TOWN OF PLAISTOW

HUMAN SERVICE DEPARMENT

145 Main Street, Plaistow, NH 03865

603-382-5200 X230 FAX:603-382-7183

CASE #:_____

FORM A

APPLICATION FOR GENERAL 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: _____ SSN # _____

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? ☐ No ☐ Yes 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 (Circle one): Medicare or Medicaid? ID Number: _____

Other Insurance: _____ EBT Card # _____

Spouse/Co-Applicant

Name: _____ Date of Birth:_____

Cell Phone: _____ Work Phone: _____ SSN # _____

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? ☐ No ☐ Yes 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 (Circle one): Medicare or Medicaid? 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 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 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 ……..	_____	_____	_____
Severance Pay ……	_____	_____	_____
Social Security (Retirement) ……	_____	_____	_____
SSDI (Social Security Disability) ……	_____	_____	_____
SSI (Supplemental Security) ……	_____	_____	_____
TANF (Temporary Assistance for Needy Families-State Welfare) ……	_____	_____	_____

Income (Continued)

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 _____)	_____	_____	_____
Rent – Option to Own	_____	_____	_____
Rent – MH Lot	_____	_____	_____
Storage Unit	_____	_____	_____
Taxes (Income/Property)	_____	_____	_____
Telephone (Landline/Cell)	_____	_____	_____
Telephone (Cable/Internet)	_____	_____	_____
Transportation (Bus/Cab)	_____	_____	_____

Expense (continued)	Monthly Expense	Any Amounts Past Due	Comments
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 lf 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

Applicant **Co-Applicant**

Print Name: _____ Print Name: _____

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 my receipt of assistance, now or in the future, I may be prosecuted for the crime 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 Plaistow** 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 **Town of Plaistow** 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

Signature: _____

Date: _____

Co-Applicant

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 **Town of Plaistow** Welfare Administrator or up to six (6) months after assistance has ended.*

FORM F

REQUIRED VERIFICATIONS

Applicant Name:_____ Date: _____

Social Security Number: _____

Date of Birth.: _____

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.

_____ _____

Lori Sadewicz, Welfare Staff Signature Applicant Signature

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

NH Department of Health & Human Services (DHHS)
Bureau of Family Assistance (BFA)

BFA Form 11
10/19

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)

BFA SR 19-29
(3YC)

FORM H

MUNICIPAL WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#: _____

Date of Birth: _____

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 Plaistow**.

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 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. Examples of ALLOWABLE EXPENSES are:

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

These costs are allowed for certain conditions:

Public Transportation for work, medical or assistance program appointments.
Telephone basic service if absence would create unreasonable risk to applicant's health/safety
Medical Insurance if determined that maintenance is essential

☒ The following are examples of UNALLOWABLE expenses in determining eligibility:

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

Note: Please refer to the *Town of Plaistow Welfare Guidelines, Section IX Determination of Eligibility and Amount, E. Standard of Need*, and *Appendix A - Allowable Levels of Assistance*

Town of Plaistow, New Hampshire

Plaistow Town Hall
145 Main Street
Plaistow, NH 03865

(603) 382-5200 X 204 Office
(603) 382-7183 Fax
Email: lsadewicz@plaistow.com
Web: www.Plaistow.com

APPENDIX A

Allowable Levels of Assistance

Food Allotment Standard

Household Size	Monthly Food
1	$281
2	$516
3	$740
4	$939
5	$1,116
6	$1,339
7	$1,480
8	$1,691
Each Additional Person	*$211*

Monthly Median Shelter Allowances (Rockingham County)

0 BR	1 BR	2 BR	3 BR
$1,273.00	$1,539.00	$1,944.00	$2,252.00

Electrical Allowances

300 kWh (0 BR)	400 kWh (1 BR)	500 kWh (2 BR)	600 kWh (3 BR)	700 kWh (4 BR)
$117.57	$151.35	$185.13	$292.05	$252.77

Figures based on average electrical use less than 100,000 kWh per month for January 2023 (Monthly Delivery Charge of $0.07857 plus Monthly Service Change <=500kWh at $0.25925 and >500 kWh at 0.13257) plus a $16.22 per month meter charge.

Petroleum Allowance

Fuel Oil (#2):	$3.60 / Gallon
Propane:	$3.33 / Gallon
Kerosene:	$4.81 / Gallon

Pricing reflected is effective 08/01/2023. Petroleum fuel pricing is updated weekly from the first Tuesday in October until the last Tuesday of March, and then updated monthly for the remainder of the year.

Natural Gas Allowance

Natural Gas 1st Tier (<100 Therms) Current Average Price is $1.66/Therm

- Btu 100,000
- Conversion Efficiency 0.8
- $/MBTU $20.76

Pricing reflected is effective 08/01/2023. Natural gas pricing is updated monthly.

Burial/Cremation Allowance

$1000

Annually Approved by Board of Selectmen : _____09/11/2023___
Approval Date

Sources: USDA SNAP Fiscal Year Cost-of-Living Adjustments (2023), https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-fy-2023-cola-adjustments.pdf#page=2
NH Housing Authority, (2023) *2023 Residential Rental Cost Survey Report* https://www.nhhfa.org/rentsurvey/
Until (2023) Residential Electric Rates (NH), Domestic Rates https://unitil.com/sites/default/files/2023-08/UES_Res_08.01.23.pdf
NH Department of Energy (2023, August), NH Fuel Prices, Average Fuel Prices in NH, https://www.energy.nh.gov/energy-information/nh-fuel-prices
Town of Plaistow Human Services Department Welfare Guidelines

C. Responsibility of Each Applicant and Recipient

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.

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.