TOWNSHIP ASSISTANCE INSTRUCTIONS

Please complete items and gather all documents on the checklist BEFORE making an appointment. You must bring all documents to your first appointment. Failure to cooperate with or to provide the township with the documentation or information which is not readily available or cannot be secured in a timely manner by the township (IC 12-20-6-1) is a cause for denial of Township Assistance.

1. BEFORE CALLING FOR APPOINTMENT
If you need assistance with utility bills (Duke, Vectren, etc.), please contact them to see if you can set-
up payment arrangements.
Apply for Food Stamps/TANF. If you are not already receiving assistance, provide evidence of your
Food Stamp application. https://fssabenefits.in.gov/bp/#/
If you are unemployed and not disabled, you MUST register at Work One.
https://www.workonecentral.org/job-seekers
2. GATHER THESE DOCUMENTS BEFORE YOUR APPOINTMENT
Current (not expired) state photo ID for everyone 18 or older in the household.
Social Security Cards for everyone in the household. For replacement cards:
https://www.ssa.gov/ssnumber/
Copy of Benefit Letter(s) if you receive Food Stamps (SNAP) and/or TANF (including your case #).
Support or custody documents for children in the household. (If applicable.)
Current, signed copy of your lease with landlord's name, address, and phone number, or a copy of
your most recent mortgage statement if you are buying your home.
If renting, please provide a current payment ledger from your landlord, or a statement from your
landlord giving the date and amount of last payment, how much is currently owed and when it was
due. Be sure landlord's contact information is on the statement, including an email.
Most recent bills/receipts for electric, gas, water, phone, internet, TV (cable/satellite).
Health Insurance/Medicaid/Medicare Verification (insurance cards are sufficient).
Verification of income (receipts/check stubs/bank statements) for the past 60 days.
Include <u>all</u> sources of income: child support, TANF, SSI, SS or funds from any other source,
including assistance from family or friends.
Last Year's Tax Return for all adults in home 18 years or older or proof of tax refund and date.
Verification of expenses for the last 60 days, including childcare costs. (Receipts, bank statements or
transaction history printed from debit/cash/ss/child support/unemployment cards.) This includes
verifying what cash withdrawals were used for.
Written documentation from your doctor, if you are off work due to illness/injury.
Completed application inserts: Assistance Compliance; Actual Income & Expense Sheet; Workforce
Development Release of Information; and the Employment Search Form.
Completed and signed Township Assistance Application.
3. CALL OUR OFFICE TO SCHEDULE YOUR APPOINTMENT – (317) 984-3826

After the **completed application and all documentation have been submitted**, this office has 72 business hours to review your application and make a determination. By signing below you are stating that you have been made aware that if all documentation and information above is not provided, it is a cause for denial of Township Assistance. If you are unable to keep your appointment, please call to reschedule.

	- •		-	
Applicant Signature		Date		



Jackson Township Hamilton County 506 W. Main Street P.O. Box 456 Arcadia, IN 46030

Robyn Cook | Township Trustee

NOTICE FOR TOWNSHIP ASSISTANCE REFERRAL REQUESTS

The Trustee's office is responsible for vetting all candidates for Township Assistance and for vetting candidate referrals to certain organizations that provide Assistance by those organizations request.

If you do not have a current application on file with the Trustee's office, you will not be eligible for any referrals except for food.

This is implemented under:

IC Code 6-2-25, Failure to Cooperate; Any failure to keep an appointment, locate necessary documents, complete an application, complete an obligation, or any other failure on the part of the client to establish legitimate eligibility for Public Assistance will be considered a failure to cooperate and be cause for denial of thirty (30) days.

IC Code 6-2-30, Failure to Provide Initial Document; A client who fails to provide the basic documentation required by the Trustee to verify need, or who fails to provide any other supporting documentation as instructed, may be denied for a period of (30) days.

IC Code 6-2-32, Failure to Report Income; A client who fails to report any income in the household – including (but not limited to) wages, tax returns, gifts, and any service of value provided to the household by any other entity – may be denied for failing to cooperate with the Trustee's investigation of circumstances and verification of need, falsification of information, and failure to provide documentation. Denial is for a period up to sixty (60) days.

