



Village of Arlington Heights  
33 S. Arlington Heights Rd.  
Arlington Heights, IL 60005  
(847) 368-5792

## **APPLICATION FOR HUMAN SERVICES PROGRAMS**

I am applying for: (check all that apply)

Financial Assistance

Counseling Subsidy

Park Scholarship (includes discount for 2 classes per person each session, C.A.P. Program, & pool passes)

C.A.P. (Children at Play) Only

New

Renewal

The purpose of these programs is to assist Village of Arlington Heights residents experiencing emergency situations with temporary financial assistance as long as funds are available. These programs are not covered by Federal or State funding and therefore are stop gap measures not long term solutions. Clients who have not been helped in the past will be given first priority. Applicants will not be eligible for assistance more than one time per 18 month period.

All information contained herein shall be kept confidential. Please read the application carefully. Any required information not included, such as copies of proof of income, will result in delays in processing. Because we receive so many applications, if all information is not included your application will go to the end of the list for processing.

Please return completed application to:

Human Services Coordinator  
Village of Arlington Heights  
33 S. Arlington Heights Rd.  
Arlington Heights, IL 60005  
847/368-5792  
Fax: 847/368-5981

All information contained herein is accurate and complete. I understand that my refusal to disclose required information will disqualify me from receiving assistance. I authorize the Village of Arlington Heights Human Services Coordinator/Disability Services Coordinator to verify any/all information given. (see disclaimer)

For programs based on a sliding scale, I agree to pay my share as determined by Human Services and understand that my failure to pay my share of the cost may result in my disqualification from the program and any other programs available through the Village of Arlington Heights' Human Services Division.

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.

Name (PLEASE PRINT NAME CLEARLY)

Date

**Signature** (applications without a signature will not be processed)

I certify that I have not received emergency assistance at any other Salvation Army Service Extension Program sites within 12 months of this application.

**Disclaimer:** I understand that this information may be shared with other churches/agencies in this area and intake personnel are authorized to obtain personal information from other sources (i.e., Catholic Charities, CEDA) concerning my case. I agree to hold harmless all volunteers, agents, counselors, offices, and directors from any claim, suit, action, demand, or liability of any kind and any nature arising out of or in any manner connected with any food, clothing, or other assistance either monetary or otherwise obtained by myself for my own use or benefit, or any family member, friend, or associate use.

You **MUST** submit the following documents for your application to be processed. If we do not have these documents, your application will **NOT** be considered.

1. **PROOF OF RESIDENCY:** (two documents with your name and address) Lease or mortgage statement and gas bill, electric bill, (no phone bills), AND picture ID with current address.
2. **PROOF OF CURRENT TOTAL HOUSEHOLD INCOME BEFORE TAXES:** W2 form (if it is the same as current amount), or 30 days' pay stubs with length of pay period indicated.  
Approvals are based upon ANNUAL **GROSS** income.
3. **PROOF OF ALL HOUSEHOLD MEMBERS:** Birth certificate or Social Security card for each member of the household.

### PLEASE COMPLETE THE FOLLOWING INFORMATION

**All questions highlighted in yellow are required information. If these are not fully completed your application will be rejected.**

**APPLICANT** Male  Female

**Full Name**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**Address**

No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City Arlington Hts. State IL Zip \_\_\_\_\_

**Telephone**

State ID#/Driver's License \_\_\_\_\_

Email: \_\_\_\_\_

**Social Security #** \_\_\_\_\_

**License Plate #** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

Own  Rent Monthly payment \_\_\_\_\_

Due to requirements from HUD for demographic information we must ask the following questions. This information will only be used for research purposes.

