City of Evanston

Health and Human Service Dept.
General Assistance Office

2100 Ridge Ave
Evanston, IL 60201

Phone: 847-448-8112
Fax: 847-448-8057

# VERIFICATION REQUEST FORM

CLIENT: _____

In order to process your application, the following verifications are required:

Date Rcvd.

_____ Bank statements, Stocks, Bonds, Retirement Accounts, and Trust Funds
_____ Birth Certificates for all household members
_____ Completed, signed application
_____ Driver's License/Photo ID with Current Address
_____ Medical Insurance Card or Current Medicaid Card
_____ Proof of all income for the last 30 days, including paystubs, Child Support, Social Security, Pensions, gifts from friends/relatives, etc.
_____ Current Lease, Section 8, proof of Mortgage, Statement of Monthly Rent F Form
_____ Social Security Card
_____ Utility Bills
_____ Verification of Snap/TANF
_____ IDES Consent To Release Information Form

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http://www.cityofevanston.org/health

# 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: _____

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: _____

## MILITARY INFORMATION

Family Member: _____ Branch: _____ Serial #: _____

Enlisted: _____ Discharged: _____ Rcvd Comp? _____

Rcvd Pension: _____

**SOURCE OF INCOME**

Person Receiving _____ Source _____

Means of Income _____ Monthly Amount _____

**PUBLIC ASSISTANCE AND RELATED PUBLIC BENEFITS**

Person Receiving _____ Source _____

Amount $ _____

**OTHER ASSETS**

- Do you own a home? [ ] Yes [ ] No
- Do you own a car? [ ] Yes [ ] No
- Are you the owner of an insurance policy? [ ] Yes [ ] No
- Do you have a Saving Account? [ ] Yes [ ] No
- Do you have a Checking Account? [ ] Yes [ ] No
-

**SPOUSE/ CIVIL PARTNER**

Name _____ Relationship _____ SSN _____

Birth Date _____ Birth Place _____ IDES Reg # _____

Monthly Amount Paid for Expenses: _____ Means of Income: _____

**OTHER HOUSEHOLD MEMBERS**

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

**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 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 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 must 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: _____

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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 carefully.*

- Under the Health Insurance Portability and Accountability Act of 1964 (HIPAA), CITY OF EVANSTON 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 to 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 of the Secretary of the US Department of Health and Human Services and
5. Contact information with respect to CITY OF EVANSTON'S policies and procedures for handling PHI. The city 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 City 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 City is not required to comply with your request, and you will be notified of what is denied.
4. You have the right to an accounting of certain disclosure 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 our health care and any related services.

**Payment:** While the City generally does not engage in billing, the City is permitted to use or disclose your PHI for that purpose.

**Health Care Operations:** The City 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 City may use and disclose PHI to business associates to facilitate health care, payment of as necessary health operations.

**Required By Law:** The City may use or disclose PHI about you as required by state and federal law. For example, the City may disclose your PHI when required by national security laws or public health disclosure laws. The City 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 City 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 City 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 City to make the following types of uses and disclosures under certain circumstances. While the City generally does not disclose PHI for those 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 City Privacy Officer or the Department of Health and Human Services I you believe your privacy rights have been violated. To file a complaint with the City, you may write to the address below. You will not be retailed against for filing such a complaint.

**Future Changes in the Notice**
CITY OF EVANSTON 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 City Supervisor at
CITY OF EVANSTON
2100 Ridge Ave
Evanston, IL 60201
(847) 448-8112

I have received a copy of the CITY OF EVANSTON Notice of Privacy Practices on _____ (Date)

Signature: _____ Date: _____

Please print your name: _____

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# 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 applications 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 that I have read & received a copy of this Notice of Rights and Responsibilities this _____ Day of _____, 20___

Signature: _____

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# NOTICE OF BENEFITS AVAILABLE UNDER THE GENERAL ASSISTANCE PROGRAM

## MONTHLY BASIC NEEDS ASSITANCE

- 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 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 medical 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. Preventative 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 that I have read and received a copy of this Notice of Benefits Available this _____ day of _____ , 20___.

Signature: _____

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# STATEMENT OF PURPOSE FOR COLLECTIONS 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 and individual's Social Security number (SSN). This statement of purpose is being provided to you because you have been asked by the City 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 if 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 your 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 City representative who issued this form to you.

Name: _____

Signature: _____ Date: _____

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# ASSSITANCE 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 CITY OF EVANSTON.

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 Jobs 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: _____

_____

_____

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# MEDICAL RESOURCES INQUIRY

Applicant/Recipient: _____ Date: _____

**You must provide information to the General Assistance Office about any medical insurance or other medical benefits that covers your 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 a 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.

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.

8. If you or your spouse is 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 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 (a0 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: _____

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# STATEMENT FOR MONTHLY RENT/MORTGAGE

Date: _____

TENANT/MORTGAGE INFORMATION

Name: _____
Address: _____
City/St/Zip: _____

**Rent/Mortgage Due for the month:** _____
**Amount Due:** _____

[ ] Recurring monthly payment while the client is eligible for General Assistance
[ ] One time only Emergency Assistance payment
Is the tenant current with the rent? **[ ] Yes [ ] No**
If No, what is the amount past due? _____
How many months past due? _____

**LANDLORD / VENDOR INFORMATION**

Name: _____
Address: _____
City/St/Zip: _____
Phone: _____

Landlord Signature: _____

**Initials**

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

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

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