STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MONTHLY GENERAL ASSISTANCE REIMBURSEMENT REPORT

PLEASE SEE INSTRUCTIONS ON THE BACK

Municipality _____ County _____ Reporting Period _____

During this reporting period we paid for _____ number of cases which included _____ number of persons.

*The total number of cases and persons in the household should be counted **one** time.

IMPORTANT All statistical information should reflect the number of cases, persons, etc., for whom assistance was actually paid for during the reporting period, not what you have authorized during the reporting period.

Breakdown:	Cases	People	Amount
Housing			
Emergency Housing(Shelter,etc.)			
Heating(all types)			
Electric Service(non heating)			
Propane gas(non heating)			
Food			
Prescriptions			
Medical Services			
Dental			
Burials/Cremations			
Diapers/BabySupplies			
Household/Personal			
All Other Needs			
TOTAL GA EXPENDED THIS PERIOD			
***Minus Total Amount Reimbursed by clients/Other Municipalities(100%)**			-

Please enter the total amount you received from clients or other municipalities for which the Department has already reimbursed you. **Do not include SSI reimbursements from the State of Maine.

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$ _____

Total GA claimed this reporting period: $ _____

Reimbursement requested at 50%: $ _____

Reimbursement requested at 90%: $ _____

Total year to date GA expended: $ _____

(from 7/1 of current State fiscal year through end of this reporting period)

State Threshold amount : $ _____

(This figure was sent to you from DHHS. Your reimbursement rate is 50% until you reach your obligation amount after which, your reimbursement rate is 90%.)

The following information is requested for GA recipients who receive TANF (Temporary Assistance for Needy Families) from the State of Maine. See instruction #6 for explaination of who is eligible for TANF.

1. Total # of TANF cases paid for _____ 2. Total GA expenditures for TANF cases $_____

The following information is requested for GA recipients who performed Workfare for the Municipality:

# of cases _____ # of People _____ # of Hours Performed _____ Dollar Value $ _____

If your municipality is reporting five cases or fewer for the reporting period, please list the case names or case numbers.

1)_____ 3)_____ 5)_____

2)_____ 4)_____

I HEARBY CERTIFY THAT THE AMOUNT CLAIMED FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. RECORDS TO VERIFY THIS CLAIM ARE ON FILE IN THE MUNICIPAL OFFICE AND WILL BE RETAINED FOR A PERIOD OF NOT LESS THAN THREE YEARS FROM THE DATE OF THIS DOCUMENT. RECORDS WILL BE AVAILABLE TO ANY REPRESENTATIVE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR AUDIT PURPOSES.

SIGNATURE: _____ DATE: _____

GA Administrator or Designee

PREPARER'S NAME: _____ PHONE: _____

Please type or print

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_____ Paid as submitted _____ Adjusted/Corrected Amount approved for Reimbursement $ _____

RETAIN COPY NUMBER 4 (GREEN) FOR MUNICIPAL FILE, FORWARD COPIES 1,2,3, WITHOUT DETACHING TO:

Department of Health and Human Services
General Assistance
11 State House Station, 268 Whitten Road
Augusta, ME 04333
(800) 442-6003