TOWN OF ANDOVER GUIDELINES

At the time of initial application, and at all times thereafter, the applicant/recipient has the following responsibilities:

1. To provide accurate, complete and current information concerning needs and resources and the whereabouts and circumstances of relatives who may be responsible under RSA 165:19;
2. To notify the welfare official promptly when there is a change in needs, resources, address or household size;
3. To apply for immediately, but no later than 7 days from initial application, and accept any benefits or resources, public or private, that will reduce or eliminate the need for general assistance. RSA 165:1-b, I (d);
4. To keep all appointments as scheduled;
5. To provide records and other pertinent information and access to said records and information when requested;
6. To provide a doctor's statement if claiming an inability to work due to medical problems;
7. Following a determination of eligibility for assistance, to diligently search for employment and provide verification of work search (the number of work search contacts to be determined by the welfare official), to accept employment when offered (except for documented reasons of good cause, RSA 165:1-d), and to maintain such employment. RSA 165:1-b, I (c);
8. Following a determination of eligibility for assistance, to participate in the workfare program if physically and mentally able. RSA 165:1-b, I (b); and
9. To reimburse assistance granted if returned to an income status and if such reimbursement can be made without financial hardship. RSA 165:20-b.
10. Emergency Shelter: In cases in which the municipality has made an appropriate referral for emergency, temporary shelter, and the applicant

refuses to accept such a referral, or if the applicant does not abide by the rules of the emergency housing/shelter, the Welfare Official may suspend the applicant by refusing to pay for alternative emergency shelter, but may not suspend the applicant by denying other forms of assistance to which he/she is otherwise entitled. The applicant must accept the least costly alternative for emergency housing assistance that is deemed suitable by the Welfare Official for applicant's household

An applicant shall be denied assistance if he/she fails to fulfill any of these responsibilities without reasonable justification. A recipient's assistance may be terminated or suspended for failure to fulfill any of these responsibilities without reasonable justification, in accordance with Section XIII(C).

Any recipient may be denied or terminated from general assistance, in accordance with Section XIII, or may be prosecuted for a criminal offense, if he/she, by means of intentionally false statements or intentional misrepresentation, or by impersonation or other willfully fraudulent act or device, obtains or attempts to obtain any assistance to which he/she is not entitled.

APPLICATION FOR ASSISTANCE

Date of Application: _____ Referred by: _____

Assistance Requested _____

Reasons for Request _____

1. General Information

Applicant

Name: _____ Date of Birth: _____

Current Address: _____

Mailing Address, if different: _____

Home Phone _____ Rent or Own? _____ How long at this address? _____

Type of Housing: _____ House _____ Apt _____ Mobile Home Other: _____

Household Composition: # 18 & Over: _____ # Under 18: _____ # of Bedrooms: _____

If at current address less than 12 months, list past 12 month's addresses:

Street	Town/City	State	Dates of Residence
_____	_____	_____	_____
_____	_____	_____	_____

Cell Phone: _____ Work Phone: _____ Social Security # _____

E-Mail Address: _____ Marital Status: _____

Education ____ High School _____ Less than High School Diploma _____ GED _____ Some College

____ 2 Year Associate ____ 4 Year Bachelor _____ Graduate Studies

Citizenship: _____ United States Other: _____

Ethnicity: _____ White/Caucasian Other: _____

Special Training/Skills: _____

Currently Employed? ____ Full Time ____ Part-Time ____ Self Employed _____ Unemployed

Have you applied for local assistance before? _____ Yes _____ No When? _____

Where? _____ Under what name? _____

Actively serving in the U.S. Military? _____ Yes _____ No If Yes, Branch: _____

U.S. Veteran? ____ Yes _____ No Discharge Date: Month:_____ Year: _____

Discharge Status _____ Honorable _____ Dishonorable Other: _____

Do you have Medicare or Medicaid? (Circle one) ID Number: _____

Other Insurance: _____ EBT Card # _____

Spouse/Co-Applicant

Name: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Social Security # _____

E-Mail Address: _____ Marital Status: _____

Education ____ High School _____ Less than High School Diploma ____ GED _____ Some College

____ 2 Year Associate ____ 4 Year Bachelor _____ Graduate Studies

Citizenship: _____ United States Other: _____

Ethnicity: _____ White/Caucasian Other: _____

Special Training/Skills: _____

Currently Employed? ____ Full Time _____ Part Time _____ Self Employed _____ Unemployed

Have you applied for local assistance before? _____ Yes _____ No When? _____

Where? _____ Under what name? _____

Actively serving in the U.S. Military? ____ Yes ____ No If Yes, Branch: _____

U.S. Veteran? ____ Yes ____ No Discharge Date: Month:_____ Year: _____

Discharge Status _____ Honorable _____ Dishonorable Other: _____

Do you have Medicare or Medicaid? (Circle one) ID Number: _____

Other Insurance: _____ EBT Card # _____

Other Household Members: List all persons living in your household:

Full Name	Relation	Birth Date	Social Security #	Health Insurance

If children listed have a biological parent not residing with you, list information on each child's biological parent. (Do not list yourself under parent's name)

