

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 four weeks pay-stubs or other proof of net wages

_____ Last four week's receipts or other proof of bills paid or currently due

_____ Employment verification form from your employer

_____ Employment termination form 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

Food Stamps

TANF

Title XX Daycare

APTD/MA

OAA

TANF Emergency Assistance

_____ You have applied for / are receiving Fuel Assistance benefits

_____ Verification of injury or illness

_____ 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, 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 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

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

EMPLOYMENT VERIFICATION FORM

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 _____ Paid weekly biweekly 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 _____

Approval Date: 08-25-2008



TOWN OF PLAISTOW
145 Main Street
Plaistow, NH 03865

ALLOWABLE LEVELS OF ASSISTANCE

FOOD LEVELS

<u>HOUSEHOLD SIZE</u>	<u>MONTHLY FOOD</u>	<u>WEEKLY FOOD</u>	<u>DAILY FOOD</u>
1	\$162.00	\$40.50	\$5.78
2	\$298.00	\$74.50	\$10.64
3	\$426.00	\$106.50	\$15.21
4	\$542.00	\$135.50	\$19.35
5	\$643.00	\$160.75	\$22.96
6	\$772.00	\$193.00	\$27.57
7	\$853.00	\$213.25	\$30.46
8	\$975.00	\$243.75	\$34.82
(add each)	\$122.00	\$30.50	\$4.35

MONTHLY MEDIAN SHELTER ALLOWANCES

0 BR	1 BR	2 BR	3 BR	4 BR
\$685.00	\$895.00	\$1,182.00	\$1,447.00	\$2,044.00

ELECTRIC ALLOWANCES

Figures based on average electric use less than 100,000 kWh per month of January and 250 kWh of demand and \$8.40 per month meter charge.

300kWh (0 BR)	400kWh (1 BR)	500kWh (2 BR)	600kWh (3 BR)	700kWh (4 BR)
\$84.13	\$109.80	\$135.47	\$161.14	\$181.93

OIL ALLOWANCE

Figures based on \$4.299 per gallon.

NATURAL GAS ALLOWANCE

Figures based on Figures based on \$10.96 Tariff Rate & \$1.8541/all therms.

CASE#: _____



TOWN OF PLAISTOW
145 Main Street
Plaistow, NH 03865

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
_____	_____	_____	_____
_____	_____	_____	_____

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 Reparis _____	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

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 it's 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.*

AUTHORIZATION FOR THE RELEASE OF INFORMATION - DHHS

I/We, _____, the undersigned, understand that from time to time,
Print Your Name & Spouse's Name if Applicable
 the local welfare administrator for _____ may require certain
Town/City

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 outline below:

Type of Information	Purpose of 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 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 if/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 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 authorization to any other person without my written permission.
This authorization shall expire 180 days from the date it is signed.

 Signature

 Date

 Spouse's 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 Signature/Printed Name

 Date

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 (workfare) 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.