**Ethnic Background:** Hispanic or Latino  Polish  Russian  Other \_\_\_\_\_  
**Race:** Alaska Native  Asian  American Indian  Black or African American   
Native Hawaiian or other Pacific Islander  Caucasian

***\*EMPLOYMENT (or If receiving unemployment list that here)***

Employers Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

How long employed \_\_\_\_\_

***Additional Employment:*** Yes  No  How long employed \_\_\_\_\_

If yes, employer's name: \_\_\_\_\_

Telephone \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

# HUSBAND/WIFE/PARTNER

## CO-APPLICANT (Spouse/Life Partner living in household)

Male  Female

Full Name \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

No. Street

City

State

Zip

Social Security # \_\_\_\_\_ DL # \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Ethnic Background:** Hispanic or Latino  Polish  Russian  Other   
**Race:** Alaska Native  Asian  American Indian  Black or African American  Caucasian   
Native Hawaiian or other Pacific Islander

## EMPLOYMENT OF SPOUSE/PARTNER

Employers Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

How long employed \_\_\_\_\_

**Additional Employment:** Yes  No

If yes, employer's name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

How long \_\_\_\_\_

### **LIST ALL ADDITIONAL FAMILY MEMBERS** (CHILDREN, PARENTS, SIBLINGS, etc. living in household)

1. Name \_\_\_\_\_ Male  Female   
Last First Middle

DOB \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

**Ethnic Background:** Hispanic or Latino  Polish  Russian  Other \_\_\_\_\_

**Race:** Alaska Native  Asian  American Indian  Black or African American   
Native Hawaiian or other Pacific Islander  Caucasian

2. Name \_\_\_\_\_ Male  Female   
Last First Middle

DOB \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

**Ethnic Background:** Hispanic or Latino  Polish  Russian  Other \_\_\_\_\_

**Race:** Alaska Native  Asian  American Indian  Black or African American   
Native Hawaiian or other Pacific Islander  Caucasian

3. Name \_\_\_\_\_ Male  Female   
Last First Middle

DOB \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

|   |
|---|
| <b>Ethnic Background:</b> Hispanic or Latino <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Other _____  |
| <b>Race:</b> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black or African American <input type="checkbox"/><br>Native Hawaiian or other Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> |

4. Name \_\_\_\_\_ Male  Female   
Last First Middle

DOB \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

|   |
|---|
| <b>Ethnic Background:</b> Hispanic or Latino <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Other _____  |
| <b>Race:</b> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black or African American <input type="checkbox"/><br>Native Hawaiian or other Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> |

5. Name \_\_\_\_\_ Male  Female   
Last First Middle

DOB \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

|   |
|---|
| <b>Ethnic Background:</b> Hispanic or Latino <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Other _____  |
| <b>Race:</b> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black or African American <input type="checkbox"/><br>Native Hawaiian or other Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> |

**Any additional family members can be added here or on the back**

# REQUIRED INFORMATION

**PLEASE LIST ALL HOUSEHOLD INCOME BEFORE TAXES**

| SOURCE OF INCOME | \$ GROSS AMOUNT IN LAST 30 DAYS |
|------------------|---------------------------------|
| WAGES            |                                 |
| CHILD SUPPORT    |                                 |
| ALIMONY          |                                 |
| UNEMPLOYMENT     |                                 |
| SSI/SSDI         |                                 |
| SOCIAL SECURITY  |                                 |
| PENSIONS         |                                 |
| OTHER            |                                 |

**Describe what has caused your financial hardship at this time:  
(Loss of employment, divorce, death in the family, unexpected expenses, etc.)**

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**If applying for financial assistance,  
Please list what you are requesting, including dollar amounts you are in need of.  
(example: rental assistance, utilities, etc.)  
Include copies of bills/expenses you are requesting help with.**

We cannot assist with internet or cable bills

| Need you are requesting | Name of Vendor | \$ Amount |
|-------------------------|----------------|-----------|
|                         |                |           |
|                         |                |           |
|                         |                |           |
|                         |                |           |

# COUNSELING ASSISTANCE ONLY

I attest that all information is true and authorize the Village of Arlington Heights to verify any or all of the information to the extent necessary.

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**Applicant Signature**  
(person filling out application)

**Date**

If applying for counseling assistance I authorize the Human Services/Disability Services Coordinator to:

1. Contact counseling agency regarding counseling services and charges.
2. Contact me and my therapist to monitor the progress of counseling services, to ascertain quality of and quantity of services provided.

List name(s) of insurance company(ies) covering participant/family:

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| Name | Address | Phone | Group # |
|------|---------|-------|---------|
|------|---------|-------|---------|

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| Name | Address | Phone | Group # |
|------|---------|-------|---------|
|------|---------|-------|---------|