Issued To: _____ SSN: _____

APPLICATION FOR GENERAL ASSISTANCE

FREEPORT TOWNSHIP
STEPHENSON COUNTY ILLINOIS

DATE ISSUED | DATE RETURNED | DATE OF ELIGIBILITY

WHY DO YOU NEED ASSISTANCE? _____

_____

GENERAL INFORMATION:

First & Middle Initial: _____ Last Name: _____

Date of Birth: _____ Place of Birth: _____

Maiden Name or Other Alias or Spellings: _____

Phone Number: _____ Who Does Phone Belong To: _____

Current Address: _____ Date moved in: _____ Monthly Rent: _____

Living Arrangements: O RENT O OWN

If Rent, Landlord's name and address _____

Related to Landlord? O YES O NO If related, relationship to landlord: _____

I have lived in this Township since _____ (mo / day / yr), this county since _____ (mo / day / yr) and this state since _____ (mo / day / yr).

My last address before moving to Illinois was: _____

Last Three Previous Addresses:

_____ Date Moved In: _____
Number Street City State Zip Date Moved Out: _____

_____ Date Moved In: _____
Number Street City State Zip Date Moved Out: _____

_____ Date Moved In: _____
Number Street City State Zip Date Moved Out: _____

Have you ever been convicted of a felony? YES NO
(Conviction will not necessarily disqualify an applicant from assistance.)

If Yes, Type _____

I AM NOW ASKING FOR ASSISTANCE FOR THE FOLLOWING PERSON(S):

Name (First / Middle / Last)	Birth Date Month/Day/Year	Birthplace City / State	Relationship	Social Security Number
			SELF	

The following persons, for whom I am **NOT** asking assistance, are living in the same house:

Name (First / Middle / Last)	Birth Date Month/Day/Year	Relationship	Present Means of Support	Amount Paid Monthly for Household Expenses

PERSONAL AND OCCUPATIONAL INFORMATION:

IDES Registration #: _____ Email Address: _____

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

If married, date of marriage: _____ Location of Marriage: _____

Spouse's Name if Applicable _____

Spouse's Date of Birth: _____ Spouse's Place of Birth: _____

If separated, state reason: _____

The current address of my spouse with whom I am NOT living with is _____

Is there a court order for child support? O YES O NO

Previous marriages of myself or my spouse are as follows: _____

Military or Naval Services: Does any member of your family have current or previous military service: O YES O NO

If YES, who has current or previous military service _____

Date Enlisted _____ Date Discharged _____ Serial # _____

If a family member has current or previous military service, he/she:

O Received Adjusted Compensation O Did Not Receive Adjusted Compensation O Receives Pension or Other Income from Such Service O Does Not Receive Pension or Other Income from Such Service

INCOME, PUBLIC ASSISTANCE, RELATED PUBLIC BENEFITS:

PRESENT INCOME and OTHER FINANCIAL INFORMATION: Fill in every blank. If none, write "None".

Sources	Employer's Name & Address	Kind of Work	Average Weekly Earnings	Began Mo/Yr
Employment: Business			$	
Employment: Self-Employment			$	
Employment: Other			$	

PAST EMPLOYMENT of Applicant: List last employer and two longest term employers:

Name of Employer	ADDRESS Number Street City State	Kind of Work	Average Weekly Earnings	Began Mo/Yr End Mo/Yr	Reason for Leaving
			$	/	
			$	/	
			$	/	

PUBLIC ASSISTANCE AND RELATED PUBLIC BENEFITS:

Source	Person Receiving	Amount	Source	Person Receiving	Amount
TANF (Public Aid)		$	S.S.D.		$
S.S.I.		$	R.S.D.I.		$
Food Stamps		$	Other		$

MEDICAL CARD:

Persons Covered	Spendown Amount (if any)

ASSISTED CARE:

Persons Covered	Expiration Date Month/Day/Year

FINANCIAL INFORMATION AND ASSETS:

CASH RESOURCES:

Source	Name of Person	Amount	Source	Name of Person	Amount
Cash on Hand		$	Lodge Unions		$
Unemployment Benefits		$	Annuities		$
Workmen's Comp		$	Alimony/Child Support		$
Veteran's Benefits		$	Estates, Court Orders		$
Government Bonds		$	Friends, Relatives		$
Other ( )		$	Other ( )		$

BANKS/SAFETY DEPOSIT BOXES/PERSONAL PROPERTY (Securities, Investments, Stocks, Bond, Notes Jewelry, Livestock, Etc.):

Name(s) on Account	Name and Address of Bank	Current Balance of Account
		$
		$
		$

REAL ESTATE owned by me or any other member of my family or in which we have interest:

