Village of Arlington Heights-Health and Human Services Department
33 S. Arlington Heights Road, Arlington Heights, IL 60005
847-368-5792 (o), 847-368-5980 (f)

APPLICATION FOR SOCIAL SERVICES

Name: ______________________ Date Received: ______________

Address: ______________________ City: Arlington Heights

State: IL Zip Code: ______________ Township: ______________

Date of Birth: ______________ Age: __________ Gender: ______________

Phone Number(s): ______________________

Languages: ______________ Referral Source: ______________

Have you or a member of your family applied for assistance within the last 18 months? ☐ Yes ☐ No

MEMBERS OF HOUSEHOLD

Name	Relationship to Applicant	Date of Birth/Age	Gender

SERVICES REQUESTED: *(check all that apply)*

☐ Counseling Subsidy ☐ Financial Assistance ☐ Holiday Assistance ☐ Disability Services
☐ CAP Scholarship ☐ Park Scholarship ☐ Access to Care ☐ Nicor Share
☐ Resource Referral ☐ Crisis ☐ APS ☐ CARE
Other: ______________________

PRESENTING ISSUES & NOTES:

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Date of Intake: ______________ Assigned to: ______________

VILLAGE OF ARLINGTON HEIGHTS
SOCIAL SERVICES PROTECTED HEATH INFORMATION THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Village of Arlington Heights ("Village") is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. The Village is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: The Village may use PHI for the purposes of treatment and health care operations, in most cases without your written permission. Examples of our use of your PHI:
For treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio, telephone, internet or fax to the hospital or dispatch center.
For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.
For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Use and Disclosure of PHI Without Your Authorization. The Village is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals;
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above, will only be made with your written authorization and that includes psychotherapy notes, other than for carrying out our own treatment, payment or healthcare operations.

RESIDENT'S COPY

You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: As a patient, you have a number of rights with respect to your PHI, including:
The right to access, copy or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If we maintain your medical information in electronic format, then you have a right to obtain a copy of that information in electronic format. If you wish to inspect and copy your medical information, you should contact our Privacy Officer.
The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend medical information that we have about you, contact our Privacy Officer.
The right to request an accounting. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment or health care operations, or when we share your health information with our business associates, like a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our Privacy Officer.
The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you. The Village is not required to agree to any restrictions you request, but any restrictions agreed to by us in writing are binding. However, if the information you ask us to restrict is needed to provide you with emergency treatment, then we may disclose the PHI to a healthcare provider to provide you with emergency treatment.
The right to notice of a breach of unsecured protected health information. If there is a breach of unsecured PHI we will notify you promptly as required by law. If you prefer to be notified about breaches by electronic mail, please contact the Privacy Officer. You may also withdraw your agreement to receive notice by e-mail at any time by contacting the Privacy Officer.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Please make any such request in writing specifying how or where you wish to be contacted. We will accommodate reasonable requests.
If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: The Village reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our Privacy Officer.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints, you may direct all inquiries to our Privacy Officer.

Privacy Officer Contact Information:
Privacy Officer, Legal Department, Village of Arlington Heights, 33 South Arlington Heights Road, Arlington Heights, Illinois 60005; (847) 368-5000

Rights, Responsibilities and Limits of Confidentiality

Services provided by The Village of Arlington Heights-Social Services Division are reserved for Arlington Heights residents only. Financial assistance is reserved for residents who are presently experiencing an emergency. This program is intended as a temporary stopgap measure, not a long-term solution. Emergency Assistance Funds are not provided by Federal or State entities. Residents may apply once within an 18-month timeframe and funds are provided based on financial need, income, and hardship at time of intake. First time applicants shall be given priority. In-kind donations and Salvation Army funds may be available to residents of unincorporated Arlington Heights.

For programs based on a sliding scale, participants must pay their portion or subsidy will be discontinued. Any scholarships or subsidies awarded will apply to future discounts only and cannot be used for reimbursement of payments already made. Scholarships and subsidies expire one year from date of approval unless otherwise indicated.

All services are confidential to the extent permitted by law, with the exception of mandated reporting situations, which include but may not be limited to: 1) disclosure of a plan or intent to harm oneself, 2) disclosure of a plan or intent to harm another individual, 3) disclosure or danger of abuse or neglect of children or vulnerable adults, and/or 4) inability to care for one's self. In these circumstances, there is a duty to act and warn in order to maintain the safety of the resident, other individuals and the community.

Financial assistance, scholarships and subsidies are a privilege, not a right. Applying for assistance, scholarship and/or subsidy does not guarantee assistance will be awarded. All information provided must be accurate and complete. Any refusal to disclose required information, complete required paperwork and/or lack of compliance with any program requirements will disqualify applicants from receiving assistance. Misuse of assistance will result in revocation of assistance and possible loss of privilege to apply in the future.

For good and valuable consideration herein acknowledged, the undersigned will release, indemnify and hold harmless the Village and its officer, agents, interns, and employees from any and all liability, losses or damages, including attorneys' fees and costs of defense the Village may suffer as a result of claims, demands, suits, actions or proceedings of any kind or nature, in the way resulting from the undersigned's receipt of services, including but not limited to, any food, clothing or other assistance either monetary or otherwise obtained by the undersigned for his or her own use or benefit, or any family member, friend, or associate's use. The undersigned will, at his or her own expense, appear, defend and pay all fees of attorneys and all costs and other expenses arising therefrom or incurred in connection therewith; and, if any judgments shall be rendered against the Village in any such action, the undersigned will at his or her own expense, satisfy and discharge same.

