APPENDIX

Township Check (Township Form No. 6)

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)

Trustee's Dog Tax/Kennel License Receipt (Township Form No. 18)

Notice of Unpaid Dog Tax (Township Form No. 82)

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

Notice of Township Assistance Action (Township Assistance Form TA-1A)

Application for Additional or Continuing Township Assistance (Township Assistance Form TA-1B)

Purchase Order for Medical Aid (Township Assistance Form TA-2)

Overseer of the Poor, General Purchase Order for Township Assistance,
Township Trustee's Office (Township Assistance Form TA-3)

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

COPY 1

HOURS WORKED	GROSS PAY	FEDERAL W/TAX	SOCIAL SEC.	STATE W/TAX	INSUR-ANCE				NET PAY	PERIOD ENDING	EMPLOYEE DETACH AND RETAIN

PRESCRIBED BY STATE
BOARD OF ACCOUNTS

TWP. FORM NO. 6 (REV. 1967)

SAMPLE

This Warrant Void Two (2) Years
After Dec. 31 of the Year of Issue.

Number _____

Approp. No. _____ $_____
Approp. No. _____ $_____
Approp. No. _____ $_____

_____ Fund _____ , _____

Pay to the
Order of _____ $ _____

_____ Dollars
100

For _____

_____
TRUSTEE OF ABOVE-NAMED TOWNSHIP

COPY 2

HOURS WORKED	GROSS PAY	FEDERAL W/TAX	SOCIAL SEC.	STATE W/TAX	INSUR-ANCE				NET PAY	PERIOD ENDING	COUNTY AUDITOR'S COPY

PRESCRIBED BY STATE
BOARD OF ACCOUNTS

TWP. FORM NO. 6 (REV. 1967)

SAMPLE

Number _____

Approp. No. _____ $_____
Approp. No. _____ $_____
Approp. No. _____ $_____

_____ Fund _____ , _____

Paid To: _____ $ _____

_____ Dollars
100

For _____

I certify this to be the exact sum received and that it is for the purpose herein stated; that no part of said sum has been retained by, returned to, or has been directly or indirectly agreed to be returned to, the Trustee or any other person.

Signed: _____
PAYEE

VOUCHER - to accompany the Annual Report and be filed with County Auditor after close of year.

COPY 3

HOURS WORKED	GROSS PAY	FEDERAL W/TAX	SOCIAL SEC.	STATE W/TAX	INSUR-ANCE				NET PAY	PERIOD ENDING	OFFICE COPY

PRESCRIBED BY STATE
BOARD OF ACCOUNTS

TWP. FORM NO. 6 (REV. 1967)

SAMPLE

Number _____

Approp. No. _____ $_____
Approp. No. _____ $_____
Approp. No. _____ $_____

_____ Fund _____ , _____

Paid To: _____ $ _____

_____ Dollars
100

For _____

Posted To Financial and Appropriation Record _____

NON - NEGOTIABLE

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					

SAMPLE

(Columnar Headings for Left Hand Side of Sheet)

Township Form No. 14 (Rev. 1955) - 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

SAMPLE

(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						

SAMPLE

(Columnar Headings for Left Hand Side of Sheet)

Township Form No. 14 (Rev. 1955) - Ruling B

INSURANCE RECORD

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

SAMPLE

(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.

Prescribed by State Board of Accounts

Township Form No. 16 (Rev. 1997)

RECEIPT

Office of Township Trustee

NO. _____

_____

_____ IN _____

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

100

ON ACCOUNT OF _____

_____

_____

Township Trustee

SAMPLE

(Original)

Amount of Receipt

NO. _____

_____

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

Date Issued _____

Issued To _____

_____

ON ACCOUNT OF _____

_____

_____

Township Trustee

SAMPLE

(Duplicate)

Prescribed by State Board of Accounts

Township Form No. 17 (Rev. 2003)

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 Duties			
(1) Assessing Duties (not county portion)			
Total for 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, except elected Township Assessors and deputies ar employees of elected Township Assessors.

(1) IC 36-6-6-10(e) states: "In a township that does not elect a township assessor under IC 36-6-5-1, the township legislative body may appropriate available township funds to supplement the salaries of elected or appointed officers to compensate them for performing assessing duties. However, in any calendar year no officer or employee may receive a salary and additional salary suppplements which exceed the salary fixed for that officer or employee under subsection (b)."

