

APPENDIX

Record of Lease Contracts and Indebtedness Other Than Bonds
(Township Form Number 14, Ruling C)

Township Trustee's Insurance Record (Township Form No. 14, Ruling B)

Receipt (Township Form Number 16)

Resolution Recommending Salaries of Township Officers and Employees (Township Form No. 17)

Application for Township Assistance (Township Assistance Form TA-1)

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Appeal Rights and Procedure

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Township Assistance Purchase Order (To be used for both medical and general purchase orders)
(Township Form TA-2)

General Purchase Order for Township Assistance (Township Form TA-3)

Report on Medical Aid Rendered (Township Form TA-4)

Prescribed by State Board of Accounts

RECORD OF LEASE CONTRACTS AND

NOTE: Use General Form No. 53 for Record of Bonded Indebtedness

	Nature of Instrument 1	Date of Issue 2	To Whom Payable 3	Purpose of Issue 4
1				
2				

(Columnar Headings for Left Hand Side of Sheet)

SAMPLE

Township Form No. 14 (Rev. 2006) - Ruling C

INDEBTEDNESS OTHER THAN BONDS

	Rate of Interest 5	Due Date of Final Payment 6	Total Amount Payable 7	PAYMENTS ON PRINCIPAL			INTEREST PAYMENTS		
				Date 8	Amount 9	Balance Due 10	Date 11	Amount 12	
1									1
2									2

(Columnar Headings for Right Hand Side of Sheet)

Prescribed by State Board of Accounts

TOWNSHIP TRUSTEE'S

	Policy Number 1	Name of Insurance Company 2	Property Covered 3	Kind of Insurance (show % of coinsurance, if any) 4	Date of Policy 5
1		Premiums Payable by Years Brought Forward			
2					

(Columnar Headings for Left Hand Side of Sheet)

Township Form No. 14 (Rev. 2006) - Ruling B

INSURANCE RECORD

	Expiration Date of Policy 6	Amount of Insurance 7	Total Premium Payable 8	PREMIUMS PAYABLE BY YEARS						
				20	20	20	20	20		
				9	10	11	12	13		
1										1
2										2

(Columnar Headings for Right Hand Side of Sheet)

Note: The last line of this form is to be ruled for totals in columns 9, 10, 11, 12 and 13, and the words "Premiums Payable by Years Carried Forward" is to be printed on this last line.

RECEIPT

Office of Township Trustee

NO. _____

_____ IN _____, 20____

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

RECEIVED FROM _____ \$ _____
 THE SUM OF _____ DOLLARS
 ON ACCOUNT OF _____ 100

SAMPLE

Township Trustee

(Original)

NO. _____

Date Issued _____

Issued To _____

ON ACCOUNT OF _____

Township Trustee

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

Amount of Receipt

SAMPLE

(Duplicate)

**RESOLUTION
ESTABLISHING SALARIES OF TOWNSHIP OFFICERS AND EMPLOYEES**

BE IT RESOLVED by the Township Board of _____ Township
 _____ County, Indiana,

That pursuant to IC 36-6-6-10(b), the salaries stated below are fixed for the officers and employees of the township
 year _____.

POSITION OF OFFICE	Number of Positions	Rate of Compensation	Per *
Township Trustee			
Township Clerk			
Members of the Township Board			
Fire Department Personnel			
Township Assistance Personnel			
Supervisors of Investigators			
Investigators			
Supervisors of Other Assistants			
Other Assistants			
Other Employees (Detail)			

SAMPLE

ADOPTED this _____ day of _____, _____.

Attest: _____
 Township Trustee

 Members of the Township Board

* Show: per year, per month, per day, etc.

Include in this resolution ALL officers and employees of the township.

Application for Township Assistance

Note: Social Sec. #'s are optional.

