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

_____ Rental Verification Form

_____ Last 4 weeks of pay-stubs or other proof of gross wages

_____ Last 4 weeks receipts or other proof of bills due or currently due

_____ You have applied for/are receiving Social Security Benefits

_____ You have applied at the DHHS District Office for

☐ Emergency Food Stamps ☐ Food Stamps ☐ TANF

☐ Title XX Daycare ☐ APTD/MA ☐ OAA

☐ TANF Emergency Assist. ☐ WIC ☐ NHEP

_____ You have applied for/receiving Fuel Assistance

_____ If available, picture ID (Adults); Birth Certificates/SS Card (minors)

_____ Savings & Checking accounts (2 consecutive current statements), liquid assets, Bankbooks

_____ Statement Child Support payments received/Child support court order

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

Other:_____

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

_____ _____

Welfare Director Signature Applicant Signature

INTAKE FORM

(to be completed at the time of each request for assistance)

DATE: _____

NAME: _____
Last First Middle Maiden

ADDRESS: _____
Street / # / Apartment Town

HOW LONG AT THIS ADDRESS? _____ TELEPHONE: _____

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

_____

NAMES AND AGES OF ALL HOUSEHOLD MEMBERS: _____

_____

_____

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

_____

_____

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

_____

_____

_____

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

Town of Northumberland

Office of Welfare Director
Groveton, New Hampshire 03582
603-636-1450

Welfare Administration Guidelines

IF YOU HAVE ANY QUESTIONS OR DO NOT UNDERSTAND ANY QUESTION BEING ASKED, DO NOT SIGN UNTIL YOU MEET WITH THE WELFARE OFFICIAL

Notice of General Assistance Rights and Requirements

Please Read Carefully

I. Application Requirements

A. All applicants must fill out a written application for assistance. Applicants for rental assistance must have a completed landlord verification form as part of their application. These forms are available at the town office.

B. Applicants must provide all relevant information necessary to determine eligibility.

C. Applicants must provide the appropriate supporting documentation when arriving at their interview. For example, applicants seeking a medication voucher must provide a doctor's prescription.

D. Applicants must notify the Welfare Officer of any changes in status within 72 hours of the change in order to maintain their eligibility. This includes changes in employment and address.

II. Applicant Rights

A. Applicants have the right to a fair hearing to appeal their decision. The request must be received in writing within five working days of the denial. The hearing will be held within three to seven days of the appeal's receipt.

B. Applicants must receive a written notice of decision with an explanation of why they are being refused if their application is denied.

C. Applications have the right to read the Town's General Assistance Ordinance. A copy is kept in the Town Office.

III. Applicant Warnings

A. Applicants who own property or who receive a legal settlement will have lien placed on the property or settlement by the Town.

B. Applicants who fail to show for their interview twice without a valid excuse will have to file a new application.

C. Failure to comply with any provision in Section I. is grounds for denial or discontinuance of assistance.

APPLICATION FOR ASSISTANCE

Date of Application _____ Referred by _____

1. General Information:

Name _____ Date of Birth _____

Address _____

Telephone _____ Social Security number _____ US Citizen? _____

Marital Status _____ Rent or Own? _____ How long at this address? _____

Spouse/Co-Applicant Name _____ SS# _____

Spouse address (if not same as applicant) _____

Assistance Requested _____

Reason for request _____

Have you applied for local assistance before? _____ When? _____

Where? _____ Under what name? _____

List below all persons living in your household:

Full Name	Relationship	Date of Birth	Social Security #

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

Street	Town/City	State	Dates of Residence

2. Housing Information:

Rent amount _____ per (month/week) _____ Date last paid _____ Date due _____

Do you have a current: ☐ Demand For Rent ☐ Notice to Quit ☐ Landlord/Tenant Writ

Total rent owed _____ Do you have a housing subsidy? _____

Utilities Included: ☐ Heat ☐ Electric ☐ Gas ☐ Water/Sewer ☐ Other

LANDLORD: Name _____ Telephone _____

Address _____

IF HOME-OWNER: Mortgage Amount _____ Date last paid _____ Owed _____

Bank/Mortgage Co _____ Address _____

3. Education / Training / Employment

	Highest Grade Attended	G.E.D. or Diploma	Special Training or Skills	Military Service
Applicant:				
Spouse/Co-Applicant:				

Applicant Work History:

Are you employed now? _____ Employer _____ Position _____

When began work _____ Date/Amount of most recent check _____

Are you unemployed now? _____ Reason _____

Date last worked _____ Employer _____ Date/Amount last check _____

Are you able to work now? _____ If not able, why not? _____

Current and two most recent jobs of yourself and all household members aged 18 & older:

Name	Employer	Pay	Weekly/ Biweekly	Employment Dates	Reason for Leaving

4. Household Assets:

Provide information regarding accounts held by you and all household members:

Name	Bank/Credit Union	Savings Acct. #	Savings Balance	Checking Acct. #	Checking Balance

Provide current value of any assets held by you and all household members:

Cash on hand (all household combined) _____ Certificates of Deposit (CD's)_____

Savings Bonds _____ Mutual Funds_____Annuities_____Stocks _____

Trust Funds_____Retirement Accounts _____Insurance Policies (cash value)_____

401k _____ Property other than primary residence _____Location _____

Other Investments _____Motorcycles/Boats/Snowmobiles/ATV's/RV's _____

Other Assets (please list) _____

Claims/settlements/income due to you or any household member

IRS Refund_____ Insurance Claim _____ Retroactive disability check_____

Retroactive Unemployment or Worker's Compensation check_____ Inheritance_____

Other Lump Sum Payment (explain) _____

Have you or any household member consulted a lawyer regarding a possible lawsuit?:

Lawyer Name/Address_____

Reason _____

Do you or any household member have a lawsuit pending? _____ Who? _____

Please give details _____

Lawyer Name/Address_____

Motor vehicles owned by you and all household members:

Owner	Auto Make	Model	Year	Value	Payments	Insurance

5. Household Income

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

	Name	Date Applied	Date Last Received	Monthly Amount
ANB (Aid to the Needy Blind)				
APTD				
Child Support				
Disability (Employer)				
Food Stamps				
Fuel Assistance				
Gifts/Loans				
Maternity Benefits				
Medicaid				
OAA (Old Age Assistance)				
Retirement				
Severance Pay				
Social Security				
SSDI (SS Disability)				
SSI (Supplemental Security)				
TANF				
Unemployment				
Vacation Pay				
Veteran's Pension				
Vocational Rehabilitation				
WIC(Women/Infants/Children)				
Worker's Compensation				
Other: [ ]				

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

Name	Agency Name	Contact Person

6. Household Expenses

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

Bank Fees _____	Diapers _____	Mortgage _____
Bus/Cab _____	Electric _____	Prescriptions _____
Cable/Internet _____	Food _____	Rent _____
Child Support Paid _____	Fuel Oil _____	Rent-To-Own _____
Car Gasoline _____	Gas, Bottled _____	School Loan _____
Car Insurance _____	Gas, Natural _____	Storage _____
Car Payment _____	Health Insurance _____	Telephone _____
Condo Fee _____	Laundry _____	Other _____
Child Care _____	Loan _____	Other _____
Credit Card _____	Lot Rent _____	Other _____

List unplanned, emergency or irregular periodic expenses during the past 30 days:

Car Inspection _____	Drivers License _____	Medical _____
Car registration _____	Fines/Court Payments _____	Sewer/Water _____
Car repair _____	Home Repairs _____	Tax (Income/Property) _____
Dental _____	Home/Rent Insurance _____	Other _____

7. Criminal Information

Have you or any member of your household ever been convicted of a felony which has not been annulled? (yes/no) _____ If yes, who? _____ When? _____

Town/City & State of conviction _____ Details of conviction: _____

Are you or any member of your household presently on parole or probation? (yes/no) _____

If yes, who? _____ Court or jurisdiction? _____

Name & phone number of parole/probation officer _____

8. Liability for Support Information

Please provide following details:

Your father _____ Address _____

Your mother _____ Address _____

Co-applicant father _____ Address _____

Co-applicant mother _____ Address _____

Your or co-applicant's adult children _____

9. 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 hereby 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 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 my receipt of assistance, now or in the future, I may be prosecuted for the crime of Unsworn Falsification (RSA 641:3)

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)

Applicant Signature	Date
Spouse or Co-applicant Signature	Date
Signature of person completing form (if not applicant)	Date

Assistance Levels

The Board of Selectmen adopted these limits on March 2, 2020

1. Shelter
   a. Rent
      1. One Bedroom - ***up to*** $137.50(covers a one week period)
      2. Two or more Bedrooms/House - ***up to*** $162.50 (covers a one week period)

2. Utilities
   a. Electric – only what is necessary to maintain or restore service
   b. Fuel – 100 gallons maximum

3. Food – Food in weekly increments
   a. For one person a maximum of $50.00 a week.
   b. For two people a maximum of $75.00 a week.
   c. For three people a maximum of $100.00 a week.
   d. For four people a maximum of $125.00 a week.
   e. For five people a maximum of $150.00 a week.
   f. For six people a maximum of $175.00 a week.
   g. For seven people a maximum of $200.00 a week.
   h. For each additional person in the household after seven add $25.00 a week.