Parent's Full name	Relationship	Birth Date	Social Security #

2. Employment History

Applicant

Employer: _____ Position: _____

Date you started work: _____ Date and Amount of last paycheck: _____

Pay period frequency: _____ Daily _____ Weekly _____ Bi-Weekly _____ Monthly _____ Quarterly

If you are currently unemployed, state reason: _____

Former Employer: _____ Position: _____

Date last worked: _____ Date and Amount of last paycheck: _____

Are you able to work now? _____ Yes _____ No If NO, why not? _____

List two most recent jobs before current:

Employer:	Pay:	Employment Dates:	Reason for leaving:
_____	_____	_____	_____
_____	_____	_____	_____

Spouse/Co-Applicant

Employer: _____ Position: _____

Date you started work: _____ Date and Amount of last paycheck: _____

Pay period frequency: _____ Daily _____ Weekly _____ Bi-Weekly _____ Monthly _____ Quarterly

If you are currently unemployed, state reason: _____

Former Employer: _____ Position: _____

Date last worked: _____ Date and Amount of last paycheck: _____

Are you able to work now? _____ Yes _____ No If NO, why not? _____

List two most recent jobs before current:

Employer:	Pay:	Employment Dates:	Reason for leaving:
_____	_____	_____	_____
_____	_____	_____	_____

Work history for other household members over 18 (list two most recent jobs):

Name	Employer:	Pay	Employment Dates	Reason for leaving:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Housing Information

Rent: _____ per (month/week) Date last paid: _____ Date Due: _____

Currently have: _____ Demand for Rent/Notice to Quit ____ Landlord/Tenant Writ

Total Rent Owed: _____

Do you have a housing subsidy? ____ Yes _____ No If YES, how much? _____

Utilities Included: _____ Heat _____ Electric _____ Gas _____ Water/Sewer ____ Other: _____

Landlord: Name _____ Telephone _____

Landlord Address: _____

IF Homeowner, List:

Mortgage payment: _____ Date last paid: _____ Date Due: _____

Bank/Mortgage Company: _____ Telephone: _____

Address: _____

Do you have a foreclosure notice? ____ Yes ____ No

4. Household Assets

Provide account information and current balances held by all household members:

Household member	Bank/Credit Union	Savings Acct #	Savings Balance	Checking Acct. #	Checking Balance

Provide current value of the following assets held by all household members:

Asset	Value	Household Member
Cash on hand (household combined)		
Certificate of Deposit (CDs)		
Retirement		
401k		
Life Insurance (Cash value)		
Investments		
Time Share		
Real Estate		

List properties and locations (other than primary residence): _____

_____

Motor vehicles owned by you and all household members:

Owner	Auto Make/Model	Year	Value	Payments	Insurance

5. Claims/Settlements/Income due to you or any household member

IRS Refund: _____ Date Rec: _____ Insurance Claim: _____ Date Rec: _____

Retroactive disability check: _____ Date Rec: _____

Retroactive unemployment or worker's compensation check: _____ Date Rec: _____

Inheritance: _____ Date Rec: _____

Other Lump Sum Payment (Explain): _____

Do you currently have an attorney pursuing any civil suit, workers compensation claim, a social security denial, etc.?

_____ Yes _____ No If YES, complete the following, and briefly explain the details of the situation:

Attorney Name: _____ Phone Number: _____

Address: _____

Details: _____

6. Household Income/Benefits

Indicate any income or benefits received or applied for by you or any household member:

Income	Household Member	Amount	Date Last Received
ANB (Aid to the Needy Blind)			
APTD (Aid to Perm/Totally Disabled)			
Child Support			
Charities/Churches			
Disability (STDA/LTDA – work)			
Gifts/Loans			
Income Tax Refund			
Maternity Pay/Benefits			
OAA (Old Age Assistance)			
Retirement Benefit			

Indicate any income or benefits received or applied for by you or any household member:

Income (Continued)	Household Member	Amount	Date Last Received
Severance Pay			
Social Security (Retirement)			
SSDI (Social Security Disability)			
SSI (Supplemental Security)			
TANF (Temporary Assistance for Needy Families-State Welfare)			
Unemployment (DES)			
Veteran's Pension			
Worker's Compensation			
Other: _____			
Other: _____			

Benefits

Child Care Assistance			
Food Stamps			
Fuel Assistance			
Medicaid			
WIC (Women/Infants/Children)			
Other: _____			
Other: _____			

Are you or any other household member working, volunteering, and/or receiving assistance from any other agencies?

Name	Agency Name and Phone #	Contact Person

7. Household Expenses

List actual or estimated regular expenses. (Not all expenses are allowable to be included in your eligibility determination, but all should be listed to show your financial situation.