Our office must have a complete application from any client requesting referrals for anything other than items provided by local food pantries.



Application for Township Assistance

							NOTE: Social	Security via	mbers are optional
PHONE NUMBER		APPLICATIO	N DATE		APPLIC	CATION TIM		CASE	NUMBER
() -		/	/				□ AM □ PM		
AREA ###-####		MM DD	YY		НН	MM (total	al:)	office	use only
Applicant's Full Name						Social S	ecurity #	Date	of Birth
					nale emale	-	-	/	/
LAST	FIRST		MI			opti	onal	MM	DD YY
Other Adult's Full Name						Social S	ecurity #	Date	of Birth
					nale emale	_	(**)	/	/
LAST	FIRST		MI			opti	onal	MM	DD YY
Other Adult's Full Name						Social S	ecurity #	Date	of Birth
		¥			nale emale		<u> </u>	/	/
LAST	FIRST		MI			opti	onal	MM	DD YY
Current Address									
									Months Years
Street Address / P.O. Box			Apt. #		Cit	y, State	Zip	[-I.	ow Long
Previous Address									
	54							u	Months Years
Street Address / P.O. Box			Apt. #		Cit	cy, State	Zip	Н	ow Long
QUESTION	AF	PPLICANT			THER	ADULT	OTI	-IER AD	ULT
What is your housing status?		Own			Ow	n		Own	
		Buying				ying		Buying	
**		Renting				nting		Renting	
		Homeless				meless		Homele	ess
		Other) Oth	ier		Other	
What is your marital status?		Married) Ma	rried		Marrie	d
		Single			Sin	gle	8	Single	
		Divorced		-	Div	rorced	9	Divorce	ed
		Separated				parated		Separat	
		Widowed) Wio	dowed		Widow	ed

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 Security numbers are optional

Person's Name Relationship Income Source (monthly) No Income Wages Yourself Social Security **AFDC** Date of Birth Print Unemployment Pension Veteran's Support Insurance Gifts Signature Social Sec. # Strike Benefits Other (optional) No Income Wages Child **AFDC** Social Security Spouse Date of Birth Print Unemployment Pension Relative Veteran's Support Room Mate Insurance Gifts Signature Social Sec. # (optional) Other Adult Strike Benefits Other No Income Wages Child **AFDC** Social Security Spouse Date of Birth Print Unemployment Pension Relative Veteran's Support Room Mate Insurance Gifts Signature Social Sec. # Other Adult Strike Benefits Other (optional) Wages No Income Child Social Security **AFDC** Spouse Date of Birth Print Unemployment Pension Relative Veteran's Support Room Mate Insurance Gifts Social Sec. # (optional) Signature Other Adult Strike Benefits Other No Income Wages Child **AFDC** Social Security Spouse Date of Birth Print Unemployment Pension Relative Veteran's Support Room Mate Insurance Gifts Signature Social Sec. # Other Adult Strike Benefits Other (optional) No Income Wages Child Social Security **AFDC** Spouse Date of Birth Print Unemployment Pension Relative Veteran's Support Room Mate Insurance Gifts Signature Social Sec. # Other Adult Strike Benefits Other (optional) Wages No Income Child / **AFDC** Social Security Spouse Date of Birth Print Pension Unemployment Relative Veteran's Support Room Mate Gifts Insurance Signature Social Sec. # Other Adult Strike Benefits Other (optional)

