____ will be recurring monthly while the client is eligible for General Assistance.

____ is a one time only **Emergency Assistance payment.**

Caseworkers Signature _____

As the landlord, I agree that upon receipt of payment from Rich Township, there will be no eviction/foreclosure proceedings initiated for the above named client for a period of 30 days.

Make check payable to _____

Address, City, State, zip: _____

Telephone: _____ Social Security/FEIN: _____

___I declare, under penalty of perjury, that I am the property owner of record.

___I declare, under penalty of perjury, that I am the lessee of the premises and therefore, an unauthorized agent of the owner, renting to the above named client. (Has Landlord given permission for you to have another occupant in your unit).

Landlord Signature _____

Note: If private citizen owns property, you must provide a copy of your State of Illinois Driver's License for identification purposes and signature verification.