PHONE NUMBER () -	APPLICATION DATE / /	APPLICATION TIME : <input type="checkbox"/> AM <input type="checkbox"/> PM	CASE NUMBER
AREA ### ####	MM DD YY	HH MM (total:)	office use only

Applicant's Full Name			Social Security #	Date of Birth
<input type="checkbox"/> male <input type="checkbox"/> female			- -	/ /
LAST	FIRST	MI	optional	MM DD YY

Other Adult's Full Name			Social Security #	Date of Birth
<input type="checkbox"/> male <input type="checkbox"/> female			- -	/ /
LAST	FIRST	MI	optional	MM DD YY

Other Adult's Full Name			Social Security #	Date of Birth
<input type="checkbox"/> male <input type="checkbox"/> female			- -	/ /
LAST	FIRST	MI	optional	MM DD YY

Current Address				— Months
Street Address / P.O. Box				— Years
Apt. #	City, State	Zip	How Long	

Previous Address				— Months
Street Address / P.O. Box				— Years
Apt. #	City, State	Zip	How Long	

QUESTION	APPLICANT	OTHER ADULT	OTHER ADULT
What is your housing status?	<input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Other	<input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Other	<input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Other
What is your marital status?	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed

This office does not discriminate on the basis of race, color, national origin, sex, religion, age, or handicap status. Anyone needing special aid, readers, or interpreters, please notify us at least 48 hours in advance.

In the following table, list ALL persons living within this household. For EACH person check the relationship to the applicant and ALL income sources for that person. Signature, affirming income, required of all household members eighteen (18) and older.

Note: Social Sec. #'s are optional.

Person's Name	Relationship		Income Source	Amount (monthly)
Print _____ Signature _____	<input type="checkbox"/> Yourself	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other
Print _____ Signature _____	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other
Print _____ Signature _____	<input checked="" type="checkbox"/> Child <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other
Print _____ Signature _____	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other
Print _____ Signature _____	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other
Print _____ Signature _____	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other
Print _____ Signature _____	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other

Total adults in the household: _____ Total children in the household: _____
 Total of ALL persons living in the household: _____
 Total GROSS income received in the household last 30 days: \$ _____

Does anyone live in this household temporarily or occasionally? YES NO
 If YES, who and how often: _____

List all motorized vehicles owned by ANY person in this household:

Type: _____ (Car/Truck/Boat/Motorcycle) Year: _____ Make: _____
 Type: _____ (Car/Truck/Boat/Motorcycle) Year: _____ Make: _____
 Type: _____ (Car/Truck/Boat/Motorcycle) Year: _____ Make: _____

QUESTION	APPLICANT	OTHER ADULT	OTHER ADULT
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What is your income status?	name: _____ <input type="checkbox"/> Wages Stopped <input type="checkbox"/> Waiting on Income <input type="checkbox"/> Receiving Income <input type="checkbox"/> No Income	name: _____ <input type="checkbox"/> Wages Stopped <input type="checkbox"/> Waiting on Income <input type="checkbox"/> Receiving Income <input type="checkbox"/> No Income	name: _____ <input type="checkbox"/> Wages Stopped <input type="checkbox"/> Waiting on Income <input type="checkbox"/> Receiving Income <input type="checkbox"/> No Income
------------------------------------	--	--	--

What is your employment status?	<input type="checkbox"/> Currently working <input checked="" type="checkbox"/> Laid off on: _____ <input type="checkbox"/> Never worked <input type="checkbox"/> Quit: * <input type="checkbox"/> Fired: * <input type="checkbox"/> Sick Leave <input type="checkbox"/> Maternity Leave <input type="checkbox"/> On strike <input type="checkbox"/> Trying to find work	<input type="checkbox"/> Currently working <input type="checkbox"/> Laid off on: _____ <input type="checkbox"/> Never worked <input type="checkbox"/> Quit: * <input type="checkbox"/> Fired: * <input type="checkbox"/> Sick Leave <input type="checkbox"/> Maternity Leave <input type="checkbox"/> On strike <input type="checkbox"/> Trying to find work	<input type="checkbox"/> Currently working <input type="checkbox"/> Laid off on: _____ <input type="checkbox"/> Never worked <input type="checkbox"/> Quit: * <input type="checkbox"/> Fired: * <input type="checkbox"/> Sick Leave <input type="checkbox"/> Maternity Leave <input type="checkbox"/> On strike <input type="checkbox"/> Trying to find work
--	---	--	--

