

Additional Information for General Assistance Application:

- Current Bank Statement/or 30 days of bank activity
 - 30 days of income
 - 30 days of bills
 - Proof of income
- Rental agreement, if applicable
- Eviction Notice, if applicable

Town Of Unity
Po Box 416
74 School St.
Unity, ME 04988
Phone: 207-948-3763 Fax: 207-948-3737

GENERAL ASSISTANCE PROGRAM

USE OF INCOME Documentation of Past 30 Days

Name: _____

Date: _____

Income: _____

Total: _____

ALL RECEIPTS:

Food: _____
Housing: _____
Utilities: _____
Phone: _____
Cable: _____
Propane: _____
Fuel: _____
Personal Care: _____
Tobacco: _____
Alcohol: _____
Magazines: _____
Pet Supplies: _____
Other: _____

Total: _____

MIS-SPENT MONEY:

Phone: _____
Cable: _____
Tobacco: _____
Alcohol: _____
Magazines: _____
Pet Supplies: _____
Other: _____

Total: _____

Total Income: _____

Less Total Receipts: _____

Unaccounted Amount: _____

Mis-spent Amount: _____

*Total: _____

Town of Unity

PO Box 416
Unity, ME 04988
207-948-3763

VERIFICATION OF RENTAL UNIT

(Must be completed by the Landlord of Manager)

Applicant: _____

Applicant Address: _____

Name all Occupants in the apartment: _____

Number of Adults: _____

Number of children: _____

How long have tenants lived there? _____

Is any tenant a relative of the owner? _____ If yes, state relationship: _____

Rent Paid:

Weekly: \$ _____ Monthly: \$ _____ Date rent is due: _____

Date Rent was last paid: _____ Amount paid: \$ _____ Amount still owed: \$ _____

Does the tenant receive rent subsidy from another agency? _____

If yes, what is the tenant's portion of rent? \$ _____

Please complete the following by placing an "x" in the appropriate type of rental unit:

Single House	_____	Utilities Included:	Total # of Rooms	_____
Apartment House	_____	Heat	# of Bedrooms	_____
Mobile Home	_____	Electricity	Does the rent have	_____
Room	_____	Gas	its own bathroom?	_____
Other:	_____	Hot Water	Its own kitchen?	_____

Legal Owner of the Property: _____

Name the check should be made out to: _____

Complete mailing address: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Manager or agent for the above owner: _____

Address: _____

Owner's e-mail address: _____

Signature: _____ Date: _____

(Owner of Manager)

This form does not guarantee the tenant's eligibility for assistance. It is also used to verify residence and accommodations. If the tenant is found eligible for rental assistance, a voucher will be given to the tenant for the payment. The voucher will then need to be returned to this office, signed by the tenant and landlord, for payment by the finance dept.

Volunteer Regional Food Pantry

LAST NAME: _____

FIRST: _____

SOCIAL SEC. NUMBER: _____

ADDRESS _____

SPOUSE _____

SS# _____

CHILDREN IN HOUSEHOLD

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

Please check any of the following that you are presently receiving.

FOOD STAMPS: _____

AFDC _____

WIC _____

SS _____

FUEL ASSISTANCE _____

OTHER _____

Are you presently using another food pantry? _____

If so, which one _____

Are you or a spouse in the military? YES _____

NO _____

What branch? _____

When _____

Was a parent, grandparent in the military? YES _____

NO _____

What war? _____

Comments: _____

SIGNATURE: _____

DATE _____

VRFP BOARDMEMBER _____

DATE _____

Revised 12/04

03/17/2025

APPLICATION FOR GENERAL ASSISTANCE

Administrator: Please read the following to the applicant or have the applicant read it in your presence.

PENALTY FOR FALSE REPRESENTATION. Whoever knowingly and willfully makes any false representation of a material fact to the overseer of any municipality or to the department or its agents for the purpose of causing that or any other person to be granted assistance by the municipality or by the State is guilty of a Class E crime and shall reimburse the municipality for that assistance. Further assistance may be denied until that person reimburses the municipality for the assistance or enters into a written agreement, which must be reasonable under the circumstances, to reimburse the municipality or that person has been ineligible for assistance for a period of 120 days, whichever period is longer. (22 M.R.S.A. § 4315).