Expense	Monthly Expense	Any Amounts Past Due	Comments
Auto Fuel			
Auto Insurance			
Auto Loan			
Auto Registration/Inspection			
Auto Repairs			
Bank Fees			
Condo Assoc Fee			
Child Care			
Child Support Paid			
Credit Card			
Credit Card			
Dental Care			
Diapers/Wipes			
Driver's License			
Electric			
Food			
Legal Fees/Fines			
Loan (Used for _____)			
Oil Heat			
Propane (Used for _____)			
Natural Gas (Used for _____)			
Health Insurance			
Home Repairs			
Home/Renter Insurance			
Laundry			
Medical Expenses			
Mortgage			
Prescriptions			
Rent (Including _____)			

Expense (Continued)	Monthly Expense	Any Amounts Past Due	Comments
Rent – Option to Own	_____	_____	_____
Rent – MH Lot	_____	_____	_____
Storage Unit	_____	_____	_____
Taxes (Income/Property)	_____	_____	_____
Telephone (Landline/Cell)	_____	_____	_____
Telephone (Cable/Internet)	_____	_____	_____
Transportation (Bus/Cab)	_____	_____	_____
Water/Sewer Bill	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

8. Extended Payment Arrangements

Do you or any household members currently have an EXTENDED PAYMENT ARRANGEMENT with an electric or Fuel company? _____ Yes _____ No If YES, complete the following:

Utility Company Name	Amount				
_____	_____	(Circle one)	Weekly	biweekly	monthly
_____	_____	(Circle one)	Weekly	biweekly	monthly
_____	_____	(Circle one)	Weekly	biweekly	monthly
_____	_____	(Circle one)	Weekly	biweekly	monthly

9. Other Assistance

Has any other organization(s) or individual helped you pay any of your bills in the last four (4) weeks?
_____ Yes _____ No If YES, complete the following:

Organization/Individual's Name	Bill Paid	Amount	Date Assisted
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Criminal Information (This information is used to assist with referrals, including housing and other programs).

Have you or any member of your household ever been convicted of a felony or misdemeanor which has not been annulled? _____ Yes _____ No If YES, complete the following:

Name	Date	Town/City/State	Detail of conviction

Are you or a household member presently on parole or probation? ____ Yes ___ No If YES, complete the following:

Name	Court	Parole/Probation Officer's Name & Phone Number

11. Liability for Support Information

Parents/step-parents, spouse or grown children may be called upon to assist in time of need. Provide the following:

Applicant

	Name	Address	Phone #
Father			
Mother			
Spouse, if not living with you			

Co-Applicant

	Name	Address	Phone #
Father			
Mother			
Spouse, if not living with you			

Adult Children:

List name, address and phone # of any adult children not living with you:

Name	Address	Phone #

12. Certifications and Signatures

I understand that if I receive assistance from the municipality, I may be required to participate in the welfare work ("Workfare") program. (RSA 165:31)

I understand that I may be required to repay any assistance provided, after deduction of the value of workfare hours I have completed. If I am returned to an income status which enables me to reimburse without financial hardship. (RSA 165:20-b)

I understand that if I am assisted, the municipality may place a lien against any real property which I own. (RSA 165:28)

I herby certify that if I have a lawsuit, worker's compensation claim, or aid from any other social service agency now pending, I have listed these in this application. I further agree to notify the Welfare Official immediately upon receipt of any money from or upon the settlement of such claim. I understand that if I am assisted, the municipality may place a lien against any property settlement or civil judgment for personal injuries which I receive within six years of receiving municipal assistance. (RSA 165:28a)

I understand that if I obtain a job after I am assisted by the municipality, and I later quit the job without good cause, I may be ineligible for local assistance from the municipality and any other New Hampshire municipality for a period of up to ninety days. (RSA 165:1-d)

I understand that if I am a recipient of Temporary Assistance for Needy Families (TANF) cash benefits and I fail to comply with TANF regulations, leading to a sanction and loss of income, the municipality may, under certain circumstances, disregard this decrease in my income. (RSA 165:1-e)

I understand that my parents/step-parents, spouse or grown children may be called upon to assist me when in need of relief if they can do so without financial hardship to themselves. (RSA 165:19)

I hereby certify that the information I have provided on this application is complete to the best of my knowledge and belief and provides a true summary of my income, assets and needs. I understand I may be required to provide documents and/or other forms of verification to prove the information requested on this application. I hereby certify that all information I will provide in response to questions asked by the welfare official is true and complete to the best of my knowledge and belief. I understand that if I knowingly give false information or withhold information related to by receipt of assistance, now or in the future, I may be prosecuted for the crim of Unsworn Falsification (RSA 641:3) and/or Theft by Deception (RSA 637).

Authorization to Release or Exchange Information*

I/We authorize any relative, physician, attorney, banker, employer, insurance company, landlord/shelter staff or any other person(s) or organization(s) having information concerning my circumstances to furnish such information to the TOWN OF _____ Welfare Administrator. The Social Security Administration, the Division of Health & Human Services and the Department of Employment Security may release information in their files to this office. I/we authorize the _____ to release information as requested to the Division of Health & Human Services, Social Security Administration, Department of Employment Security, school personnel, attorney, physician, landlord, other _____ town welfare offices, or any agencies providing supportive services regarding medical, house/shelter, or financial assistance.