Recorded in Name of	Address	Description	Present Value	Date Purchased	Date and Amount Last Taxes Paid	Present Mo. Inc.
			$		$	$

AUTOMOBILES, TRUCKS, MOTORCYCLES, FARM EQUIPMENT, BOATS, RV, RECREATIONAL EQUIPMENT, ETC:

Owner	Make, Model, and Year	Date Purchased	License Plate # and Mo/Yr Issued	Present Sale Value / Amount Owed
				$
				$
				$

LIFE INSURANCE POLICIES: (All life insurance policies in force of lapsed, held by me and all members of my family)

Person Insured	Name of Company	Type of Policy	Amount	Mo. Prem.	Date Last Premium Paid	Loans Made Date	Loans Made Amount
			$	$			$

MEDICAL, HOSPITAL, SURGICAL, OR OTHER HEALTH INSURANCE BENEFITS available to me or other members of my family:

Name of Company	Type of Coverage	Annual Premium

DEBTS:

Debt Owed To	Description	Monthly Payment	Total Amount Owed
			$
			$
			$
			$
			$

POLICY OF NON-DISCRIMINATION ON THE BASIS OF DISABILITY

The Township of Freeport does not discriminate on the basis of disability in the admission or access to, or treatment or employment in, its programs or activities.

Patrick A. Sellers, Supervisor of Freeport Township, 201 East Exchange Street, Freeport, Illinois 61032, is responsible for compliance with the non-discrimination requirements contained in section 35.107 of the Department of Justice regulations. Information concerning the provisions of the Americans with Disabilities Act, and the rights provided hereunder, are available from the Township Supervisor.

EQUAL EMPLOYMENT OPPORTUNITY STATEMENT

The Township of Freeport does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or the provision of services.

This application must be signed by the APPLICANT and all ADULT DEPENDENTS (persons 18 years of age or over, for whom Assistance is being requested. HOWEVER, if the person in need of assistance is too ill, or otherwise mentally or physically unable to complete an application, this application may be filed by the SPOUSE, PARENT, ADULT CHILD, OR ADULT BROTHER or SISTER 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 the above and foregoing application for Assistance, and declare under the penalties of perjury that to the best of my knowledge and belief the information supplied in this application and all accompanying statements or documents 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 of any new or additional income or resources. Further, by my signature I hereby authorize any person, bank, firm, corporation, transfer agent, agency, institution, or any Government agency to furnish to the Supervisor of General Assistance whatever information the said Supervisor of General Assistance may request relative to account, deposits, investments, securities, RSDI benefits, or business of any kind whatsoever.

_____ _____

Signature of Applicant Date

The undersigned state that they are members of the family of the above named applicant and the General Assistance has been requested by said applicant for them. The undersigned state that they have read the foregoing statements, and that they declare under the penalties of perjury that they have knowledge of the fact and that the said statements are true, correct, and complete. The undersigned agree to notify the Supervisor of General Assistance of any change whatsoever in resources listed herein and further, by their signature hereby authorize any person, bank, firm, corporation, transfer agent, institution, or any Government agency to furnish to the Supervisor of General Assistance whatever information the said Supervisor of General Assistance may request relative to accounts, deposits, investments, securities, RSDI benefits, or business of any kind whatsoever of the undersigned.

Signatures of Member of Family:

_____ _____

Date 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.

_____

Name and Address of Application

_____

Signature and Address of Individual Making Application on BEHALF of the Person Listed Above

_____

Relationship to Applicant

Date: _____ Name: _____

Address: _____
Street City State Zip

COVID 19
FREEPORT TOWNSHIP
CHECKLIST

It is necessary that you return the following items to determine your eligibility
Only as they apply to you

- ☐ proof of current residence (rental information form)
- ☐ current lease agreement
- ☐ photo id – drivers license
- ☐ social security card
- ☐ citizenship status (Ins card/registration/papers)
- ☐ birth certificates
- ☐ Income Tax Refund information, Federal and State, W-2's
- ☐ marriage/divorce/separation papers/orders of protection
- ☐ proof of current income/assets (wages, interest, bank accounts, savings, checking, bank CD's)
- ☐ all records of other income or potential income
- ☐ any type of retirement resources/pensions
- ☐ any legal claims/potential claims/workers compensation/personal injury claims etc.
- ☐ probation/parole/DOC release papers/requirements/conditions
- ☐ educational grants/scholarships/loans
- ☐ proof of medical coverage (if any) medical insurance (i.e.: Medical Card, Assisted Care, Cobra)
- ☐ diabetes verification from doctor
- ☐ all utility bills including water/sewer, gas, electric
- ☐ SNAP benefit verification from DHS (Department of Human Services)
- ☐ documentation of Social Security filing or denial
- ☐ doctor verification that not able to work
- ☐ documentation of unemployment filing or denial
- ☐ _____
- ☐ _____