* answers require explanation below

Other Financial Information						
	Applicant		Other Adult		Other Adult	
Do you have life insurance?	Yes	No	Yes	No	Yes	No
Do you have another type of insurance?	Yes	No	Yes	No	Yes	No
Do you have any investment holdings? (Stocks, Bonds, CD's, IRA's)	Yes	No	Yes	No	Yes	No
Do you have any cash on hand? If YES, give amount	Yes	No	Yes	No	Yes	No
Do you have a checking account?	Yes	No	Yes	No	Yes	No
Do you have a savings account? If YES, give name of each bank and current balance	Yes	No	Yes	No	Yes	No
Does anyone in the household have any claims, including lawsuits, against a person, insurance company, employer, or government agency from which you (they) expect to receive a recovery (money)?	Yes	No	Yes	No	Yes	No
If yes, explain: _____						

PROPERTY OWNERSHIP			
	Applicant	Other Adult	Other Adult
Do you own any property?	YES NO	YES NO	YES NO
If YES, address: _____			
Name of mortgage company: _____			
Amount of mortgage payment: _____			
Number of years owned: _____ Approximate market value of home: _____			

RENTAL HISTORY	
Number of adults on the lease: _____	Co-lessee's name (if any): _____
Name of apartment complex or landlord: _____	
Address of complex or landlord: _____	
Phone number of complex or landlord: _____	
What date did you move into this rental unit: _____ Monthly rent amount: _____	
Is anyone in the household related to the landlord? YES NO If yes, state relationship: _____	
Are any utilities included? YES NO If yes, which ones? _____	

EMPLOYMENT HISTORY		
	Applicant	Other Adult
	name: _____	name: _____
Your most recent employer: _____		
Date you started work there: _____		
Date you last worked there: _____		
Reason not working now: _____		
2nd most recent employer: _____		
Date you started work there: _____		
Date you last worked there: _____		
Reason not working now: _____		

MILITARY SERVICE			
	Applicant	Other Adult	Other Adult
Serial Number: _____			
Enlistment Date: _____			
Branch of Service: _____			
Discharge Date: _____			

CITIZENSHIP
Is everyone in the household a U.S. citizen? YES NO
If no, please explain status by which you are in the U.S.: _____

FAMILY INFORMATION

Applicant's Maiden Name (if married): _____

Household members' relatives (parents, brothers, sisters, grandparents, aunts, uncles) including "step" relatives:

Name	Address	Phone	How have they helped? Are they willing to help?

SAMPLE

CHILD SUPPORT

If there are minor children in the home, is child support ordered for them by a court? YES NO

If not will you go to court to get support? YES NO

If NO, explain: _____

Are you receiving child support? YES NO If YES, how much? _____

Name and address of child(ren)'s other parent if not in household: _____

OTHER SOURCES OF HELP

Have you or someone in the household been helped from any other source such as churches, multi-service centers, or friends whom you have not already listed on this form? YES NO

If YES, who, how much and when? _____

CURRENT DEBTS OF ALL HOUSEHOLD MEMBERS

Amount of debt	Date Purchased	Name of Creditor	Items Purchased	Value	Amount Paid	Last Pay Date

OTHER PUBLIC ASSISTANCE

**Are you receiving or have you applied for the following:
APPLICANT**

	YES	NO	Date applied: ___ \ ___ \ ___	Amount: _____
Subsidized Sec. 8, HUD, or other public housing:				
Utility Allotment	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Food Stamps	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
AFDC Welfare	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Other Trustee Office	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Social Security (any type)	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
V.A. Benefits (any time)	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
EAP Utility assistance	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
FEMA Funds	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Unemployment Benefits	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Grants/Loans	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Any other type of help	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____

OTHER ADULT

	YES	NO	Date applied: ___ \ ___ \ ___	Amount: _____
Subsidized Sec. 8, HUD, or other public housing:				
Utility Allotment	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Food Stamps	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
AFDC Welfare	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Other Trustee Office	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Social Security (any type)	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
V.A. Benefits (any time)	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
EAP Utility assistance	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
FEMA Funds	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Unemployment Benefits	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Grants/Loans	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Any other type of help	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____

OTHER ADULT

	YES	NO	Date applied: ___ \ ___ \ ___	Amount: _____
Subsidized Sec. 8, HUD, or other public housing:				
Utility Allotment	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Food Stamps	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
AFDC Welfare	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Other Trustee Office	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Social Security (any type)	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
V.A. Benefits (any time)	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
EAP Utility assistance	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
FEMA Funds	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Unemployment Benefits	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Grants/Loans	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____
Any other type of help	YES	NO	Date Applied: ___ \ ___ \ ___	Amount: _____