Applicant

Print Name: _____

Signature: _____

Date: _____

Co-Applicant

Print Name: _____

Signature: _____

Date: _____

_____ Signature of person completing form (if not the applicant)

_____ Print Name

_____ Date

** The above authorization to release or receive information is in effect for as long as the applicant is currently seeking assistance from the _____ Welfare Administrator or up to six (6) months after assistance has ended.*

Authorization to Release Information

Printed Name of Person to Whom the Release of Information Pertains

Case #, RID #, or MID #, if known

I hereby authorize and request:

Name and Address of Individual or Agency Providing the Information:

to provide the following information:

to:

Name and Address of Individual or Agency Receiving the Information:

I grant my permission for the reproduction of the above information to be given to the individual or agency named. Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual/agency I have named.

This authorization expires 12-months from the date this form is signed.

Information released cannot be re-released by the receiving individual/agency without additional authorization.

(Signature)

(Date)

(Printed Name)

If the signature above is not that of the person to whom the information pertains, the relationship of the signer to that person must be indicated. In addition, the signature must be witnessed.

(Relationship)

(Witness)

(Date)

Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases religion or political beliefs.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: SNAP Hotline.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

FORM C

NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF TOWN OF ANDOVER

You have the following rights:

1. You have a right to make a written application for assistance, even if the welfare officer tells you that you are not eligible.

2. You have a right to receive a prompt written decision telling you whether or not you will receive assistance each time you apply for assistance.

3. You have a right to have in writing the reason why you have been denied assistance or have been given only some of the assistance you requested.

4. You have a right to appeal any decision you do not agree with. You must appeal within five (5) working days after you received your decision.

5. You have a right to have a hearing to present your case.

6. You have a right have your assistance continued if you are already receiving assistance when you request a fair hearing.

7. You have a right to review the information in your file before your hearing.

8. You have a right to see the guidelines used by the welfare officer in making decisions on your application.

9. You have a right to be given a written notice of conditions before you are suspended from receiving assistance for failing to obey the guidelines.

10. You have a right to refuse to participate in municipal workfare program if you must care for a child under the age of five (5), or to conduct a job search if you must care for a child under the age of one year (1), if you are disabled or ill, or if you must take care of a member of your family who is disabled or ill.

FORM D

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

I/We, _____, authorize any relative, physician, lawyer, banker, employer, insurance company, mental health professional, school official or other person or organization having information concerning my/our circumstances to furnish such information to the Municipal Welfare Department. I/We also authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth and Families, Division of Adult and Elderly, New Hampshire Legal Assistance, any City/Town Welfare Department, shelter, Department of Employment Security, Veteran's Administration and Fuel Assistance, or any non-profit agency to release information from their files to the Municipal Welfare Department.

_____ _____

Applicant Signature Date

_____ _____

Spouse or Co-applicant Signature Date

_____

Signature of person completing form (if not applicant); Relationship to applicant

_____

Date

FORM E

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

(specific agency/individual)

I understand that as part of the administration of the general assistance program, a municipal welfare official may verify information I have provided on my application for assistance and any other information that would affect my eligibility. My signature below authorizes _____, town/city of _____ welfare official, to obtain information from _____regarding factors relevant to my application for general assistance benefits.

This authorization shall expire one year from the date it is signed.

A photocopy of this signed authorization may be used in place of an original.

_____ _____

Applicant Date

_____

Welfare Official

FORM F

REQUIRED VERIFICATIONS

Applicant Name: _____ Date: _____

Social Security Number: _____ D.O.B.: _____

Address: _____ Phone: _____

YOUR APPOINTMENT IS SCHEDULED FOR: _____

You must provide the following verification/documentation at this appointment or assistance may be delayed or denied:

_____ Completed Application Form A

_____ Rental Verification Form J and copy of any written lease agreement

_____ Last four weeks pay-stubs or other proof of net wages for all adult members of household

_____ Last four week's receipts or other proof of bills paid or currently due, utility disconnect notices

_____ Employment verification Form I from your employer

_____ Employment termination Form I from your last employer

_____ You have applied for / are receiving Social Security benefits

_____ You have applied at the HHS District Office for:

- ❑ Emergency Food Stamps
- ❑ SNAP (Food Stamps)
- ❑ TANF
- ❑ Title XX Daycare
- ❑ APTD/MA
- ❑ OAA
- ❑ TANF Emergency Assistance
- ❑ Medical

_____ You have applied for / are receiving Fuel Assistance benefits

_____ Verification of injury or illness Form H

_____ You have applied for / are receiving Unemployment Compensation

_____ If available, picture ID (Adults); Birth certificate/SS card (minors)

_____ Vehicle registration

_____ Savings and checking account, liquid asset statements, bank/debit card account printout

_____ Statement child support payments received / Child support court-ordered payments made

_____ Statement from room-mate(s) regarding division of expenses

Other: _____

I understand that failure to provide the indicated information may result in delay and/or denial of my request for assistance, and I understand that if approved for assistance I may be required to do a job search and participate in workfare.