1. HOUSEHOLD (Please type or print)

[illegible]

2. HOUSEHOLD INFORMATION

Does everyone in the household receive SNAP benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does everyone in the household have Maine Care? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has your household applied for LIHEAP? <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you reached the TANF 60 month time limit? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is anyone sanctioned by TANF? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does anyone in the household have a warrant for their arrest as a result of a felony conviction? <input type="checkbox"/> YES <input type="checkbox"/> NO	Did you or anyone in your household serve in the U.S. Military? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has your household filed an income tax return? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list date and amount:	Do you have subsidized housing? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list your monthly amount:	
	Has anyone applied for a VA Pension?	Has anyone received an income tax refund? Date: Amount:	Has anyone received a lump sum? Date: Amount:	
Is everyone in the household a U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO NOTE: If any household member does not have permanent status, affidavit must be completed.		Is any other person, or agency assisting with your household expenses (rent, electric, heat etc.)? If yes, please explain:		

NAMES AND ADDRESSES OF EMERGENCY CONTACTS WHO ARE NOT IN THE HOUSEHOLD (PARENTS, GRANDPARENTS AND ADULT CHILDREN WHO ARE NOT MEMBERS OF THE HOUSEHOLD)

1. Name:		2. Name:	
Mailing Address:		Mailing Address:	
Relationship:	Telephone #:	Relationship:	Telephone #:

3. EMPLOYMENT INFORMATION – APPLICANT

Section 3-A Complete section 3-A if one or more members of your household are employed.

Currently employed household member #1:	Currently employed household member #2:
Name:	Name:
Employer:	Employer:
Date of last paycheck:	Date of last paycheck:
Amount of last paycheck:	Amount of last paycheck:
Date of next paycheck:	Date of next paycheck:
Additional Comments:	

Section 3-B Complete section 3-B if one or more members of your household are able to work but are unemployed.

Able-Bodied unemployed household member #1:	Able-Bodied unemployed household member #2:
Name:	Name:
Previous Employer #1:	Previous Employer #1:
Reason Job Ended:	Reason Job Ended:
Last Date of Employment:	Last Date of Employment:
Previous Employer #2:	Previous Employer #2:
Reason Job Ended:	Reason Job Ended:
Last Date of Employment:	Last Date of Employment:
Highest Level of Education Completed:	Highest level of Education Completed:
Additional Comments:	

Section 3-C Complete section 3-C if one or more members of your household are unable to work for medical reasons.

Disabled unemployed household member #1:			Disabled unemployed household member #2:		
Name:			Name:		
Disability preventing work?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Disability preventing work?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Medical statement verifying?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Medical statement verifying?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Active SSI/SSDI application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Active SSI/SSDI application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Completed IAR on file?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Completed IAR on file?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an attorney?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have an attorney?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
What stage are you at in your application for SSI?SSDI?			What stage are you at in your application for SSI?SSDI?		
Additional Comments:					

4. ASSISTANCE REQUESTED

ASSISTANCE REQUESTED: Please list each type of assistance being requested and enter the amount of the request.			
ASSISTANCE		AMOUNT	
1. Food		\$	
2. Rent		\$	
3. Mortgage		\$	
4. Electricity		\$	
5. LP Gas		\$	
6. Heating Fuel		\$	
7. Household/Personal Supplies		\$	
8. Prescriptions/Medical		\$	
9. Water		\$	
10. Sewer		\$	
11. Other (Specify):		\$	
TOTAL ASSISTANCE REQUESTED		\$ 0.00	