X ______________________________ X ______________

Resident Signature **Date**

Waiver

At times, we are asked to share anonymous success stories of residents who have received assistance through our program. Names and identifying details are removed or altered to protect client confidentiality. Please indicate if you consent or decline to having your story anonymously shared:

❑ Consent ❑ Decline

CAP and Park Scholarship Applicants

All questions below are required information for all members of household. Demographic information is required to comply with HUD requirements and is used for research purposes only. Scholarships are available for residents of Arlington Heights only and are determined based on our Sliding Scale Chart.

1. **PROOF OF ARLINGTON HEIGHTS RESIDENCY**:
   - Driver's license, State ID, or Country ID
   - Lease **OR** mortgage statement **AND** Utility bill (gas or electric-no phone bills)
2. **PROOF OF ALL HOUSEHOLD MEMBERS**: (one of the following)
   - ID for each member of the household with address (for children we will accept medical card, school registration forms, school fee waivers, or reduced lunch program enrollment form)
3. **PROOF OF CURRENT TOTAL HOUSEHOLD INCOME BEFORE TAXES**:
   - 3 months pay stubs with length of pay period indicated **OR** Completion of the Self Certification Form with tax returns
4. **ITEMIZED BANK STATEMENT FROM THE LAST 30 DAYS**
5. **ADJUSTED GROSS INCOME COMPUTATION WORKSHEET & SELF CERTIFICATION LETTER (for independent contractors)**

INCOME

$_______________ Current Annual Income _________ Number of household members

Office Use only: ☐ Extremely Low ☐ Low ☐ Moderate ☐ Does not qualify

APPLICANT INFORMATION

Please identify BOTH Ethnicity and Race for each applicant.

APPLICANT 1

Last Name(s): ______________________________ First Name: ______________________________

Relationship to applicant: ____

Ethnicity ☐ Latino/Latina/Latinx ☐ Non-Latin

Race

☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African-American
☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American and White
☐ Asian and White ☐ American Indian/Alaskan Native and White
☐ Multi-Racial ☐ American Indian/Alaskan Native and Black/African American

APPLICANT 2

Last Name(s): ______________________________ First Name: ______________________________

Relationship to applicant: ____

Ethnicity ☐ Latino/Latina/Latinx ☐ Non-Latin

Race

☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African-American
☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American and White
☐ Asian and White ☐ American Indian/Alaskan Native and White
☐ Multi-Racial ☐ American Indian/Alaskan Native and Black/African American

CAP and Park Scholarship Applicants

APPLICANT 3

Last Name(s): ______________________________ First Name: ________________________

Relationship to applicant: ____

Ethnicity ☐ Latino/Latina/Latinx ☐ Non-Latin

Race

☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African-American
☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American and White
☐ Asian and White ☐ American Indian/Alaskan Native and White
☐ Multi-Racial ☐ American Indian/Alaskan Native and Black/African American

APPLICANT 4

Last Name(s): ______________________________ First Name: ________________________

Relationship to applicant: ____

Ethnicity ☐ Latino/Latina/Latinx ☐ Non-Latin

Race

☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African-American
☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American and White
☐ Asian and White ☐ American Indian/Alaskan Native and White
☐ Multi-Racial ☐ American Indian/Alaskan Native and Black/African American

APPLICANT 5

Last Name(s): ______________________________ First Name: ________________________

Relationship to applicant: ____

Ethnicity ☐ Latino/Latina/Latinx ☐ Non-Latin

Race

☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African-American
☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American and White
☐ Asian and White ☐ American Indian/Alaskan Native and White
☐ Multi-Racial ☐ American Indian/Alaskan Native and Black/African American

APPLICANT 6

Last Name(s): ______________________________ First Name: ________________________

Relationship to applicant: ____

Ethnicity ☐ Latino/Latina/Latinx ☐ Non-Latin

Race

☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African-American
☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American and White
☐ Asian and White ☐ American Indian/Alaskan Native and White
☐ Multi-Racial ☐ American Indian/Alaskan Native and Black/African American

Please add additional family members to the back of this sheet.

Monthly Expenses

Category	Expense	Monthly Payment	Amount Outstanding	Shut-off Notice
Housing	Rent or Mortgage	$	$	
	Second Mortgage	$	$	
	Repairs/Upkeep	$	$	
	Assessments	$	$	
Utilities	Gas	$	$	
	Electric	$	$	
	Phone, Cable, Internet	$	$	
	Water/Sewage	$	$	
	Garbage	$	$	
Food	Groceries	$	$	
	Restaurants	$	$	
Insurance	Health	$	$	
	Life	$	$	
	Disability	$	$	
	Car	$	$	
	Renters/Home	$	$	
Medical	Medical/Medications	$	$	
	Dental	$	$	
Transportation	Public Transportation	$	$	
	Car Payment/Repairs	$	$	
	Gasoline/Oil	$	$	
	Parking/Tolls	$	$	
Family Support	Child Care	$	$	
	Elder Care	$	$	
	Child Support	$	$	
	School Tuition	$	$	
	Religious Donations	$	$	
Personal	Laundry	$	$	
	Personal Hygiene	$	$	
	Clothing	$	$	
	Gambling	$	$	
	Entertainment	$	$	
	Liquor/Cigarettes	$	$	
	Health Club	$	$	
	Gifts	$	$	
	Pets	$	$	
Debt	Credit Cards	$	$	
	Loans	$	$	
	Student Loans	$	$	
	Miscellaneous	$	$	
NET INCOME (After taxes and deductions)		$		
EXPENSES		$		
TOTAL (Subtract Expenses from Net Income)		$		