_____ _____

Welfare Staff signature Applicant signature

FORM G
{TOWN OF ANDOVER} WELFARE INTAKE

{Insert Phone #}

COMPLETE SECTION I: **DATE:** _____ **Appt. Date /Time:** _____

Name: _____
Last / other names used **First** **Middle**

Physical Address: _____ _____
Street **Town or City** **How long at this address?**

Date of Birth: _____ **SS#** _____

Please list all other household members with ages: _____

Income Amount & Source: _____

What type of emergency assistance are you **requesting** at this time? _____

Have you **received** prior assistance from this office? ☐ Yes ☐ No If yes, when? _____

PHONE#: _____ CELL PHONE #: _____

_____ _____
Applicant Signature / Date **Signature of person completing form** (if not applicant)

********** **BELOW FOR OFFICE USE ONLY**: **********
Notes

DO NOT COMPLETE SECTION II: PROVIDE THE FOLLOWING **ITEMS CHECKED** AND/OR REQUESTED BELOW FOR YOUR APPOINTMENT **OR POTENTIAL ASSISTANCE COULD BE DELAYED.**

- ☐ Application Form – (Completed)
- ☐ Picture ID
- ☐ Last 4 Weeks RECEIPTS / BILLS
- ☐ **VERIFICATION YOU HAVE APPLIED TO THE FOLLOWING DHHS RESOURCES:**
  FOOD STAMPS ☐ TANF ☐ MEDICAID ☐ APTD ☐
- ☐ Fuel Assistance Application/Appointment
- ☐ Rental Verification form completed by the Landlord & **COPY OF YOUR LEASE**
- ☐ Housing Authority /NH Housing Authority
- ☐ Employment Verification form ☐ Employment Termination Request form
- ☐ Verification of injury or illness (Medical Form)
- ☐ Verification of application for Unemployment Compensation
- ☐ You may be REQUIRED to provide documented JOB SEARCHES

VERIFICATION OF THE FOLLOWING RESOURCES:

- ☐ Child Support
- ☐ Unemployment Compensation
- ☐ SS / SSI / SSD
- ☐ TANF/APTD/OAA
- ☐ Last 4 weeks proof of income
- ☐ Checking Account/Debit Card (Statement)
- ☐ Savings Account (Bank Statement)

FORM H

MUNICIPAL WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#: _____ **dob:** _____

I hereby request the release by a doctor, hospital or clinic to the Municipal Welfare Department, or its authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization. A photocopy of this signed release may be used in place of an original, in effect for six months from date of my signature below:

_____ _____
APPLICANT SIGNATURE **DATE**

TO THE PHYSICIAN OR CLINIC:

The person named above has indicated that he/she is currently unable to work and is in treatment with you. New Hampshire General Assistance laws require able-bodied welfare applicants to seek and retain work as a condition of continued assistance, with the goal of minimizing the period of assistance necessary. The Municipality also may require welfare recipients to work in any capacity that the recipient is able in exchange for assistance. For these reasons, will you please briefly respond to these questions:

What is the condition(s) for which you are treating this person? _____

What is the nature and extent of this individual's limitations? _____

Is this person disabled? No ❑ Yes ❑ (If yes, please clarify below)
❑ Temporarily ❑ Permanently ❑ Partially ❑ Totally

Date incapacity began: _____ Expected to end: _____

When will this individual be capable of returning to work? What type of work would be suitable for this individual? Please describe any limitations: _____

_____

_____

Medications Prescribed: _____

_____ _____
Physician Name / Signature **Date**

Thank you for taking the time to complete this form.
Please contact the Municipal Welfare Department if you have any questions.

FORM I

EMPLOYMENT VERIFICATION FORM

I, _____, authorize the release of information regarding my employment to the Town of _____.
Signature of Employee:_____ Date_____
Full Name of Employee: (print)_____

This form must be completed by the employer/former employer in order to be valid documentation for the purpose of administration of municipal assistance.

Employer_____ Phone

_____ _____

Address_____
Employee Name: _____

Date of Hire _____Date starting/started work_____Hourly Pay Rate _____

Full/part time _____ Hours per week_____ Paid ❑ weekly ❑ biweekly ❑other ____

Pay Period Ending Actual Date of Payment Gross Pay Net Pay Check/Direct Deposit

_____

_____

_____

_____

_____

==========

If_____ is no longer employed by your company:

Date of termination/separation_____ Date/net amount of last paycheck _____

Reason for termination/separation _____

_____ _____
Authorized Signature and Title Date
Print Name:_____Phone # or Email:_____

FORM I

EMPLOYMENT VERIFICATION FORM

I, _____, authorize the release of information regarding my employment to the Town of _____.
Signature of Employee:_____ Date_____
Full Name of Employee: (print)_____

This form must be completed by the employer/former employer in order to be valid documentation for the purpose of administration of municipal assistance.

Employer_____ Phone

_____ _____

Address_____
Employee Name: _____

Date of Hire _____Date starting/started work_____Hourly Pay Rate _____

Full/part time _____ Hours per week_____ Paid ❑ weekly ❑ biweekly ❑other ____

Pay Period Ending Actual Date of Payment Gross Pay Net Pay Check/Direct Deposit

_____

_____

_____

_____

_____

==========

If_____ is no longer employed by your company:

Date of termination/separation_____ Date/net amount of last paycheck _____

Reason for termination/separation _____

_____ _____
Authorized Signature and Title Date
Print Name:_____Phone # or Email:_____

FORM J

RENTAL VERIFICATION FORM

THIS FORM MUST BE COMPLETED BY THE LANDLORD

THIS FORM IS FOR ASSESSMENT OF ELIGIBILITY. A FINAL ELIGIBILITY OF RENT ASSISTANCE MAY NOT BE YET DETERMINED. A WRITTEN NOTICE OF DECISION WILL BE GIVEN TO YOUR TENANT.