5. USE OF INCOME - REPEAT APPLICANTS ONLY - PRIOR 30 DAYS (Office use only)

Income:	\$	
	\$	
	\$	
Total: (A)	\$ 0.00	
Household Receipts		
Food	\$	
Housing	\$	
Electricity	\$	
Propane	\$	
Heating Fuel	\$	
Household	\$	
Personal	\$	
Prescriptions/Medical	\$	
Water	\$	
Sewer	\$	
Other:	\$	
	\$	
Total:	\$	
Total: (B)	\$ 0.00	
Notes:		
Other Receipts		
Phone	\$	
Internet	\$	
Cable/Subscription Services	\$	
Alcohol/Tobacco	\$	
Restaurants/Entertainment	\$	
Vacations/Travel	\$	
Pet Food	\$	
Fines/Bails	\$	
Other:	\$	
	\$	
Total: (C)	\$ 0.00	
Total Income: (A)	\$ 0.00	
Less Household Receipts: (B)	\$ 0.00	
Total Other Receipts: (C)	\$ 0.00	
D. Unaccounted Money (A)-(B)-(C)	\$ 0.00	
E. Total of (C + D)	\$ 0.00	
Misspent + Unaccounted (Added to Line 9, section 6)	\$ 0.00	

6. PROJECTED 30 DAY INCOME

INCOME: Enter the amount of all money to be received (in the next 30 days) by: (1) the applicant; (2) the applicant's family; and (3) unrelated household members. Report how often income is received.

TYPE OF INCOME	MONEY APPLICANT RECEIVES		MONEY FAMILY RECEIVES		MONEY OTHERS RECEIVE		OFFICE USE ONLY
	AMOUNT	FREQUENCY	AMOUNT	FREQUENCY	AMOUNT	FREQUENCY	MONTHLY TOTAL
A. Employment	\$	BIWEEKLY	\$	MONTHLY	\$		\$
B. TANF	\$	MONTHLY	\$		\$	MONTHLY	\$ 0.00
C. SSI – Supplemental Security Income	\$	MONTHLY	\$		\$		\$ 0.00
D. State Supplement (\$10 if receive SSI)	\$	MONTHLY	\$		\$		\$ 0.00
E. Social Security (other)	\$	MONTHLY	\$		\$		\$ 0.00
F. Unemployment or Workers Comp	\$	MONTHLY	\$		\$		\$ 0.00
G. Military/Veteran Benefits	\$	MONTHLY	\$		\$		\$ 0.00
H. Retirement or Pension Plan	\$	MONTHLY	\$		\$	MONTHLY	\$ 0.00
I. Child/Spousal Support	\$	MONTHLY	\$	MONTHLY	\$		\$ 0.00
J. Bank Accounts and Cash On Hand	\$		\$		\$		\$ 0.00
K. Income In Kind	\$		\$		\$	MONTHLY	\$ 0.00
L. Post-Secondary financial aid, grants	\$		\$	MONTHLY	\$		\$ 0.00
M. Other (please specify)	\$	MONTHLY	\$		\$		\$ 0.00
For Repeat Applicants Only:							
N. Investment Asset(s) Value (See Section 7, C)							\$ 0.00
O. Misspent Income & Unverified Expenditures (during the last 30 days) (See Section 5, Line E)							\$ 0.00
SUBTOTAL – MONTHLY HOUSEHOLD INCOME							\$ 0.00
P LESS: Total verified monthly work-related expenses: Child Care: \$ _____ Mileage: (RT miles _____ * # of days a week: _____ * # of weeks per month: _____ * ordinance mileage: _____) = 0.00 Other: _____							\$ 0.00
TOTAL – MONTHLY HOUSEHOLD INCOME							\$ 0.00

7. ASSETS

ASSETS: Check yes for each asset owned and enter the value. Enter who in the household owns the asset.

TYPE OF ASSET	VALUE	ASSET OWNED BY
A. Home	\$	
B. Real Estate (other than home)	\$	
C. Investments: Stocks, Bonds, Retirement Account(s), Life Insurance, etc.	\$	
D. Vehicle(s) (i.e., car, truck, motorcycle)	\$	
Additional vehicles	\$	
E. Recreational Vehicle (s) (i.e., camper, ATV, snowmobile, boat)	\$	
F. Other	\$	