Prescribed by State Board of Accounts

Township Form No. 18 (1997)

Expires One Year
From Date of Issue

DOG TAX/KENNEL LICENSE RECEIPT
_____ TOWNSHIP
_____ COUNTY, INDIANA

NO. _____

_____
(Date Issued)

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

SAMPLE

RECEIVED OF _____

STREET/R.R. NO. _____ CITY/TOWN _____ ZIP _____

THE SUM OF _____ DOLLARS

IN FULL PAYMENT OF DOG TAX/KENNEL LICENSE FOR ONE YEAR FROM DATE OF ISSUE

No.		Breed	Sex	Age	Tag No.	Fee
	Neutered Dogs					
	Nonneutered Dogs					
	Each Additional Dog					
	Major Kennel License (15 or More Dogs)					
	Minor Kennel License (Less Than 15 Dogs)					
					Total Amount Due	

KENNEL LICENSE
The above-named is hereby licensed to conduct a _____ dog kennel if
Major or Minor
the kennel license fee has been paid.

Signed: _____ Trustee/Assessor

Prescribed by State Board of Accounts

Township Form No. 18 (1997)

Expires One Year
From Date of Issue

DOG TAX/KENNEL LICENSE RECEIPT
_____ TOWNSHIP
_____ COUNTY, INDIANA

NO. _____

_____
(Date Issued)

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

SAMPLE

RECEIVED OF _____

STREET/R.R. NO. _____ CITY/TOWN _____ ZIP _____

THE SUM OF _____ DOLLARS

IN FULL PAYMENT OF DOG TAX/KENNEL LICENSE FOR ONE YEAR FROM DATE OF ISSUE

No.		Breed	Sex	Age	Tag No.	Fee
	Neutered Dogs					
	Nonneutered Dogs					
	Each Additional Dog					
	Major Kennel License (15 or More Dogs)					
	Minor Kennel License (Less Than 15 Dogs)					
					Total Amount Due	

KENNEL LICENSE
The above-named is hereby licensed to conduct a _____ dog kennel if
Major or Minor
the kennel license fee has been paid.

Signed: _____ Trustee/Assessor

Prescribed by State Board of Accounts

Township Form No. 18 (1997)

Expires One Year
From Date of Issue

DOG TAX/KENNEL LICENSE RECEIPT
_____ TOWNSHIP
_____ COUNTY, INDIANA

NO. _____

_____
(Date Issued)

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

SAMPLE

RECEIVED OF _____

STREET/R.R. NO. _____ CITY/TOWN _____ ZIP _____

THE SUM OF _____ DOLLARS

IN FULL PAYMENT OF DOG TAX/KENNEL LICENSE FOR ONE YEAR FROM DATE OF ISSUE

No.		Breed	Sex	Age	Tag No.	Fee
	Neutered Dogs					
	Nonneutered Dogs					
	Each Additional Dog					
	Major Kennel License (15 or More Dogs)					
	Minor Kennel License (Less Than 15 Dogs)					
					Total Amount Due	

KENNEL LICENSE
The above-named is hereby licensed to conduct a _____ dog kennel if
Major or Minor
the kennel license fee has been paid.

Signed: _____ Trustee/Assessor

Form Prescribed by State Board of Accounts Township Form No. 82 (Rev. 1987)

Office of the Trustee

of _____ Township, _____ County

NOTICE OF UNPAID DOG TAX

Name _____

Address _____

_____

SAMPLE

You are hereby notified that the assessment records of this township show that the state dog tax (license fee) for the year _____ has not been paid on a dog or dogs described as follows:

Neutered	_____	Color	_____	Breed	_____
Nonneutered	_____	Color	_____	Breed	_____
Each Additional	_____	Color	_____	Breed	_____

If payment is made to the township trustee within 10 days of this notice the total amount due will be

$ _____

Date of Notice _____

_____

Trustee _____ Township

_____ County

(Over)

This notice is served pursuant to Public Laws 192 and 193 of Acts of 1987 and provides in part:

> "Each township trustee shall perform the duties imposed by this chapter. If a dog owner has failed to turn in a dog for taxation purposes, the trustee shall notify the owner that the trustee is listing the unpaid taxes within a period of ten (10) days, at which time the person will be assessed double the amount of taxes provided by this chapter unless the person owning the dog appears voluntarily within the ten (10) days and:
>
> (1) proves to the satisfaction of the trustee that the person owned no such dog at the time the census was made; or
>
> (2) makes an affidavit to be kept on file by the trustee to the effect that the failure to report a dog for taxation was not intentional and was not purposely omitted for the purpose of avoiding payment of taxes."

SAMPLE

Application for Township Assistance

Note: Social Sec. #'s are optional.