Tenant's Name: _____ Date: _____

Address: _____

(Number/Street) (Apt. #) (City) (State)

Number of adults in apartment: _____ Number of children in apartment: _____ _____

List of people in apartment:

_____

_____

_____

Occupancy date: _____ Security Deposit: Amount: $_____ Date paid:

_____

Rent amount: $_____; paid ❑ monthly ❑ weekly ❑ other _____

Number of Bedrooms:_____ If subsidized rent, please list tenant portion: $_____

Rent Includes: ❑ All utilities ❑ No Utilities ❑ Hot Water ❑ Heat ❑ Electric

Type of Heat: ❑ Electric ❑ Oil ❑ Gas ❑ Other _____

Date last rent was paid: _____ Amount Paid: $ _____ Back rent owed: $

_____ _____

(if back rent is owed, please attach accounting of months and amounts)

For IRS reporting, landlord's Tax ID or Social Security # <u>must</u> be provided:

Tax ID #: _____ **OR** Social Security #:

_____

Failure to provide the correct Tax ID or Social Security # may subject payments to backup withholding.

CHECK IS TO BE MADE PAYABLE TO: (PLEASE PRINT)

_____ _____

Landlord's Name Telephone / Fax Numbers

_____

Landlord Address

_____

Name of Manager or other Representative

_____

_____

Landlord Signature Date

FORM K

BUDGET WORKSHEET

Name _____ Date _____

A. Available assets and income:

_____	_____ mo/wk
_____	_____ mo/wk
_____	_____ mo/wk
_____	_____ mo/wk

A. Total available income: _____

B. Allowable Expenses:

	Actual Expenses	Allowed Expenses	Ineligible Expenses
Rent/Board/Mortgage	_____ mo/wk	_____ mo/wk	_____
Electric	_____ mo/wk	_____ mo/wk	_____
Gas	_____ mo/wk	_____ mo/wk	
Fuel Oil	_____ mo/wk	_____ mo/wk	
Water/sewer	_____ mo/wk	_____ mo/wk	_____
Cooking fuel	_____ mo/wk	_____ mo/wk	_____
Telephone	_____ mo/wk	_____ mo/wk	
Food	_____ mo/wk	_____ mo/wk	
Personal & Household	_____ mo/wk	_____ mo/wk	
Medical/Prescription	_____ mo/wk	_____ mo/wk	
Transportation	_____ mo/wk	_____ mo/wk	
Childcare/Daycare	_____ mo/wk	_____ mo/wk	
Car payment	_____ mo/wk	_____ mo/wk	
Gasoline	_____ mo/wk	_____ mo/wk	
Other	_____ mo/wk	_____ mo/wk	
Other	_____ mo/wk	_____ mo/wk	

Other _____ mo/wk _____ mo/wk

_____

Other _____ mo/wk _____ mo/wk _____

B. Total Allowed Expenses: _____ _____

C. Eligibility: [A. Income (-) B. Expenses]:_____

(If A is greater than B, applicant is ineligible. If A is less than B, applicant is eligible.)

Assistance will be provided as follows:

_____ $ _____

_____ $ _____

_____ $ _____

Note: This form should accompany a Notice of Decision. The welfare official should use discretion in accepting actual expenses relative to employment, work search, medical needs, etc.

FORM L

NOTICE OF DECISION

Name _____ Date _____

☐ Your application for general assistance is **GRANTED**. You will receive:

_____

_____

☐ You must COMPLY with the following conditions in order to be eligible to continue to receive assistance. You must comply within 7 days of receipt of this notice, unless another time period is indicated. Willful failure to comply with these conditions may result in a suspension of assistance.

_____

_____

_____

_____

☐ Your application for general assistance is **DENIED** for the following reason(s).

- ☐ Do Not Meet Standard of Need
- ☐ Other, specifically:_____

_____

☐ Your assistance is **SUSPENDED** from _____ to _____ for the following reason(s):

- ☐ Failure to complete required work search
- ☐ Failure to complete assigned workfare hours
- ☐ Failure to apply for other forms of assistance, specifically _____
- ☐ Misrepresentation of material facts, specifically _____
- ☐ Other, specifically:_____

☐ You are also suspended until you comply with the conditions imposed by taking the following actions:

_____

==========

☐ **Your next appointment is**_____.

I understand the action described above. I further understand that if my assistance has been denied or suspended I have the right to request a fair hearing within five (5) working days of receipt of this notice, and that if I am currently receiving assistance, my assistance may be continued, at my request, until the hearing.