Total adults in the house	Ja o I d	Le			т.	1 1 1 1		1 ,				
Total adults in the house Total of ALL persons liv	zino znom	in the hou	sehold:		10ta	l childre	en in th	e househ	old:			
Total GROSS income re												
			0 41/01/01/01		recor	20 days	. 4/					
Does anyone live in this	hou	sehold ten	porarily	Or O	ccas	ionally?	Y	ES	NO)		
If YES, who and how of												
List all motorized vehicl	es o	wned by A	NY pers	son ir	thi	s housel	nold:					
Туре:		(Car / Tru	ck / Boa	at / M	otor	cycle)	Year:		_ Ma	ke:		
l .	Type: (Car / Tr											
Type:												
			CK / DOa	11 / 101	Otor	cycle)	rear:		_ Ma	ke:		
QUESTION		APPLICA	NT			OTHE	R ADU	LT		OTHER A	ADULT	
				Name:				N:	me!			
What is your income status?	? 🔲	Wages Sto						l		Wages Sto		
•		Waiting or		•						Waiting or		
		Receiving				Receiv	ing Inco	me		Receiving		
		No Incom	е			No Inc	ome			No Incom	е	
What is your employment		Currently	working			Curren	tly worl	cing		Currently	working	
status?		Laid off o				Laid of	ff on:			Laid off o		
		Never wor	ked							Never wor	ked	
		Quit: *				Quit: *				Quit: *		
* answers require explanation below		Fired: *				Fired: *				☐ Fired: *		
explanation below		Sick leave							☐ Sick leave			
		Maternity	leave			☐ Maternity leave				Maternity	leave	
*		On strike	find mad	i				1		On strike	01 1 1	
		Trying to				Trying	to find	WORK		Trying to	tind work	
		OTHE	R FINA	NCIA	LI	NFORM	IATIO	1				
D 1 110 1			Appl				Other	Adult		Other	Adult	
Do you have life insurance		2	Yes	No			Yes	No		Yes	No	
Do you have another type			Yes	No			Yes	No		Yes	No	
Do you have any investme			Yes	No			Yes	No		Yes	No	
(Stocks, Bonds, CD's Do you have any cash on		,	V- ~	Ma			3.7	».T		T Y		
IF YES, give amount	lianu	•	Yes	No			Yes	No		Yes	No	
Do you have a checking ac	CCOHI	nt ⁹	Yes	No			Yes	No		yes	No	
Do you have a savings acc			Yes	No			Yes	No		Yes	No	
IF YES, give name of ea				110			103	140		103	110	
& current balance												
Does anyone in the housel	old	have any c	laims, inc	cludin	g la	wsuits, a	against a	person.	insur	ance comp	anv.	=1
employer or government ag	gency	from whi	ch you (t	they)	expe	ct to rec	ceive a	ecovery	(mon	ey)? YES	NO NO	
If yes, explain:									`			

Do you own any pr IF YES, address: _		icant No	Other Adul Yes No	Yes No
	company:			
-9	e payment:			
Number of years ov	vned: Approxi	mate marl	ket value of home:	
	REI	NTAL HI	STORY	
Number of adults of	n the lease: Co-les	see's nam	e (if any):	
Name of apartment	complex or landlord:			
Address of complex	or landlord:			
Phone number of co	omplex or landlord:		No.	
What date did you	move into this rental unit:		Monthly rent a	mount:
Is anyone in the hou	sehold related to the landl	ord? YES	S NO If yes, state	relationship:
Are any utilities inc	luded? YES NO If yes	, which of	nes?	
	EMDI ()VMDNT	HICTORY	
	Applic		Other Adul	t Other Adult
	Аррис	aitt	Name	
X.F.				
	ployer:			
	k there;			1
	there:			
Reason not working	now:			
2nd most recent emp	oloyer:			
				1
Date you started wor	K there:			
Date you started wor				
Date you started wor Date you last worked	there:			
Date you started wor Date you last worked	I there:			
Date you started wor Date you last worked	I there:			
Date you started wor Date you last worked	I there:		ERVICE	
Date you started wor Date you last worked Reason not working	MILI Applicant			Other Adult
Date you started wor Date you last worked Reason not working Serial Number:	I there:		ERVICE	Other Adult
Date you started word Date you last worked Reason not working the Serial Number: Enlistment Date:	MILI Applicant		ERVICE	Other Adult
Date you started wor Date you last worked Reason not working Serial Number: Enlistment Date: Branch of Service:	MILI Applicant		ERVICE	Other Adult
Date you started wor Date you last worked Reason not working Serial Number: Enlistment Date:	MILI Applicant		ERVICE	Other Adult
Date you started wor Date you last worked Reason not working Serial Number: Enlistment Date: Branch of Service:	MILI Applicant		ERVICE Other Adult	Other Adult