8. EXPENSES

MONTHLY EXPENSES	ACTUAL COST FOR NEXT 30 DAYS	MAXIMUM AMOUNT (OFFICE USE ONLY)	ALLOWED AMOUNT (OFFICE USE ONLY)
1. Food	\$	\$	\$0.00
2. Rent – Number of Bedrooms: Name and Address of Landlord:	\$	\$	\$ 0.00
3. Mortgage – Mortgage Holder:	\$	\$	\$0.00
4. Electricity –Hot Water Y/N Electric Heat Y/N	\$	\$	\$0.00
5. LP Gas	\$	\$	\$0.00
6. Heating Fuel TYPE:	\$	\$	\$0.00
7. Household/Personal Supplies	\$	\$	\$0.00
8. Prescriptions/Medical	\$	\$	\$0.00
9. Water	\$	\$	\$0.00
10. Sewer	\$	\$	\$0.00
11. Other essential needs (specify)	\$	\$	\$0.00
	\$	\$	\$0.00
TOTAL MONTHLY HOUSEHOLD EXPENSES	\$ 0.00	\$0.00	\$ 0.00

9. OTHER EXPENSES

NOTE: The administrator should be aware of the following to gain an understanding of the applicant's financial situation.

A. Do you have any debts (i.e., bank loans, car payments, credit cards)? ☐ YES ☐ NO

If YES, give (1) name; (2) purpose money was borrowed; and (3) amount (list below).

NAME	PURPOSE	AMOUNT
1.		\$
2.		\$
3.		\$

10. DEFICIT (Office use only)

A. Overall Maximum Level of Assistance Allowed (See GA Ordinance Appendix A)	\$	D. Deficit (If line A is greater than line B)	\$ 0.00
B. Income (See Section 6)	\$ 0.00	E. *Surplus (If line B is greater than line A)	\$ 0.00
C. Result (Line A minus line B)	\$ 0.00	* Note: If a surplus exists, applicant is not eligible for regular GA. Proceed to Section 10 to determine if "unmet need" results in eligibility for "emergency" GA	

11. UNMET NEED (Office use only)

A. Allowed Expenses (See Section 8)	\$ 0.00	D. Unmet Need (Amount from line C, but <u>only</u> if line A is greater than line B)	\$ 0.00
B. Income (See Section 6)	\$ 0.00	E. Deficit (See Section 10, line D)	\$ 0.00
C. Result (Line A minus line B)	\$ 0.00	F. Amount of GA Eligibility (The lower of line D and line E)	\$ 0.00

INSTRUCTIONS:

- If Section 10, line B (income) is greater than line A (overall maximum), then applicant has a surplus of \$ _____ and will not be eligible for General Assistance unless the GA administrator determines there is need for emergency assistance.
- If Section 11, line A (allowed expenses) is greater than line B (income), the result will be an "Unmet Need" (line D).
- If there is both an "Unmet Need" (Section 11, line D) and a "Deficit" (Section 11, line E), the applicant will be eligible for the lower of the two amounts. This lower amount is the amount of assistance the applicant is eligible for in the next 30-day period, or a proportionate amount for a shorter period of eligibility (i.e., if the applicant needs one week's worth of GA assistance, they should receive 1/4 of the 30-day amount).

Administrator: Please read the following to the applicant or have the applicant read it in your presence.

In accordance with Maine law (22 M.R.S.A. § 4321) you have the right to be given a written decision concerning your application within 24 hours of submitting a completed application. If you disagree with the administrator's decision on the application, you have the right to a fair hearing before an impartial hearing authority. If you believe that the municipality has violated state law with respect to your application, you have the right to notify the State Department of Health and Human Services in Augusta (1-800-442-6003)

STATEMENT BY APPLICANT: I hereby affirm that the facts in this application are true, correct and complete, and that I have not knowingly withheld any information. I understand the Administrator has the right to verify any information necessary to determine my eligibility and hereby give my consent. I understand if I refuse to give my consent it may result in my not being eligible to receive assistance; therefore, I hereby give my express permission for the Administrator to contact the following specific sources or persons to verify any or all information material to the determination of General Assistance eligibility for my household:

- Employer(s) (past/present);
- Persons, organizations or businesses referenced in this application;
- Past, present and/or future landlords;
- Bank(s) or financial institutions;
- The Department of Health and Human Services or any department of the State of Maine;
- The area Community Action Program;
- Relatives, specify: _____
- Persons/vendors to whom I owe money (i.e. utility company, fuel dealer, car dealership);
- Physician(s) with information related to my ability to work or receive other benefits;
- Housing Authority (local and/or state);
- The following specific sources of information _____

Applicant's Signature: _____ Date: _____

Secondary Applicant's Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____