2026 Application For Uniform Voucher

Phone Number ( ) -	Application Date / /	Application Time : ☐ AM ☐ PM	Case Number
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**

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 martial 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 in advance at least 48 hours.

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 is 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	**N/A**
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	**N/A**
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	
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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	

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 appllication 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 with heating fuel or electric service 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, who may be eligible for other public assistance shall within fifteen (15) working days of the emergency assistance, file an application with the appropriate government agency. If the applicant, or a member of the applicant's household, fails to file within fifteen (15) working days, no further Trustee assistance may be granted for sixty (60) days following the 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 any 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 **NOT APPLICABLE**

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 **Calumet Township Case Manager**, the investigator of township assistance for **Calumet** Township **Lake** 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 application for township assistance from Calumet Township Lake County, IN.

(2) my application for public assistance from the Division of Famliy and Children 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 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