

## TOWN OF HAMPSTEAD

### 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.**

\_\_\_\_\_  
Human Services Coordinator

\_\_\_\_\_  
Applicant signature

**TOWN OF HAMPSTEAD**  
**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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____





**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 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

# TOWN OF HAMPSTEAD

## 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

\_\_\_\_\_  
Human Services Coordinator



# TOWN OF HAMPSTEAD

## 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

## 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)

# TOWN OF HAMPSTEAD

## BUDGET WORKSHEET

Name \_\_\_\_\_

Date \_\_\_\_\_

### A. Available assets and income:

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

### A. Total available income:

\_\_\_\_\_

### B. Allowable Expenses:

	<u>Actual Expenses</u>	<u>Allowed Expenses</u>	<u>Ineligible Expenses</u>
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.

# TOWN OF HAMPSTEAD

## EMPLOYMENT SEARCH RECORD

NAME: \_\_\_\_\_

*[In order to remain eligible for assistance, you are required to do a job search of 3-5 contacts daily. Use this form to list each employer you contact.]*

DATE	EMPLOYER	PHONE NUMBER	JOB OR TYPE OF WORK	TYPE OF CONTACT Visit/Phone/ Mail/Resume	PERSON CONTACTED	TIME OF DAY	RESULTS
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

## **TOWN OF HAMPSTEAD**

### **Job Search Criteria**

1. Applicants must register at NH Works, 29 South Broadway, Salem, NH 03079 (603-893-9185) within 7 days of filing an application with the Hampstead Human Services Coordinator. NH Works helps residents of New Hampshire to gain sufficient skills, education, employment and financial independence.

OR

If you have young children and are unable to work you must register at The State of NH Department of Health and Human Services, NH Employment Program, 154 Main Street, Suite 1, Salem, NH 03079 (1-800-852-7492) within 7 days of filing an application with the Hampstead Human Services Coordinator.

2. Written verification from either NH Works or NH Employment Program, which you have registered within the required time frame of 7 days, must be presented to the Human Services Coordinator.
3. Week one of job searches must include 4 job searches per day, 5 out of the 7 days of the week. These job searches can be done by phone, internet, walk-ins, etc. Document each contact on the work sheet form provided. You must be sure every contact is listed, dated and includes a phone number.
4. Week two job searches must include 4 job searches per day, 5 out of the 7 days of the week. These job searches must be IN PERSON. Document every contact on the job search form, remember to include dates, person you spoke with, and phone numbers.
4. Week three job searches must include 4 job searches per day, 5 out of the 7 days of the week. These job searches must be IN PERSON. Document every contact on the job search form, remember to include dates, person you spoke with, and phone numbers. You must also register for Labor Ready Services, 16 South Willow Street, Manchester, NH (603-647-1237). Written verification that you have registered must be presented to the Human Services Coordinator. If you work a full 8 hour day for Labor Ready document that on your job search form. You are not required to perform a job search on a day you work a full 8 hour shift. Any hours worked less than 8 hours, requires job searches be done on that day.

---

Applicant Signature

Date

**TOWN OF HAMPSTEAD**  
**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

**TOWN OF HAMPSTEAD**  
**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.*

**TOWN OF HAMPSTEAD**  
**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