Has anyone in the household been terminated from, refused or had AFDC payments reduced? YES NO
If YES, why? _____

Has anyone in the household ever been convicted of welfare fraud under IC 35-43-5-7? YES NO
If YES, when and where? _____

CONSENT TO THE DISCLOSURE OF INFORMATION TO THE TOWNSHIP TRUSTEE

I, _____, Case Number _____, residing at _____, Indiana, consent to the disclosure of the following information to _____, the investigator of township assistance for _____ Township _____ County, Indiana:

Information that will verify my:

1. Countable income.
2. Countable assets.
3. Wasted resources.
4. Relatives capable of providing assistance.
5. Past or present employment.
6. Pending claims or causes of action.
7. A medical condition if relevant to work or workfare requirements.
8. Any other information required by law.

This information may be used only in connection with:

- (1) my township assistance application from _____ Township _____ County, IN.
- (2) my application for public assistance from the Division of Family and Children county offices and the Office of Medicaid Policy and Planning.
- (3) others (if any). _____

SAMPLE

Signature of Applicant	Signature of Other Adult	Signature of Other Adult
Date Signed	Date Signed	Date Signed

This consent form expires 180 days after the date of signing.

ACKNOWLEDGMENT AND PLEDGE OF CONFIDENTIALITY BY THE TOWNSHIP

The undersigned township trustee or employee acknowledges that he/she may, in the course of employment, have access to certain personal information and that such information is to be treated as confidential, and is to be released and exchanged only with agencies related to the undersigned employment by the township in reviewing and investigating this application or as otherwise provided by law.

Trustee or Employee	Date Signed
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(THIS PAGE FOR TOWNSHIP USE ONLY)

WORK ORDER:

Given _____ Amount _____ Completed _____

STATISTICAL SUMMARY OF THIS APPLICATION

Date	# Recipients Rec'v. Benefit	Utility \$ Benefits	Housing \$ Benefits	Food \$ Benefits	Health Care \$ Benefits	Other	Total \$ Benefits

SAMPLE

Training Program Referral	Referrals	Workfare Hours	Time Spent on Application

CASE RECORD OF INVESTIGATION

NOTICE OF TOWNSHIP ASSISTANCE ACTION

Name _____ Case No. _____
(Last) (First) (Middle)

Address: _____

Action taken or to be taken on your request(s) is as follows:

Your request for: _____
(specify type(s) of relief requested: i.e., food, rent, etc.)

Has been:

- Approved as follows without workfare (if certain requirements are met): _____
- Approved and in accordance with IC 12-20-10-2 to be worked off at (location): _____
Hours: _____ Obligated adult household member: _____
- Partially approved as follows: _____
- Partially denied for the following reason(s): _____
- Denied for the following reason(s): _____
- Pending for an additional seventy-two (72) hours because: _____

COMMENTS: _____

Your request for: _____
(specify type(s) of relief requested: i.e., food, rent, etc.)

Has been:

- Approved as follows without workfare (if certain requirements are met): _____
- Approved and in accordance with IC 12-20-10-2 to be worked off at (location): _____
Hours: _____ Obligated adult household member: _____
- Partially approved as follows: _____
- Partially denied for the following reason(s): _____
- Denied for the following reason(s): _____
- Pending for an additional seventy-two (72) hours because: _____

COMMENTS: _____

Your request for: _____
(specify type(s) of relief requested: i.e., food, rent, etc.)

Has been:

- Approved as follows without workfare (if certain requirements are met): _____
- Approved and in accordance with IC 12-20-10-2 to be worked off at (location): _____
Hours: _____ Obligated adult household member: _____
- Partially approved as follows: _____
- Partially denied for the following reason(s): _____
- Denied for the following reason(s): _____
- Pending for an additional seventy-two (72) hours because: _____

