General Assistance Application Process:

YOU MUST:

- Have a valid Illinois ID or Driver's License
- Have a Social Security Card
- Live in Rockford Township
- No children in the household under the age of 18 years old
- Be a US citizen

The following forms are in this packet and must be completed:

- GA Applicant Information Form (Complete all parts and sign and date form)
- Application for General Assistance (Complete all parts and sign and date form on page 4)
- Rental Agreement (To be completed by property owner/landlord ONLY)
- Income Report (Please list your income for the past 30 days. If there is none, please mark as $0 and sign/date form)
- Attending Physician's Statement (This must be completed if you are unable to work or have work restrictions. You must fill in the top of the form, sign and date before submitting to your doctor.)
- Intake Request for Information – Parole/Probation (You must have your Parole/Probation Officer complete if you are ACTIVELY on Parole or Probation.
- You must attach a copy of your Illinois ID/DL and your Social Security Card
- If you are working, you must submit a copy of your last 30 days of paycheck stubs.
- If you are receiving Unemployment Benefits, you will need a copy of your benefits received within the last 30 days. You will need to print this out online through the IDES website (https://www2.illinois.gov/ides/Pages/default.aspx).
- Current Checking and Savings Account balance printouts if any.

You may drop off forms in attached envelope to Rockford Township at 315 N. Church Street. Otherwise you may:

1. Fax to 815-962-8963 or
2. Scan and email to accounting@rockfordtownshipil.gov

Once you have submitted your forms - a Case Worker will contact you by phone for further instructions.

If you have questions, please contact our office at 815-962-8855.

PLEASE SUBMIT ALL REQUIRED FORMS IN A PACKET. DO NOT RETURN FORMS ONE AT A TIME!

11/25/2020

GA Applicant Information Form

Name: (First)_____(Middle)_____(Last)_____

SS#: _____ DOB: _____Phone #: _____

Address: _____ Zip Code: _____

Other Members of the Household:

Name: _____ Name: _____

Name: _____ Name: _____

Please accurately answer the questions below. This information will be verified. Failure to accurately report information may result in a denial of your case.

Do you have income? (Link is not income) Yes No If you are working, you must provide proof from the last 30-days

Are there minor children living in the household? Yes No

Are you actively receiving LINK/SNAP benefits? Yes No If Yes, $_____ Link/Snap

Have you been convicted of a Class X or Class 1 felony involving drugs? Yes No

If Yes, What Year? _____ What County & State? _____

Date your last rent or mortgage was paid: _____

Have you ever lived in a Rockford Housing Authority or Winnebago County Housing Authority Property?
Yes No If so when? _____

Are you a US Citizen? Yes No | Are you a Veteran? Yes No | Are you pregnant? Yes No

I authorize Rockford Township General Assistance office to utilize the above information in order to determine my eligibility for assistance, and to investigate my background for purposes of determining if I meet the eligibility requirements of this program. I further authorize Rockford Township General Assistance to discuss my background and share my information with any local, state or federal agency as needed to determine my eligibility.

Signature_____Date: _____

FOR OFFICE USE ONLY			
UCB		COOK	
DHS		ID/DL	
WINN		DATE LAST INQUIRY	
WI		DATE LAST INTAKE	
EMAG		DATE LAST GRANT	
DOC		OTHER:	

Revision 08/13/19

TOWNSHIP OF ROCKFORD

315 NORTH CHURCH STREET
ROCKFORD, ILLINOIS 61101-1034
(815) 962-8855 • FAX (815) 962-8963

Jasper St. Angel
-SUPERVISOR-

APPLICATION FOR GENERAL ASSISTANCE
ALL BOXES MUST BE COMPLETED

APPLICATION IS GOOD FOR 30-DAYS FROM DATE ISSUED

YOU MAY RETURN FOR AN INTERVIEW MONDAY THRU FRIDAY @ 8:00 AM ON OR AFTER: _____

Date Issued:
Interview Date:

I. Personal Information

Last Name	First Name	Middle Name:
Current Address Apt #	City:	Zip Code:
Phone #: Cell Phone #	SS#:	Date of Birth: Age:
Marital Status: Never Married: _____ Married: _____ Div: _____ Sep: _____ Widowed: _____	Home: Rent: _____ Own: _____ Amt of monthly payment: _____	Date last rent or mortgage was paid: Date: _____ Amt paid: _____
Date of Divorce: _____ Date of Separation: _____ _____ County: _____	Are you currently approved for Section 8 Housing? Yes _____ No _____	Are you currently residing in Section 8 Housing? Yes _____ No _____
Birth Place: Are you a U.S. Citizen?	How long have you lived in Winnebago County? Yrs: ____ Mos: ____	Is it your intent to remain in this County? Yes ____ No ____
Veteran: Yes _____ No _____ What Branch of Service: _____	Dates of Service: From: _____ To: _____	Type of Discharge: Do you have discharge paperwork? Yes _____ No _____
How many biological children do you have? Other Children	How many children live with you?	What are the ages of children living with You?
What do you need assistance with?	Are you receiving a link card? Yes _____ No _____ What amount/month? _____	Are you court ordered to pay child support? Yes _____ No _____ How much/month? _____