		FAM	ILY INFORMATION			
	members' relative		rs, sisters, grandparents, Phone			ney helped?
						1)
		(CHILD SUPPORT	7.01		
If not will If NO, expl Are you red	you go to court tain:ceiving child sup	port? YES	NO if YES, how m if not in household:	uch?		
centers or f	riends whom you	have not already	elped from any other sollisted on this form?	YES NO		service
Amount of Debt	Date Purchased	RRENT DEBTS Name of Creditor	OF ALL HOUSEHOL	D MEMBERS Value	Amount	Last Pay Date

F	XI	Fi	2.7	\mathbf{E}_{-}	IN	$_{ m JF}$	\cap R	! N	1 4	TT	\cap	N	Ĭ

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
22					
					=
			-		
	lls in someone else and whose name?				
at is your reason	n for asking for Tru	ıstee help?	□ No	Income	
,		, T		t Enough Income	
				come Stolen	
				nergency Event	
S NO	mergency or extrao				in your applicat
ES, explain:					
- 1.Ci - 11 1 / -		.l			
ecifically, what ai	e you asking for he	eip with today?			

		OTH	ER PUBLIC ASS	SISTANCE	
	Are you r	eceivin	ng or have you app	olied for the following	g:
			APPLICAN	T	
Subsidized Sec. 8, HUD, or o	-		_		/
Utility Allotment	YES	NO			Amount:
Food Stamps	YES	NO		/	
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:		
Grants / Loans	YES	NO	Date Applied:		Amount:
Any other type of help	YES	NO	~ ~		
			OFFICE AND		
Calaidia d Cara O IIIID	41 1.1		OTHER ADU		,
Subsidized Sec. 8, HUD, or o			_		/
Utility Allotment	YES	NO			Amount:
Food Stamps	YES	NO			
AFDC Welfare	YES	NO	- ~		
Other Trustee Office	YES	NO			
Social Security (any type)	YES	NO			
V.A. Benefits (any time)	YES	NO			
EAP Utility Assistance	YES	NO		//	
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 ADU	LT	
Subsidized Sec. 8, HUD, or o	ther publ	ic hous			/
Utility Allotment	YES	NO			Amount:
Food Stamps	YES	NO			
AFDC Welfare	YES	NO		1 1	
Other Trustee Office	YES	NO			
Social Security (any type)	YES	NO			
V.A. Benefits (any time)	YES	NO			
EAP Utility Assistance	YES	NO			
FEMA Funds	YES	NO			
Unemployment Benefits	YES	NO			
Grants / Loans	YES	NO			
Any other type of help	YES	NO	~ ~		
Any other type of help	1123	NO	Date Applied:	//	Amount:
Has anyone in the household If YES, why? Has anyone in the household					
If YES, when and where?					

Signature of Other Adult

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 cooperate 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 Code 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 of heating fuel or electric services assistance unless the applicant has applied for assistance as stated under IC 12-20-16-3. IC 12-20-16-5 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 for 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.

Signature of Other Adult

I HAVE READ THE ABOVE NOTICE OF PUBLIC LAW.

Signature of Applicant

0				_			0	
Are you will	ing to w	vork for ti	ne township and acti	ively se	ek employn	ent as a condition	of rece	eiving trustee assistance?
Applicant:	YES	NO	Other Adult:	YES	NO	Other Adult:	YES	NO
If no, explain	why n	ot: =						- 1. M
				Af	fidavit			
						-		tion is true and correct to
		_	• •		•	•	•	and household, and that I
		-				-		rom myself and members
					•	•		o other means of support 3-5-7 (Welfare Fraud) and
am eligible to			-	unat 1 m	ave not beet	r convicted under	C 33-4.	5-5-7 (Wenale Flaud) and
	0 100011	e to midin	p abotoveneo.					
Signa	ture of a	Applicant	S	ignature	of Other Ad	ult —	Sign	ature 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