4. **REPEALED**

5. Medical
   a. Medications - $200 limit

6. Other/Emergency Expenses - $50 limit (One time only based on circumstances)

7. Time Limits
   Unless otherwise specified, total period of assistance per application not to exceed four week period.

FILL IN STARRED ITEMS ONLY

BUDGET WORKSHEET

* Name _____ * Date _____

A. Available assets and income: OFFICE USE ONLY

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

A. Total available income: _____

B. Allowable Expenses:

	* Actual Expenses		OFFICE USE ONLY 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 [illegible] to employment, work search, medical needs, etc.

RENTAL VERIFICATION FORM

THIS FORM MUST BE COMPLETED BY THE LANDLORD

Tenant's Name: _____ Date: _____

Address: _____

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

Number of Household Members: _____ List of Household Members: _____

_____

_____

_____

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

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

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 # must be provided:

Tax ID #: _____ OR Social Security #: _____

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

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____, the undersigned, understand that from time to time,
Print Your Name

the local welfare administrator for _____ may require certain information about
Town/City

assistance I am applying for or receiving from the NH Department of Health and Human Services, Division of Family Assistance (DFA). When information cannot be provided by me personally, I hereby authorize DFA to release the following information to the local welfare administrator for the specific purposes outlined below:

Type of Information	Purpose for Requesting this Information
Date of DFA application(s), type(s) of assistance applied for, date of eligibility determination, expected date of benefit issuance, amount of cash grant (if applicable) and/or the reason my case closed or my application was denied	Basic administration of my local welfare assistance cas including verification of information provided by me fc determining eligibility for local welfare assistance
Date my Medicaid case opened and my Medicaid Identification Number(s)	Processing of Medicaid reimbursements if/when, during the tim my Medicaid application was pending, the local welfar administrator makes an expenditure on my behalf for an ite covered by Medicaid
Date of any sanction of my cash assistance grant	Determining countable household income also called "deeming
Reason for any sanction of my cash assistance grant	Helping me to remove the sanction

I understand that I have the option to provide any or all of the requested information myself.

I understand that any use of the above information inconsistent with these purposes is forbidden.

I understand that the local welfare administrator may not release information provided under this authorizat to any other person without my written permission.

This authorization shall expire 180 days from the date it is signed.

_____ _____
Signature Date

If the signature above is not that of the person to whom the requested information pertains, the relationship the signer to that person must be indicated, the signature must be witnessed, and verification that the signe has the authority to represent the person in these matters with DFA must be provided upon DFA request.

_____ _____ _____
Relationship to You Witness Date

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

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

Weeks Medical Center

Addressograph

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Weeks Medical Center staff involved with my care planning needs management to exchange verbal or written information concerning the coordination of services for my continued care and medical treatment.

I further understand the information shared may include any/all contained in my medical records of the hospital, physician office practice and home health. This confidential information may include reference to diagnoses and/or treatment of alcohol or other chemical dependencies, psychiatric conditions, and/or sexually transmitted diseases (including HIV information) if any of these situations apply.

- ☐ All records (Including records of alcohol and drug treatment, HIV, AIDS, psychiatric notes or sexually transmitted diseases.)
- ☑ All dates
- ☐ Include only dates of care from: _____ to _____
- ☐ Do not include records related to alcohol and drug treatment, HIV, AIDS, Psychiatric notes or sexually transmitted diseases.)

Services:

[ ] Transportation
[ ] CAP
[ ] Meals on Wheels
[ ] PAP Program
[ ] Fuel Assistance
[ ] All the above
[ ] Caleb Group
[ ] Handicapped ramp construction or other construction
[ ] Lifeline
[ ] Equipment (DME) Durable Medical Equipment
[ ] VT / NH Medicaid
[ ] SS Benefits
[ ] Weeks Health Access (Including Pharmaceutical Assistance Program Screening)
[ ] New Hampshire Health Access screening
[ ] Other Town of Northumberland

+ _____ + _____
Patient's Signature or Mark — Date

_____ _____
Witness to above signature if Patient's Mark — Date

_____ _____
Second witness to above signature if Patient's Mark — Date

_____ _____
Legal Guardian or Durable Power of Attorney for Health Care or person responsible for patient — Date

EXPIRATION DATE: This authorization will expire on (no later than one year from today) _____
(If no date is stated, this authorization expires one year from the date it was signed)

COPY PROVIDED: The patient will be provided a copy of this authorization.

Form # 92