PHONE NUMBER	APPLICATION DATE	APPLICATION TIME	CASE NUMBER
( ) -	/ /	. . ☐ AM ☐ PM	
AREA ### ####	**MM DD YY**	**HH MM (total:)**	**office use only**

Applicant's Full Name				**Social Security #**	**Date of Birth**
			☐ male ☐ female	— —	/ /
LAST	**FIRST**	**MI**		**optional**	**MM DD YY**

Other Adult's Full Name				**Social Security #**	**Date of Birth**
			☐ male ☐ female	— —	/ /
LAST	**FIRST**	**MI**		**optional**	**MM DD YY**

Other Adult's Full Name				**Social Security #**	**Date of Birth**
			☐ male ☐ female		/ /
LAST	**FIRST**	**MI**		**optional**	**MM DD YY**

SAMPLE

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

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

QUESTION	APPLICANT	OTHER ADULT	OTHER ADULT
What is your housing status?	☐ Own ☐ Buying ☐ Renting ☐ Homeless ☐ Other	☐ Own ☐ Buying ☐ Renting ☐ Homeless ☐ Other	☐ Own ☐ Buying ☐ Renting ☐ Homeless ☐ Other
What is your marital status?	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ 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 circle 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	☐ Yourself	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	
Print Signature	☐ Child ☐ Spouse ☐ Relative ☐ Room Mate ☐ Other Adult	/ / **Date of Birth** – – **Social Sec. #** (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits	Wages AFDC Pension Support Gifts Other	

SAMPLE

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
		name: _____	name: _____
What is your income status?	☐ Wages Stopped ☐ Waiting on Income ☐ Receiving Income ☐ No Income	☐ Wages Stopped ☐ Waiting on Income ☐ Receiving Income ☐ No Income	☐ Wages Stopped ☐ Waiting on Income ☐ Receiving Income ☐ No Income
What is your employment status? ** answers require explanation below*	☐ Currently working ☐ Laid off on: _____ ☐ Never worked ☐ Quit: * ☐ Fired: * ☐ Sick Leave ☐ Maternity Leave ☐ On strike ☐ Trying to find work	☐ Currently working ☐ Laid off on: _____ ☐ Never worked ☐ Quit: * ☐ Fired: * ☐ Sick Leave ☐ Maternity Leave ☐ On strike ☐ Trying to find work	☐ Currently working ☐ Laid off on: _____ ☐ Never worked ☐ Quit: * ☐ Fired: * ☐ Sick Leave ☐ Maternity Leave ☐ On strike ☐ Trying to find work

* _____

SAMPLE

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?	Yes	No	Yes	No	Yes	No
If YES, give amount	$_____		$_____		$_____	
Do you have a checking account?	Yes	No	Yes	No	Yes	No
Do you have a savings account?	Yes	No	Yes	No	Yes	No
If YES, give name of each bank and current balance						

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
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: _____	Other Adult 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:			

SAMPLE

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

EXPENSE INFORMATION

List below any payments made by any household member to any source in the last thirty (30) days:

Amount	Paid to	Date Paid	Amount	Paid to	Date Paid

SAMPLE

What do you owe today on your rent or mortgage? $_____

What do you owe today on your utilities? _____

Electricity $_____ Gas/Heating $_____ Water $_____ Cable $_____

Telephone $_____ Sewer $_____ Trash Removal $_____ Cable $_____

Are any of these bills in someone else's name? YES NO

If YES, which ones and whose name? _____

What is your reason for asking for Trustee help?

- ☐ No Income
- ☐ Not Enough Income
- ☐ Income Stolen
- ☐ Emergency Event

Has there been an emergency or extraordinary circumstance you wish the Trustee to consider in your application? YES NO

If YES, explain: _____

Specifically, what are you asking for help with today?

_____

OTHER PUBLIC ASSISTANCE

Are you receiving or have you applied for the following:

APPLICANT

Subsidized Sec. 8, HUD, or other public housing:	YES	NO	Date applied: _________		
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

Subsidized Sec. 8, HUD, or other public housing:	YES	NO	Date applied: _________		
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:	_____

SAMPLE

OTHER ADULT

Subsidized Sec. 8, HUD, or other public housing:	YES	NO	Date applied: _________		
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? _____

READ CAREFULLY * NOTICE OF PUBLIC LAW

Indiana Code 12-20-6-9 requires the township trustee to investigate my circumstances, and the cause of my condition. I understand that I am required to operate in such investigation. I understand that Indiana Code 12-20-6-8 requires the trustee to notify me of the action taken (approval, denial, pending) on my case within 72 hours (excluding weekends and legal holidays) and that the trustee must retain a copy of each application whether or not relief is granted.