_____ _____

Welfare Applicant Date Welfare Official Date

FORM M

WORKFARE PROGRAM
REPORTING FORM

In accordance with RSA 165:31, any recipient of general assistance may be required to work for the municipality at any available job that is within the capacity of the recipient. As a condition of continuing eligibility for assistance, you are required to participate in the workfare program as described below. Any failure to participate as required may result in suspension of assistance.

Recipient Name_____ Total hours owed _____

Work site assigned _____ Supervisor _____

First date to report _____ Daily shift, from_____to_____

(dates and shift may change with permission of welfare official)

TO BE COMPLETED BY WORK SITE SUPERVISOR

Form to be returned on a weekly basis.

Date	Weekday	# Hours Assigned	# Hours Time In	Time Out	Worked	Supervisor Initials
_____	Sunday	_____	_____	_____	_____	_____
_____	Monday	_____	_____	_____	_____	_____
_____	Tuesday	_____	_____	_____	_____	_____
_____	Wednesday	_____	_____	_____	_____	_____
_____	Thursday	_____	_____	_____	_____	_____
_____	Friday	_____	_____	_____	_____	_____
_____	Saturday	_____	_____	_____	_____	_____

TOTAL HOURS WORKED _____

Supervisor signature_____ **Date** _____

Recipient/workfare participant certification:

I understand that failure to fully comply with the workfare program, without just cause, may result in denial of further assistance. I further understand that workfare is for the purpose of working off hours in exchange for assistance granted and that no actual wages will be paid to me.

_____ _____

Recipient/workfare participant signature Date

FORM N

EMPLOYMENT SEARCH RECORD

NAME:_____

[In order to remain eligible for assistance you are required to complete a job search of 3-5 contacts daily. Use this form to list each employer you contact.]

	DATE	EMPLOYER	PHONE NUMBER/EMAIL	JOB OR TYPE OF WORK	TYPE OF CONTACT Visit/Phone/ Mail/Online	PERSON CONTACTED/WEBSITE	TIME OF DAY	RESULTS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

FORM O

FAIR HEARING REQUEST

You have the right to request a Fair Hearing within five (5) business days of receipt of the Notice of Decision of denial or suspension of benefits, or a decision which you do not believe is consistent with the Municipal Welfare Guidelines or State Laws. To review this decision the Fair Hearing will be conducted by an impartial hearings officer. You will have an opportunity to review the content of you welfare file prior to your hearing and present your case to the hearing officer, who will render a decision withing seven (7) business days from the hearing.

I/We, _____ hereby request a Fair Hearing to review the decision dated_____ regarding my application for general assistance.

I/We ❑ want / ❑ do not want my current assistance to continue until my hearing has been decided. I understand that if I lose my hearing, I will be obligated to repay the assistance provided to me during the time the appeal is being decided.

_____ _____

Applicant Signature Date Co-Applicant Signature Date

_____

Address of Applicant(s)

Within seven (7) business days of receipt of this notice by the Welfare Official a hearing will be scheduled. You will be notified in writing of the place, date and time of the hearing.

FORM P

NOTICE OF FAIR HEARING

DATE: _____

TO: _____

ADDRESS: _____

_____

_____

☐ Your Fair Hearing has been scheduled for:

Date: _____

Time: _____

Place: _____

If you are unable to appear at this time, please contact the Welfare Official immediately. Failure to appear may result in the denial of your Fair Hearing request.

☐ Your request for a Fair Hearing has been denied for the following reason (s): _____

_____

_____

_____

Sincerely,

_____

Welfare Official

FORM Q

FAIR HEARING DECISION

_____ _____

Client Name Represented by

VS

_____

Municipality

Date of Hearing _____ Hearing Officer(s) _____

_____

_____

_____

ADJUDICATION

(Include Guidelines, facts relied upon, reasons for decision and any relief ordered. Use extra paper if necessary, or attach written decision to this signed form)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date_____ **Hearing Officer** _____

FORM R

NOTICE OF PROPERTY LIEN

TO: Register of Deeds for the County of _____

RE: Lien on Real Property pursuant to RSA 165:28 and any and all acts in Amendment thereof for aid given by the municipality of _____

DESCRIPTION OF PROPERTY: Land and Building(s) located at No._____ Street, City/Town of _____being Assessor's Map(s) And Lot(s) No. and/or Volume and Page No. _____

RECIPIENT: _____of the City/Town of _____in the County of _____, State of New Hampshire

BE IT KNOWN: that the City/Town of _____has expended funds for and on behalf of the above-named recipient for which funds the City/Town is entitled to a Lien and hereby asserts a Lien pursuant to RSA 165:28 and any and all acts in amendment thereof.

STATE OF NEW HAMPSHIRE

CITY/TOWN OF_____ _____**, ss.**
(County)

BY: _____**DATE:**_____
Director of Welfare/Human Services

Subscribed and sworn to before me:

_____ **My commission expires:** _____
(Notary Public)

NOTE: Lien is valid even without acknowledgement/Signature of recipient.

NOTE: County Register of Deeds requires 1-3" top margin with 1" all other margins (margins displayed are not in conformity) – no less than 10 pitch in Times New Roman or Arial (Sample is Times New Roman 12 pitch which is acceptable).

