

# TOWN OF STRATHAM

## 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: \_\_\_\_\_

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: \_\_\_\_\_

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? Other Insurance: \_\_\_\_\_

**Spouse/Co-Applicant**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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: \_\_\_\_\_

Special Training/Skills: \_\_\_\_\_

Currently Employed?     Full Time     Part-Time     Self Employed     UnemployedHave 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? Other Insurance: \_\_\_\_\_

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

Full Name	Relation	Birth Date	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	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## 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  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 Balance	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
Other: _____	_____	_____	_____
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
_____	_____	(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**

##### **Applicant**

Print Name: \_\_\_\_\_

##### **Co-Applicant**

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 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 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 \_\_\_\_\_ 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

Co-Applicant

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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.

# FORM B

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

BFA Form 11  
10/19

## Authorization to Release Information

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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:**

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**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.

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(Signature)

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(Date)

---

(Printed Name)

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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.

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(Relationship)

---

(Witness)

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(Date)

BFA SR 19-29  
(3YC)

## FORM C

# NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF \_\_\_\_\_

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.

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Applicant Signature

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Date

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Spouse or Co-applicant Signature

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Date

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Signature of person completing form (if not applicant);

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Relationship to applicant

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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.

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Applicant Signature

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Date

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Welfare Official

## FORM F

## REQUIRED VERIFICATIONS

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
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.*

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Welfare Staff signature

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Applicant signature