Indiana Cod 12-20-16-2 prohibits the Trustee from providing medical assistance if the applicant could qualify for that assistance under the Hospital Care for the Indigent Program (IC 12-16). The township may not provide assistance for payment for more than 30 days heating fuel or electric services assistance unless you have applied for assistance from the Division of Disability, Aging, and Rehabilitative Services as stated under IC 12-20-16-3. IC 12-20-6-5 provides that applicants, or a member of the applicant's household, granted emergency township assistance, file an application with the appropriate government agency. If the applicant, or a member of the applicant's household, failed to file within fifteen (15) working days, no further Trustee assistance may be granted for sixty (60) days following emergency Trustee assistance granted. Applicants for food assistance may not be provided food assistance for more than thirty (30) days unless an application food stamps is filed with the Division of Family and Children. IC 12-20-10-1 provides that if applicants applying for aid are in good health, or if any member of their household are so, the trustee shall require those able to work to seek employment and the trustee shall refuse any aid until the trustee is satisfied that the persons claiming help are endeavoring to find work for themselves. IC 12-20-11-1 requires a recipient or other adult member of the household, with certain exceptions, to do work needed to be done within the county or an adjoining township in any other county for any governmental unit having jurisdiction in those townships.

I HAVE READ THE ABOVE NOTICE OF PUBLIC LAW.

Signature of Applicant	Signature of Other Adult	Signature of Other Adult

Are you willing to work for the township and actively seek employment as a condition of receiving trustee assistance?

Applicant: YES NO OTHER ADULT: YES NO OTHER ADULT: YES NO

If no, explain why not: _____

SAMPLE

AFFIDAVIT

I certify and affirm under penalties of perjury that the information I have given on this application is true and correct to the best of my knowledge and belief in every respect as to myself and members of my family and household, and that I have not withheld any information on matters bearing upon the eligibility and need for relief from myself and members of my family and household, and that I and the members of my family and household have no other means of support than those stated in this application. I also certify that I have not been convicted under IC 35-43-5-7 (Welfare Fraud) and am eligible to receive township assistance.

Signature of Applicant	Signature of Other Adult	Signature of Other Adult

Note: All household members eighteen and older must sign where indicated for application to be complete.

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 my 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

(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: _____

SAMPLE

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 of Application: _____ **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

Please do not write in this column.

CASE NO. _____

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

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

SAMPLE

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 ANYON IN YOUR HOUSEHOLD IN THE PAST THIRTY (30) DAYS	AMOUNT ($) REQUESTED	VERIFIED AMOUNT
Date Received: *Received from:* *Received for:*		

(OVER)

LIST ALL PURCHASES, EXPENSES, OR BILLS PAID BY YOU OR MEMBERS OF YOUR HOUSEHOLD IN THE PAST THIRTY (30) DAYS:

Please do not write in this column.

Paid for:	*Date Paid:*	*Paid to:*	**AMOUNT ($) PAID OUT**	**ALLOWED/ VERIFIED**
rent\mortgage				
electric service				
gas service				
water service				
sewer service				
phone payment				
food purchased				
babysitting/childcare				
transportation costs				
medical expenses				
insurance payment (state type)				
household items (specify)				
loans/charge payments				
other monthly cost (specify)				
cable television				
other (specify)				
other (specify)				
Expenses OWED (not paid) at this time:				
rent/mortgage amount:				
utilities (type and amount owed):				
other bills (specify type and amount owed):				

SAMPLE

AFFIDAVIT

I affirm under the penalties of perjury that the information I have given on this application is true and correct to the best of my knowledge and belief in every respect as to myself and members of my family and household and has not changed since my last request for assistance other than what has been stated on this form; and that I have not withheld any information on matters bearing upon the eligibility and need for relief from myself and members of my family and household, and that I and the members of my family and household have no other means of support than those stated in this application. I also certify I have not been convicted under IC 35-43-5-7 (Welfare Fraud) and am eligible to receive township assistance.

Applicant Signature _____ Date _____ Other Adult in Household _____ Date _____

Other Adult Signature _____ Date _____ Time of Day: _____:_____ A.M./P.M.

OFFICE USE ONLY

TOTAL INCOME $_____ **ALLOWED EXPENSES $**_____ **SURPLUS/DEFICIT $**_____

Investigator Notes: _____

Investigator Signature: _____

Form Prescribed by State Board of Accounts

Township Form TA-2 (Revised 2003)

PURCHASE ORDER FOR MEDICAL AID

Purchase Order No. .....