COMMENTS: _____

Date of Application: _____ Time: _____ AM/PM

Date this Notice Sent: _____ Time: _____ AM/PM

Township Trustee's Signature

APPEAL RIGHTS AND PROCEDURE

1. The township trustee shall act on your application within seventy-two (72) hours. (Excluding weekends and the State's legal holidays listed in IC 1-1-9) in accordance with IC 12-20-6-7.
2. If you disagree with the action taken on your case, you have a right to appeal to the board of county commissioners. Your request for an appeal should be in writing or orally as may be required by the board of commissioners. The appeal must be made within fifteen (15) days from the date the township trustee denies assistance, if the applicant has been informed of his right to appeal and the procedure for such appeal.
3. The hearing on your appeal may be conducted by the board of county commissioners or by a hearing officer appointed by that board within ten (10) working days after your appeal is received. In hearing the appeal, the board shall be governed by the uniform relief standards of eligibility and need established by the township trustee, to the extent the standards comply with existing law, for granting township assistance in the township.
4. At the hearing of your appeal you shall appear in person, may retain counsel, and may have persons speak in your behalf. This office is also entitled to be represented. However, you have the right to examine any evidence it introduces and to cross-examine its witnesses. You will be notified of the decision of the board within five (5) working days after the hearing.
5. If you wish to appeal the above action, fill out the appeal request form below.
6. You or the township trustee may appeal a decision of the board of county commissioners to a circuit or superior court in the county. In hearing an appeal, the court shall be governed by uniform relief standards of eligibility and need established by the township trustee for granting township assistance in the township. If legally sufficient standards have not established, the court shall be guided by the circumstances of the case.

APPEAL REQUEST - TOWNSHIP ASSISTANCE ACTION

_____ County Board of Commissioners

Date: _____

(Address)

You are hereby notified of an appeal to the action by the Township Trustee, _____
_____ Township, _____ County, Indiana, on the
township assistance case of the undersigned, and a hearing is requested for the following reason(s): _____

SAMPLE

I certify that the above statements are true and correct to the best of my knowledge and belief.

Name

Street Name and Number or R.R.

_____, IN _____

Telephone

City or Town

Zip Code

APPLICATION FOR ADDITIONAL OR CONTINUING TOWNSHIP ASSISTANCE

DATE: _____
 NAME: _____ PHONE: _____
 ADDRESS: _____

*Please do not
write in this
column.*

CASE NO.

Number of persons living at your address: _____
 Since your application with the trustee's office dated _____ has your income, resources or household size changed? YES ___ NO ___
 Are you or anyone else in the household working? YES ___ NO ___
 Are you or any member of your household under a doctor's care? YES ___ NO ___
 Have you/they applied for disability? YES ___ NO ___
 If YES, what is the status of the case? _____

SINCE THE DATE OF YOUR MOST RECENT APPLICATION:

Have you applied for AFDC? YES NO If receiving, give amount: _____
 Have you applied for Food Stamps? YES NO If receiving, give amount: _____
 Have you applied for Unemployment? YES NO If receiving, give amount: _____
 Have you applied for Energy Assistance? YES NO If receiving, give amount: _____
 Have you applied for / received assistance from any other source? YES NO If YES, explain: _____

What has been the household's: **Total Income: \$** _____ **Total Expenses: \$** _____

TODAY I AM REQUESTING ASSISTANCE WITH THE FOLLOWING:	AMOUNT (\$) REQUESTED	ACTION

INCOME AND EXPENSES

INCOME is any source of benefit to you, or any number of your household, whether money or payment assistance. This includes: work income, AFDC, housing assistance, odd job money, sick pay, relative or church assistance, EAP/Project Safe payments, Worker's Compensation, Social Security benefits, unemployment, child support, vacation pay, tax returns, bartered goods, etc.

EXPENSE is any bill you have already paid or anything on which you used the above income.

LIST ALL MONEY, INCOME, BENEFITS RECEIVED BY ANYONE IN YOUR HOUSEHOLD IN THE PAST THIRTY (30) DAYS:	AMOUNT (\$) RECEIVED	VERIFIED AMOUNT
<i>Date Received:</i> _____ <i>Received from:</i> _____ <i>Received for:</i> _____		

(OVER)

TOWNSHIP ASSISTANCE PURCHASE ORDER

(TO BE USED FOR BOTH MEDICAL AND GENERAL PURCHASE ORDERS)

