

If you have not applied for assistance or it has been longer than three (3) months, please complete.
Form F Town of Hinsdale Welfare Department rev 5/09 Tel 603 336 5710 Ext. 18, Fax 603 336 5711

REQUIRED VERIFICATIONS

Applicant Name: _____ Date: _____
Last 4 of Social Security Number: _____ D.O.B.: _____
Mailing Address: _____ Phone: _____
Physical Address: _____

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 (completed by your Landlord)
- _____ Last four week's pay-stubs or other proof of net wages
- _____ Last four week's receipts or other proof of ANY bills and expenditures paid or currently due
- _____ Employment Verification form from employer (completed by your Employer)
- _____ Employment Termination form from last employer (completed by Employer)
- _____ You have applied for/ are receiving Social Security benefits (Document that confirm status)
- _____ You have applied at the HHS District Office for:
 - _____ Emergency Food Stamps _____ Food Stamps _____ TANF
 - _____ Title XX Daycare _____ APTD/MA _____ OAA
 - _____ TANF Emergency Assistance (Documentation to confirm status)
- _____ You have applied for/ are receiving Fuel Assistance benefits (Documents that confirm status)
- _____ Verification of injury or illness
- _____ You have applied for/ are receiving Unemployment Compensation (Document that confirm status)
- _____ Vehicle Registration
- _____ Savings and checking account, liquid asset statements, bankbooks
- _____ Statement of child support payments received/ Child support court order
- _____ ID of all in home (social security card, drivers license, birth certificate)
- _____ 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 /or Town Workfare Program.

Welfare Staff signature

Applicant signature

APPLICATION FOR ASSISTANCE

Date of Application: _____ Referred by: _____

1. General Information:

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Last 4 #'s of Social: _____ US Citizen? _____

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

Spouse/Co-Applicant Name: _____ SS# (last 4): _____

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	Last 4 of Soc. Sec. #

If you have resided at your current address less that 12 months, please list last 2 years addresses:

Street	Town/City	State	Date of Residence

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)	_____	_____	_____	_____
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?

<u>Name</u>	<u>Agency Name</u>	<u>Contact Person</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Household Expenses:

List actual monthly expenses, and accompany with a receipt. (Not all expenses will be allowable and may not be included in your eligibility determination, but should be listed to show your financial situation).

Bank Fee	_____	Diapers	_____	Mortgage	_____
Bus/Cab	_____	Electric	_____	Food	_____
Cable/Internet	_____	Prescriptions	_____	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	_____	Dental	_____
Car Registration	_____	Home Repairs	_____
Car Repair	_____	Medical	_____
Drivers License	_____	Sewer/Water	_____
Fines/Court Payments	_____	Other	_____
Home/Rent Insurance	_____	Other	_____
Tax (Income Property)	_____	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 the following details:

Father's Name: _____ Address: _____

Mother's Name: _____ 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 list 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 165-28-a)

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 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 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.

I understand that if I am gainfully employed, but my income and assets are not sufficient to meet necessary household expenses, I may be eligible to receive general assistance. However if I without good cause refuse a job offer or referral to suitable employment, participation in the workfare program, or voluntarily leave a job without good cause I may be ineligible for continuing general assistance. The Welfare Official shall first determine whether there is good cause for such refusal, taking into account my ability, physical and mental capacity of the applicant, transportation problems, working conditions that might involve risks to health or safety, lack of adequate childcare or any other factors that might make refusing a job reasonable. These employment requirements shall extend to all adult members of my household. (RSA 165:1-d)

Applicants Signature: _____ Date: _____

Spouse or Co-Applicant Signature: _____ Date: _____

Signature of person completing form: _____ Date: _____

(If not applicant)

AUTHORIZATION FOR THE RELEASE OF INFORMATION -DHHS

I, _____, the undersigned, understand that from time to time, the local welfare

Print Name

administration for **Town of Hinsdale Welfare Department** may require certain information about assistance I am applying for or receiving from the New Hampshire 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 case grant (if applicable) and/or the reason my case closed or my application was denied.	Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance.
Date my Medicaid case opened and my Medicaid Identification Number(s).	Processing of Medicaid reimbursements I/when, during the time my Medicaid application was pending, the local welfare administrator makes an expenditure on my behalf for an item covered by Medicaid.
Date of any sanction of cash assistance grant.	Determining countable household income also called "deeming".
Reason for any sanction of my cast 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 administration may not release information provided under this authorization 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 of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

Relationship to you

Witness

Date

FORM C

**NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE
FROM THE MUNICIPALITY OF HINSDALE**

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 to review the information in your file before your hearing.
7. You have a right to have your assistance continued if you are already receiving assistance when you request a Fair 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 follow the guidelines.
10. You have a right to refuse to participate in the municipal workfare program or to conduct a job search if you must care for a child under the age of five (5), if you are disabled or ill, or if you must take care of a member of your family who is disabled or ill.

I/We received a copy of the Notice of Rights from the Town of Hinsdale Welfare Department

THESE ARE YOUR RIGHTS TO KEEP

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

I/We, _____,
Print Name

authorize any relative, physician, lawyer, 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 Care, 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 release information from their files to the Town of Hinsdale Municipal Welfare Department.

Applicant Signature

Date:

Spouse or Co-Applicant Signature:

Date:

Signature of person completing form (if not applicant):

Date:

Relationship to applicant: _____

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 of Hinsdale 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

Date

FORM G

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:

NAME 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

EMPLOYMENT VERIFICATION FORM

For the Town of Hinsdale Welfare Department

Fax 603 336-5711

To Employer: _____ Date: _____

Address: _____

Phone: _____

For the purpose of administration of municipal assistance, the following information is required for:

(Name of Employee)

Date of Hire _____ Date starting/started work _____ Hourly Pay Rate _____

Full/part time _____ Hours per week _____ O weekly O biweekly O other

Date of first/most recent paycheck _____ Net amount _____

If _____ is no longer employed by your company:

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

Reason for termination/separation _____

Signature and Title of immediate supervisor or person completing form

Date

Please complete and return this form to requesting applicant,
or send to Town of Hinsdale Welfare Department.
PO Box 13 Hinsdale NH 03451

Fax # 603 336 5711, Phone # 603 336 5710 ext. 18 with any questions.

Thank you

Town of Hinsdale Welfare Department

Rental Verification Form

THIS FORM MUST BE COMPLETED IN FULL BY THE LANDLORD

Fax 603 336 5711 Phone 603 336 5710 ext. 18 with any questions

Tenant's Name: _____ Date: _____

Address: _____
(number/Street) (Apt. #) (City) (State)

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

Number of Bedrooms in Apt. or House: _____

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

Rent Amount: \$ _____ paid Monthly Weekly Other

If subsidized rent, please list tenant portion: \$

Rent Includes: All Utilities Hot Water Heat Electric No Utilities

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