TRUSTEE'S OFFICE

..... Township, ... County, Indiana. ....., ...

TO .....

PLEASE SUPPLY ..... CASE NO. .....

Address .....

WITH THE FOLLOWING SERVICES

Office Call ..... $ .....

House Call ..... $ .....

..... $ .....

(Calls include all usual and ordinary medicines)

Unusual Medicines (itemize fully as to quantity, price, kind and necessity, Limited to U.S.P. and N.F.)

..... $ .....

..... $ .....

Mileage, not over ..... miles, ... $ .....

(one way only outside city limits)

Tooth extraction, child's ..... Teeth $ .....

Tooth extraction, adult's ..... Teeth $ .....

..... $ .....

Hospitalization (itemize fully) .....

..... $ .....

Surgery (describe fully) .....

..... $ .....

Other Medical Services .....

..... $ .....

O.B. Case, including all prenatal and postnatal care $ .....

TOTAL AMOUNT OF THIS ORDER $ =====

Statement of Patient as to illness .....

.....

Disbursing Clerk ..... Authorized by ..... Township Trustee

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.

Purchase orders are valid only for the month in which they are written. Thus, an order given on the 20th day of the month would be void after the last day of that month insofar as permitting the recipient thereafter to obtain assistance. Obtain new purchase order from Trustee if necessary in order to carry out this requirement.

All township assistance claims rendered, etc., will be on a calendar month basis. Claims must be rendered on the basis of the last past calendar month and for no other period.

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.

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

Required by Governor's Commission on Unemployment Relief.

200M - 5-35

SAMPLE

Form Prescribed by State Board of Accounts

Township Form TA-3 (Revised 2003)

No. _____

GENERAL PURCHASE ORDER FOR TOWNSHIP ASSISTANCE

TOWNSHIP TRUSTEE'S OFFICE

IN, _____ County, _____ Township, _____, _____
Date of Order

To _____

Please Supply _____ Case No. _____

WITH THE FOLLOWING:

Food - - - - - - - $ _____ _____ - - - $ _____ _____ - - - $ _____

Fuel - - - - - - - - $ _____ _____ - - - $ _____ _____ - - - $ _____

Clothing - - - - - $ _____ _____ - - - $ _____ _____ - - - $ _____

DISBURSING CLERK _____ Total Amount of This Order $_____

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 or other items authorized by this order.

Signed _____

(See the reverse side for instructions relative to filing this order and for detailed list of supplies, etc., to be furnished customer)

Required by Governor's Commission on Unemployment Relief

SAMPLE

ITEMIZE FULLY ALL ITEMS FURNISHED

Quantity	Size	Description	Unit Price		Total Amount	
				TOTAL		

SAMPLE

INSTRUCTIONS

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.

Purchase orders are valid only for the month in which they are written. Thus, an order given on the 20th day of the month would be void after the last day of that month insofar as permitting the recipient thereafter to obtain assistance. Obtain new purchase order from Trustee if necessary in order to carry out this requirement.

All township assistance accounting invoices rendered, etc., will be on a calendar month basis. Invoices must be rendered on the basis of the last calendar month and for no other period.

Creditors are required to return their copies of township assistance purchase orders at the time they file their monthly claims. Such monthly statements and invoices must show the purchase order number for each charge billed the Trustee's office. Signatures of the customer and vendor must be on all purchase orders billed for and returned to the Trustee's office. A separate claim must be filed for each township.

Form Prescribed by State Board of Accounts | Township Form TA-4 (Revised 2003)

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. _____ _____ $ _____
_____ $ _____ Other Medical Services _____
Mileage, _____ miles (one way only outside city limits) _____ $ _____ _____ $ _____
Tooth extraction, Child's _____ Teeth $ _____ O. B. Case, including all prenatal and post-natal care _____ $ _____
Tooth extraction Adult's _____ Teeth $ _____ TOTAL CHARGES $ _____
_____ $ _____

PATIENT'S RECEIPT

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

Signed _____
(Patient or head of household)

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.

Signed _____

SAMPLE

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 pur-chase order cannot be exceeded.

EMERGENCY SERVICE

Gernerally a township is not under obligation to pay a claim for medical or surgical aid unless such services have been ordered or contracted bor 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 surgion rendering the relief necessary would be entitled to payment therefor from the township without having been ordered by the trustee to perform such sevices. (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