AITKIN COUNTY HEALTH & HUMAN SERVICES

204 First Street NW
Aitkin, MN 56431

Phone: 800-328-3744/218-927-7200
Fax: 218-927-7210/7293

Proofs Needed for Emergency Program

Following are the items we will ask for when you file an application for Emergency Programs and are attached in this packet:

- ☐ Completed & signed DHS-5223 Combined Application Form or an online application at https://mnbenefits.mn.gov

- ☐ DHS-2243A, General Authorization for Release of Information (This allows us to speak with them if we can resolve your emergency)
  - Filled in the **NAME OF THE BUSINESS** you have the emergency with such as:
    - Landlords, utility company, fuel company, etc.
    - Add your account number if you know it
  - Any agency you are also working with to resolve the emergency such as:
    - Lakes & Pines, Salvation Army, etc.
  - Signed by the applicant or account owner
  - *Complete one form per business/agency*

- ☐ Complete the Emergency Funds Worksheet (Gold Sheet)
  - This is where you list the payments for household expenses you have **paid** in the last 60 days

- ☐ Emergency Assistance Limits Form (Gold Sheet) completed and signed

- ☐ Income proof for all household members received in the last 60 days

- ☐ Bank statements for the last 60 days

- ☐ Proof of your emergency, such as:
  - Eviction notice/foreclosure, disconnect notice, etc.

If all of the documents are supplied with the application, it will allow us to make a determination more quickly.

Thank you for your help!

Please list the all ***paid*** household expenses for the 60 days prior to the application date:

You must provide receipts for all purchases and payments as available.

60 day time period from _____ to _____.
(60 days prior to application) (Date of application)

1st 30 days	2nd 30 days	
From _____to _____	From _____ to _____	
_____	_____	Housing, rent, mortgage, insurance, taxes, etc.
_____	_____	Electric
_____	_____	Heat (Natural Gas, Propane, Fuel Oil, Etc.)
_____	_____	Garbage
_____	_____	Water, Sewer
_____	_____	Cable/Satellite
_____	_____	Phone
_____	_____	Cell phone
_____	_____	Internet
_____	_____	IRS Payment
_____	_____	Car Payment
_____	_____	Car Insurance
_____	_____	Car Maintenance
_____	_____	Gas expense
_____	_____	Loan Payments Type: _____
_____	_____	Credit Card Payments list: _____
_____	_____	Life Insurance Payments
_____	_____	Medical Bills / Medical Insurance Payments
_____	_____	Charitable Contributions
_____	_____	Groceries
_____	_____	Dining out, business or pleasure
_____	_____	Home maintenance expense/upkeep, lawn svc
_____	_____	Household items-tools, furniture, appliances
_____	_____	Clothing
_____	_____	Educational expenses - school supplies/lunch
_____	_____	Personal care products
_____	_____	Personal services - hairdresser, nail technician
_____	_____	Gifts - Christmas, birthday, etc.
_____	_____	Entertainment - movies, etc.
_____	_____	Newspaper or magazine subscriptions
_____	_____	Alcohol or tobacco purchases
_____	_____	Pet expenses
_____	_____	Childcare expenses
_____	_____	Misc. purchases - books, etc.
_____	_____	Other - type: _____

Signature: _____ Date: _____

"This institution is an equal opportunity provider."

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Emergency Assistance Limits

I have applied for:

☐ **Emergency General Assistance (EGA)**

☐ **MFIP Crisis Funds (EA)**

I applied for this on _____. I understand I must meet program rules
date of application
and any assistance issued will depend on the funding availability.

I understand that if I am approved for this assistance, I will not be eligible to receive assistance from EGA or MFIP crisis fund programs for 12 months from the date the assistance is issued. If I have received this assistance anywhere in Minnesota, I will not be eligible for 12 months from the date assistance was issued.

I understand that if I am receiving cash assistance through the GA, MSA or MFIP programs, vendor payments will be made on my behalf for my shelter and utility costs up to the amount of my cash grant.

_____ _____
Applicant Signature Date

_____
Financial Worker

DEPARTMENT OF HUMAN SERVICES

DHS-2243A-ENG 5-19

CHILDREN AND FAMILY SERVICES - ECONOMIC ASSISTANCE AND EMPLOYMENT SUPPORTS

General Authorization for Release of Information

Date:

To:

PLEASE FILL HIGHLIGHTED AREAS

Business that you have an emergency with:

Address:

Phone:

For emergency event such as eviction or utility disconnect

Case number:
Worker name:
Worker phone: 218-927-7200
Worker fax: 218-927-7210
Agency name: Aitkin County HHS
Agency address:
204 First ST NW
Aitkin, MN 56431

We need to verify information for the person(s) listed below:

PERSON'S NAME	ACCOUNT NUMBER
PERSON'S NAME	ACCOUNT NUMBER
PERSON'S NAME	ACCOUNT NUMBER

Please provide the information requested. **Attach verification documents *or* record the information on the back of this form and sign where indicated.** Return the form to the requesting agency. On the bottom half of this form is a signed authorization to release information to the human services agency listed above.

Thank you for your cooperation.

Authorization for release of information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.
- **This authorization will end one year from the date I sign it, unless the law allows for a longer period**

CLIENT SIGNATURE	DATE	**ORIGINAL COPY FOR AGENCY**
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	**PROVIDE COPY FOR CLIENT**

CASE NUMBER:

To be completed by verifying agent

(Mail or fax to agency address/fax number on first page)

VERIFYING AGENT'S SIGNATURE:	
PHONE NUMBER:	DATE:

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ: ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ: የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီအပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

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Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

DEPARTMENT OF HUMAN SERVICES

DHS-2243A-ENG 5-19

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