FORM S

NOTICE OF PROPERTY LIEN DISCHARGE

TO: Register of Deeds for the County of _____

RE: Lien on Real Property pursuant to RSA 165:28 and any and all acts in Amendment thereof for aid given by the municipality of _____

DESCRIPTION OF PROPERTY: Land and Building(s) located at No._____Street, City/Town of _____being Assessor's Map(s) And Lot(s) No. and/or Volume and Page No. _____

RECIPIENT: _____of the City/Town of _____in the County of _____, State of New Hampshire

BE IT KNOWN: that the above-referenced property lien is hereby satisfied and discharged.

BY: _____ **DATE:**_____
Director of Welfare/Human Services

NOTE: County Register of Deeds requires 1-3" top margin with 1" all other margins (margins displayed are not in conformity) – no less that 10 pitch in Times New Roman or Arial (Sample is Arial 12 pitch which is acceptable).

FORM T

RENT VOUCHER – LANDLORD DELINQUENCY

The municipality of _____ hereby authorizes payment to

_____ on behalf of _____ of
[landlord] *[tenant]*

_____ in the amount of $_____.
[tenant address]

for rent due and owing for the period _____ to _____

NOTICE OF APPLICATION OF RENT PAYMENTS TO DELINQUENCIES

TO:_____
[landlord]

You are hereby notified that, pursuant to RSA 165:4-a, $ _____ of the above-authorized payment will be applied to your delinquent ❑ TAX ❑ SEWER ❑ WATER ❑ ELECTRIC bill owed to the municipality for your property located at _____ (address of property with delinquency). You are also notified that, pursuant to RSA 540:9-a, any application by a municipality of amounts owed to it by a landlord pursuant to RSA 165:4-a, shall constitute payment by the tenant of the amount applied by the municipality to delinquent balances of the landlord.

_____
Welfare Official

❑ Landlord copy

❑ Town/City copy (tax, sewer, water, electric)
Note: send lower portion only

❑ Welfare copy

FORM U

UPDATE APPLICATION FORM

(Needs to be reviewed and updated for changes from first application at each time of request of assistance.)

DATE:_____ NAME: _____
Last First Middle

ADDRESS: _____
Street / # / Apartment Town Zipcode

TELEPHONE: _____

WHAT TYPE OF ASSISTANCE ARE YOU REQUESTING AT THIS TIME? _____

_____

CHANGES OF ALL HOUSEHOLD MEMBERS: _____

_____

_____

LIST ALL CHANGES OF SOURCES AND AMOUNTS OF HOUSEHOLD'S EARNED AND UNEARNED INCOME. THIS INCLUDES CASH, SAVINGS AND CHECKING/BANK ACCOUNTS:

_____

_____

INDICATE ANY UPDATES OR CHANGES IN YOUR ASSISTANCE OR APPICATIONS FOR FOOD STAMPS, CASH ASSISTANCE, SOCIAL SECURITY, FUEL ASSISTANCE, UNEMPLOYMENT, ETC.

_____

_____

INDICATE ANY CHANGES IN YOUR PERSONAL SITUATION SINCE YOUR LAST REQUEST.

_____

_____

I understand that if I knowingly give false information or withhold information related to my receipt of assistance, now or in the future, I may be prosecuted for a crime.

_____
SIGNATURE

FORM V

BASIC NEEDS POLICY

Per Municipality Welfare Guidelines, it is the applicant/recipient's responsibility to utilize any available benefits or resources to reduce the need for Municipal General Assistance. The Welfare Department will direct the applicant/recipient to apply for all other resources and also will require the applicant/recipient to use current resources to meet basic needs in order to reduce the need for Municipal General Assistance.

Under continuing Municipal General Assistance or in applying in the future, you will be required to use your earned or unearned resources for allowable basic need expenses only. ALLOWABLE EXPENSES are:

Rent/Mortgage	Diapers
Food	Electric/Heating Bills
Non-food hygiene products	Prescriptions

These costs are allowed for certain conditions:

Public Transportation for work, medical or assistance program appointments.
Telephone basic service to find or keep employment.

The following are examples UNALLOWABLE expenses in determining eligibility:

Telephone beyond basic service for 1 per household.	Bail payments.
Credit Card Payments	Repayment of Personal Loans
Loan Payments	Restaurant/Fast Food
Cable & Internet	Tobacco/Alcohol products
Insurance Payments	Entertainment/Movie Services

As a Condition of Assistance, you will be required to first use all available resources, as directed, to meet your basic needs. Unaltered, dated receipts for these expenses may be required. Should you choose to use your resources for other than basic expense needs as outlined above and/or in your written decision from the Welfare Department, those amounts will be considered available to you and your assistance will be reduced accordingly and a sanction or denial may be issued.

I/We have read and reviewed the Basic Needs Policy with the Welfare Administrator.

_____	_____
Applicant Signature	Co-Applicant Signature
_____	_____
Date	Date

Please note: This is an example form. Your Municipal Welfare Guidelines may have different allowance basic need expenses. You will need to adjust this form to your Municipality Welfare Guidelines that reflect your municipality expenses and allowances.