Purchase Order No. _____ Township, _____ County, Indiana _____

TO _____

PLEASE SUPPLY _____ CASE NO. _____

Address _____

WITH THE FOLLOWING SERVICES

Food ---	\$ _____	Electric ---	\$ _____	\$ _____
Heating Fuel --	\$ _____	Water ---	\$ _____	\$ _____
Clothing	\$ _____	Gas ---	\$ _____	\$ _____
Office Call	_____	Hospitalization (itemize fully)	_____	_____
	\$ _____			\$ _____
Prescription Medicines (itemize fully as to quantity, price, kind and necessity)	_____	Surgery (describe fully)	_____	_____
	\$ _____			\$ _____
	\$ _____	Other Medical/Dental Services (List)	_____	_____
	\$ _____			_____
	\$ _____	TOTAL AMOUNT OF THIS ORDER		\$ _____

Statement of Patient as to illness _____

Disbursing Clerk _____ Authorized by _____ Township Trustee

CUSTOMER'S RECEIPT

I have received in full the items authorized by this order.

Signed _____

VENDOR'S STATEMENT

I have furnished the customer with the full amount of supplies, services, or other items authorized by this order.

Signed _____

INSTRUCTIONS: This form to be made out in triplicate; original to doctor or vendor, duplicate filed alphabetically in assistance office, triplicate remaining in book in numerical order. Use indelible pencil or ink. Do not use check marks. Write out number of services authorized in words (as "one").

Wherever possible, at the time the purchase order is written, the total amount of the order must be inserted in the space provided for the same.

Doctors or vendors are required to return their copies of township assistance purchase orders at the time they file their monthly claims. Such monthly claims must show the purchase order number for each number for each charge billed the Trustee's office. A separate claim must be filed for each township.

Both the signature of the patient and the doctor or vendor must be submitted with the claim for each office call, or other service for which a charge is rendered. Any charge shall not exceed the amount prescribed in the fee schedule in force.

REPORT ON MEDICAL AID RENDERED

On Purchase Order No. _____ Township _____ County, Indiana
 Name of Patient _____ Date of Service _____
 Address _____ Case Number _____
 Diagnosis _____
 Office Call \$ _____ Hospitalization (itemize fully) _____
 House Call \$ _____ \$ _____
 (Calls include all usual and ordinary medicines.) Surgery (describe fully) _____
 Unusual Medicines, (itemized fully as to quantity, price, kind and necessity. Limited to U. S. P. and N. F. _____ \$ _____
 Mileage, _____ miles (one way only outside city limits) _____ \$ _____ Other Medical Services _____ \$ _____
 Tooth extraction, Child's _____ Teeth \$ _____ O. B. Case, including all prenatal and post-natal care _____ \$ _____
 Tooth extraction Adult's _____ Teeth \$ _____
 _____ \$ _____
TOTAL CHARGES \$ _____

DOCTOR'S OR VENDOR'S STATEMENT
 I have furnished the customer with the full amount of services, or other items listed above and authorized by this order.

PATIENT'S RECEIPT
 I have received in full the items and services listed above and authorized by this order.

Signed _____ Signed _____
 (Patient or head of household)

INSTRUCTIONS

Signature of patient or head of household must be obtained on properly itemized report blank on both emergency and other services rendered. All payments for emergency calls and tentative authorizations are contingent upon results of relief investigation by visitor.

This form to be made out in triplicate. Original submitted with purchase order and claim, duplicate to be retained by person rendering service.

Do not charge for any miles except those actually and necessarily traveled outside of the city limits for the purpose of the call. Calls to be grouped whenever possible in trips. Only one mileage charge allowed when more than one call made on same or in same household. Mileage one way only allowed.

When purchase order authorizes more than one call or service, separate report blanks must be submitted for each and every call and service rendered. This report can cover only one charge. Every charge must be specifically authorized by purchase order. Amount authorized by purchase order cannot be exceeded.

EMERGENCY SERVICE

Generally a township is not under obligation to pay a claim for medical or surgical aid unless such services have been ordered or contracted for by the township trustee. However, in case of extreme emergency where delay for the purpose of communicating with the trustee might result in loss of life or other serious consequences to the patient, the physician or surgeon rendering the relief necessary would be entitled to payment therefor from the township without having been ordered by the trustee to perform such services. (See Nowcomer V. Jefferson Twp. 181 Ind. 1) legal Guide to public Officials fo Indiana, published by State Board of Accounts 1932.

It is contemplated by the law that the overseer of the poor "****shall, in cases of necessity, promptly provide medical and surgical attendance for all of the poor in his township who are not provided for in public institutions****."

Required by Governor's Commission on Unemployment Relief