Ι,	_, Case Number,	residing at
		, Indiana, consent to
the disclosure of the following informati	on to	, the investigator of
township assistance for	Township	County, Indiana:
Information that will verify my	<i>r</i> :	
1. Countable income.		
2. Countable assets.		
3. Wasted resources.		
4. Relatives capable of	providing assistance.	
5. Past or present empl	loyment.	
6. Pending claims or ca	auses of action.	
7. A medical condition	if relevant to work or workfare requirem	nents.
8. Any other information	on required by law.	
This information may be used only in co	onnection with:	
(1) My township assistance application	fromTownship	County, IN.
(2) My application for public assistance	from the Division of Family and Childre	en county offices and the Office of
Medicaid Policy and Planning.		
(3) Others (if any).		
Signature of Applicant	Signature of Other Adult	Signature of Other Adult
Date Signed	Date Signed	Date Signed
This conser	nt form expires 180 days after the date of si	igning.
A CWAIONH EDCMEAUT AN		A DAY THE TOXINGHID
ACKNOWLEDGMENT AIN	D PLEDGE OF CONFIDENTIALITY	BY THE TOWNSHIP
The undersigned township trustee or en	nployee acknowledges that he/she may,	in the course of employment, have
access to certain personal information ar	nd that such information is to be treated a	as confidential, and is to be released
	to the undersigned employment by the toy	wnship in reviewing and investigating
this application or as otherwise provided	i by law.	
(<u> </u>		
Trustee or Employee		Date Signed

(THIS PAGE FOR TOWNSHIP USE ONLY)

WORK ORDER:

diven =							
		STATISTIC	CAL SUMMAR	RY OF THIS	APPLICATIO	N ————————————————————————————————————	
Date	# Recipients Rec'd. Benefit	Utility \$ Benefits	Housing \$ Benefits	Food \$ Benefits	Health Care \$ Benefits	Other	Total \$ Benefits
-				12			
Tra	nining Program Referral	Refe	rrals	Workfai	re Hours		Spent on lication
							*

CASE RECORD OF INVESTIGATION

NOTES:

ACTUAL INCOME & EXPENSES SHEET

NAME:	MONTH:	DATE:

INCOME	AMOUNT	EXPENSES	AMOUNT	EXPENSES	AMOUNT
Applicant		Food (Non-SNAP)		TV (Satellite/Cable)	
Spouse		Rent/House Payment		Credit Card 1	
Child Support		Phone (cell/home)		Credit Card 2	
SSD		Internet		Loans 1	
SSI		Electricity (Duke)		Loans 2	
Pension		Propane/Fuel Oil		Loans 3	
FoodStamps/SNAP		Natural Gas (Vectren)		Rent-to-Own	
TANF		Water/Sewer		Alcohol	
List Other Below:		Medication/RX's		Tobacco	
		Car Payment #1		Student Loans	
		Car Payment #2		Eating Out	
		Car Insurance		Entertainment	
		Gasoline		Savings	
		Clothing/Shoes		Pet Expenses	
		Child Support		Medical Bills	
		School Lunches		Gambling	
		Childcare		Legal Expenses	
		Laundry/Hygiene		Back Taxes/IRS	
		Health Insurance			
		Life Insurance			
7		Co-Pays, etc.			
TOTAL INCOME:		TOTAL EXPENSES:			

MOIE2:

Jackson Township Trustee – Hamilton County

PO Box 456 506 W. Main Street Arcadia, IN 46030

Phone: 317.984.3826 Fax: 260-232-4644

<u>trustee@jacksontownshiptrustee.com</u> www.jacksontownshiptrustee.com



Jackson Township Hamilton County 506 W. Main Street P.O. Box 456 Arcadia, IN 46030

Robyn Cook | Township Trustee

Township Board | Jeff Roberts | Glen Schwartz | Randy Hill

ASSISTANCE COMPLIANCE

I, the undersigned, have found myself to be in need of township assistance. Whether I received that assistance, or was denied, I understand that the following are requirements that I need to comply with, should I apply for township assistance again in the future. The requirements are as follows:

- I am aware that I will need to provide proof of application for employment to at least five **hiring** places of employment, if I am unemployed at the time of my application.
- I will need to supply the township with receipts accounting for **ALL** my expenditures, for the past **60 days**, from the date of application.
- I understand that anything above basic cell phone and/or internet packages will need to be shut off.
- I am aware that should I apply for township aid again in the future, I will have **NO WASTED** resources such as tobacco and/or alcohol, or any other item that is not a necessity.