II. Education

Last Grade Completed? _____	High School Diploma? Yes ___ No ___ GED? Yes ___No ___	What year completed? _____ What school? _____
Are you currently attending classes? Yes _____ No _____	GED/H.S. Yes _____ No _____	Are you attending college classes? Yes _____ No _____ How many credit hours? _____

III. Employment History

List below your current job or if not currently working, the last three (3) jobs you have held (including temporary agency jobs):

Name & Address of Employer:	Date Employment Began: _____ Date Employment Ended: _____	Reason for Separation:
Name & Address of Employer:	Date Employment Began: _____ Date Employment Ended: _____	Reason for Separation:
Name & Address of Employer:	Date Employment Began: _____ Date Employment Ended: _____	Reason for Separation:

Are you capable of working? Yes _____ No _____ If able to work, do you have any medical/ Psychiatric restrictions? Yes _____ No _____	List your work restrictions:	When was the last time you saw any Doctor?

IV. Present Income & Financial Information

Employment Income: $	Unemployment Compensation Weekly Amount: $ _____	Self-Employment Income: Monthly Amount: $ _____
Worker's Compensation Benefits: $ _____/weekly	Veteran's Benefits: Monthly: $ _____	Social Security Benefits SSI: $ _____ SSD: $ _____ Death/Survivor's Benefits $_____
Long Term and/or Short-Term Disability: Monthly Amount: $ _____	Child Support Received: Monthly Amount: $_____	Are you currently receiving cash Assistance from the Illinois Department Of Human Services? Yes _____ No _____ How much/month? _____
Pension and/or Retirements Benefits? Monthly Amount? _____	Earnfare: Are you participating: Yes ___ No ___	Earnfare: Monthly amount received? _____

IV. Present Income & Financial Information (Continued)

Checking account? Yes ____ No ____ Bank/Credit Union: _____ Current Balance: $ _____	Savings Accounts? Yes ____ No ____ Bank/Credit Union? _____ Current Balance: $ _____	Annuities? Yes _____ No _____ Amount? _____
Cash on hand: $ _____	Have you filed your Income Tax this year? Yes _____ No _____	Did you receive an income tax refund this year? Yes _____ No _____ Amount Received? _____ Date Received? _____

V. Assets

Real Estate: Address: Present Value: Mortgage Amount: Single family: Yes _____ No _____	Cars/Trucks: Make/Model: _____ Amount Owed: _____ Is vehicle insured? Yes _____ No ____ Insurance Company: _____	Safety Deposit Boxes: Where: _____ Value of Contents: _____

VI. Health Insurance

Medical Card: Yes _____ No _____ Pending: _____	Other medical insurance: Yes _____ No _____ Is this insurance COBRA? Yes _____ No _____ What Company: _____ Monthly Premium: _____

VII. Criminal History

Failure to notify this office of your complete criminal history (regardless of year of conviction) in this or any other state or county will be cause for denial of application for 90-days or case closure for 90-days.

Are you currently on Parole? Yes_____ No _____ Parole Officer: _____	What County & State: _____ Convicted of: _____ Conviction Date: _____	Are you compliant with your parole requirements? Yes _____ No _____
Have you ever been on Parole? Yes _____ No _____	What County & State: _____ Convicted of: _____ Conviction Date: _____	Did you complete your parole Satisfactorily? Yes _____ No _____
Are you currently on Probation? Yes _____No _____ Probation Officer: _____	What county & State? _____ Convicted of: _____ Conviction Date: _____	Are you compliant with your probation requirements? Yes _____ No _____
Have you ever been on Probation? Yes _____ No _____	What County & State? _____ Convicted of: _____ Conviction Date: _____	Did you complete your probation satisfactorily? Yes _____ No _____

I have completed this application for General 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, I hereby authorize any person, bank, firm, corporation, transfer agent, agency, institution, or the Department of HHS to furnish to the Supervisor of General Assistance whatever information that may be requested relative to accounts, deposits, investments, securities, RSDI benefits, or business of any kind whatsoever.