Caseworker:_____

FREEPORT TOWNSHIP QUESTIONNAIRE

Have you ever received Township assistance before? Please circle: Yes or No

If so, what year did you receive assistance? Year _____

Do you have income? Please circle: Yes or No

If yes, please check: ___SSI ___SSDI ___Work ___Other (list)_____

Do you have children living with you under the age of 18? Please circle: Yes or No

Are you married? Please circle: Yes or No

Are you a veteran? Please circle: Yes or No

Do you have any felonies? Pleas circle: Yes or No

If yes, please check: ___Drugs __DUI ___Other (list)_____

What class is your felony?

___Class X ____Class 1 ____Class2 ___Class 4 Other: _____

If all this information is accurate and correct, please sign and date this document.

_____ _____

Signature of Client **Date**

Freeport Township Medical Release *(Page 1 of 2)*

(To be completed by attending physician)

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, or assessing if the patient can return to work.

Notes to physician

1. This form is not intended for Workers' Compensation Board (WCB) purposes. For a work-related injury or illness, the required WCB forms must be completed.
2. This form **does not replace** forms related to an employee's ability to work that are required by:
   - Workers' Compensation Board,
   - third-party insurers, or
   - employer-funded medical benefit plans.
3. Where choices are indicated below, please mark your selection.
4. Please sign and date both pages 1 and 2, and keep a copy of this form.

When completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide a diagnosis or treatment information.

Physician's name and address (typewritten or printed)

_____

_____

I saw_____ on_____.
(Print patient's name) (Date)

Date of injury or illness_____.
(Date)

This patient is medically able to work with limitations or restrictions as of_____.
(Date)

Restrictions or limitations (see page 2 for details)

In my opinion, these restrictions or limitations are:

☐ Temporary:
- ☐ _____days
- ☐ less than 2 weeks
- ☐ 2 to 4 weeks
- ☐ 4 to 6 weeks
- ☐ 6 weeks to 3 months
- ☐ more than 3 months

☐ Permanent

Date of next appointment is (indicate **n/a** if not applicable)_____.
(Date)

My opinion is based on the factors indicated below:

☐ Information provided by the patient

☐ My examination of the patient and my assessment of the findings and health information

I have provided this form to the patient named above.

_____ _____
(Physician's signature) (Date)

Freeport Township Medical Release *(Page 2 of 2)*

(To be completed by attending physician)

Specific functional restrictions and/or limitations

Patient's name _____

Check ☑ only those items that apply in Section A, and provide details in Section B.

section a

	Restriction	Limitation
Physical		
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Lifting	☐	☐
Carrying	☐	☐
Pushing/Pulling	☐	☐
Climbing stairs	☐	☐
Climbing ladders	☐	☐
Climbing scaffolding	☐	☐
Crouching	☐	☐
Crawling	☐	☐
Kneeling	☐	☐
Bending/Twisting/Turning	☐	☐
Repetitive activity	☐	☐
Sustained postures	☐	☐
Gripping	☐	☐
Reaching	☐	☐
Fine dexterity	☐	☐
Balance	☐	☐
Vision/Hearing/Speech	☐	☐
Other *(specify in section B)*	☐	☐

Does patient require medical aids (e.g. splint, brace) or personal protective equipment (e.g. gloves, mask)?

☐ No ☐ Yes *(specify in section B)*

Definitions

Restriction: This patient is advised not to perform this activity in any capacity.

Limitation: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration.

	Restriction	Limitation
Mental		
Thinking/Reasoning	☐	☐
Concentration	☐	☐
Memory	☐	☐
Critical decision-making	☐	☐
Interpersonal contact	☐	☐
Alertness	☐	☐
Other *(specify in section B)*	☐	☐
Environmental		
Exposure to heat/cold	☐	☐
Exposure to dust/fumes/odors	☐	☐
Exposure to chemicals	☐	☐
Food handling	☐	☐
Other *(specify in section B)*	☐	☐
Other		
Shift/attendance duration	☐	☐
Consecutive shift attendance	☐	☐
Shift work	☐	☐
Overtime	☐	☐
Operating vehicle	☐	☐
Operating equipment	☐	☐
Working at heights	☐	☐
Other *(specify in section B)*	☐	☐

section B

Please provide necessary details about any restrictions or limitations you have identified. Typically, it is not necessary to provide a diagnosis or treatment information.

_____

_____

I have provided this form to the patient named above.

_____ _____

(Physician's signature) (Date)