By signing this form, I am stating that I have been made aware of these requirements that will apply if I request township assistance again. I understand that if I do not comply with these requirements, that this could be used as a reason for denial for future assistance.

Signature of applicant	Date	
Township Representative	Date	





RELEASE OF INFORMATION

*NAME OF APPLICAN (PRINT)
*SOCIAL SECURITY:
*CURRENT DATE:
I authorize the Indiana Department of Workforce Development to release all wage and unemployment benefit information to the agency listed below.
*SIGNATURE OF APPLICANT
Check this box if Power of Attorney is attached
By signing below you agree that you understand that data we release to you is protected under state law (IC 22-4-19-6) and federal regulations (20 CFR § 603.5) as confidential information. You also confirm that you have verified the applicant's identity by viewing some type of photo identification. *NOTE: RELEASE MUST BE SUBMITTED WITHIN 90 DAYS OF APPLICANT SIGNING RELEASE FORM.
*Signature of Requestor:
Requesting Agency:
Fax Number:
*REQUIRED FIELDS: For questions email EmployVerification@dwd.IN.gov

Employment Search Form Jackson Township Trustee – Hamilton County

Explanation of Work Requirement

The office of the Township Trustee requires any able-bodied adult of a family or household seeking assistance to search for and accept employment, the conditions of which do not violate State and Federal Laws. Where and when feasible, this office may require a recipient to do any work needed for any governmental unit or not-for-profit agency within Hamilton County (including the State) having jurisdiction in those townships unless:

- 1. The applicant is not physically able to perform the proposed work.
- 2. The applicant is a minor or over sixty-five (65) years of age.
- 3. The applicant has full-time employment at the time township assistance is received.
- 4. The applicant is needed to care for a person because of that person's age or physical condition.
- 5. No work is available for the applicant.

Proof of Medical Disability

An applicant who claims a physical and/or mental disability as a reason to not accept employment must provide a current doctor's statement or accept a referral to obtain a current medical evaluation verifying such condition. Applicant will be required to periodically provide an updated statement for their file.

Employment Search Forms

The Trustee may require employment search forms be turned in on a bi-weekly basis by every member of the household who are not employed and able to work. At least five (5) jobs must be applied for each week. The responsibility falls on the applicant to prove he/she is actively seeking employment. Falsification may result in a denial of township assistance.

Employment Counseling/Referral

If you are unemployed and not disabled, you MUST register at Work One, https://www.workonecentral.org/job-seekers. The Trustee may refer clients to employment counseling, employment possibilities, training programs, etc. Failure to follow trustee recommendations may result in denial of assistance. State statues require that the Trustee shall refuse aid until he/she is satisfied the applicant has endeavored to find work for themselves.

I HAVE READ AND UNDERSTAND THE ABOVE.

Applicant Signature	Date

Employment Search Form Jackson Township Trustee – Hamilton County

Date:

Please provide the names of at least five (5) companies/positions (per week) that you have applied for since you applied for assistance or since you became unemployed.

Applicant Name:

DATE APPLIED	COMPANY	POSITION	METHOD OF APPLICATION (IN PERSON/ONLINE)	WHERE WAS JOB LISTED? (WEBSITE/PAPER, ETC.)
WEEK ONE				(**************************************
WEEK TV	WO.			
W-EK 1				

I certify that I have applied for the positions listed above. I give you permission to contact the employers listed above to verify this fact. I understand falsification may result in denial of township assistance.

Applicant Signature	Date