The General Assistance Office shall not disclose information regarding a General Assistance applicant or recipient except for any purpose directly connected with the administration of public aid under the Illinois Public Aid Code, including the investigation and verification of eligibility factors and the sharing of information with the Illinois Department of Human Services and other governmental units.

_____ _____

Signature of Applicant Date

I hereby make Application for General Assistance in behalf of the person named below, and certify that to the best of my knowledge and belief the information furnished herein in a true statement of his (or her) income, assets, and resources.

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 phone 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 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

_____

Printed Name Address City/State/Zip Telephone #

_____

Signature and Address of Individual making Application for General Assistance in BEHALF of the Person Named Above.

_____

Relationship to Applicant.

Subscribed and sworn to before me this

_____day _____, _____

_____

Notary Public

TIPS TO APPLICANT WHEN LOOKING FOR A RESIDENCE. PLEASE CONSIDER THE FOLLOWING:

1) There can be no more than three (3) unrelated persons in the household.

2) One bedroom per person, unless two persons are a couple; that couple may share a bedroom.

3) The Landlord Agreement must be filled out by the Property Owner. If it is filled out by the Property manager, Rockford Township must have a copy of the Management Agreement between the Owner and the Property Manager on file.

4) If the property is owned by a family member, that family member must be utilizing it as a rental property and cannot reside there.

5) Rockford Township will not pay to any unit that has more than 3 bedrooms unless it is a boarding house WITH a Special Use Permit.

6) The property must be located within Rockford Township.

7) Basement and attic living will not be approved for ANY member of the household.

8) You must be moved in at the time of the home visit.

9) Utilities must be on and working at the time of the home visit.

10) Unit must have a functional kitchen including a refrigerator, stove and sink.

ROCKFORD TOWNSHIP GENERAL ASSISTANCE OFFICE

315 NORTH CHURCH STREET
ROCKFORD, ILLINOIS 61101

INCOME REPORT

THIS IS A FULL ACCOUNT OF ALL INCOME – IN CASH OR KIND – INCLUDING EARNINGS, UNEMPLOYMENT COMPENSATION BENEFITS, SOCIAL SECURITY OR OTHER PENSIONS, ROOMERS AND BOARDERS, INCOME TAX REFUNDS, EXPECTED TO BE RECEIVED BY MYSELF AND OTHER MEMBERS OF MY HOUSEHOLD WITHIN THE NEXT 30 DAYS.

PERSON RECEIVING INCOME	SOURCE OF INCOME	GROSS AMOUNT RECEIVED	DATE RECEIVED
	TOTAL INCOME		

I certify that the above report is true and complete for the above stated period.

DATE _____ (SIGNED) _____

ADDRESS _____

Rev. 07/2020

TOWNSHIP OF ROCKFORD

315 NORTH CHURCH STREET
ROCKFORD, ILLINOIS 61101-1034
(815) 962-8855 • FAX (815) 962-8963

Jasper St. Angel
-SUPERVISOR-

Attending Physician's Statement

DATE: _____ Patient Name: _____ DOB: _____

Issued by: _____ Intake ☐ Case Management ☐

Authorization for Release of Information: I hereby authorize release of this medical information to Rockford Township General Assistance:

_____ Date: _____
Signature of Applicant/Client

Date of scheduled appt:	Name of Physician:

PHYSICIAN: PLEASE COMPLETE THE FOLLOWING INFORMATION:

DIAGNOSIS:

Diagnosis/ICD-10 Code(s): (Please list all diagnoses.)

WORK STATUS:

Work Status (Abilities/Limitations):	ONLY FILL OUT IF PATIENT IS ABLE TO WORK.
1) Is this patient able to work? Yes ☐ No ☐ How many hours/day may patient work? _____hrs. How many days/week may patient work? _____days	Does this patient have any restrictions and/or limitations for work? Yes ☐ No ☐ If yes, what are the restrictions/limitations?
IF PATIENT IS NOT ABLE TO WORK AT THIS TIME: What is the anticipated return to work date? _____	

CLASSROOM STATUS:

Is this patient able to participate in GED or HS classes?	Since you have stated this patient is able to work, may he/she participate in Vocational Training through the Department of Rehabilitation Services?
Yes ☐ No ☐	_____ Yes _____ No

RETURN TO CLINIC:

Next Appointment:		
Months: _____	Weeks: _____	Days: _____
Physician Signature:		Date:
Physician's Name (Print)		Phone:

THIS FORM MUST BE FULLY COMPLETED PRIOR TO CLIENT/PATIENT RECEIVING ANY ROCKFORD TOWNSHIP ASSISTANCE.

Revised 11/19/2020