



TOWN OF LONDONDERRY
WELFARE DEPARTMENT

c/o CHS 14 Tsienneto Road Suite 301 Derry, NH 03038
Tel: 603-425-2545 Fax 603-425-2378

REQUIRED VERIFICATIONS: Form F

Applicant Name: _____ Date: _____
Social Security Number: _____ D.O.B.: _____
Address: _____ Phone: _____

YOUR APPOINTMENT IS SCHEDULED FOR: _____

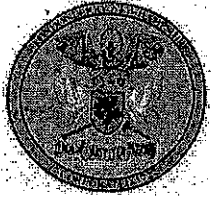
You must provide the following verification/documentation at this appointment
or assistance may be delayed or denied:

- 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 (Derry 965-3029)
Verification of injury or illness
You have applied for / are receiving Unemployment Compensation (627-7841)
If available, picture ID (Adults); Birth certificate/SS card (minors)
Vehicle registration Subsidized Housing/Section 8 (472-8623)
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



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APPLICATION FOR ASSISTANCE: FORM A

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:

	<u>Name</u>	<u>Date Applied</u>	<u>Date Last Received</u>	<u>Monthly Amount</u>
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?

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

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

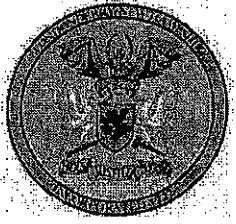
Date

Spouse or Co-applicant Signature

Date

Signature of person completing form
(if not applicant)

Date



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**NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE
FROM THE MUNICIPALITY OF LONDONDERRY, NH: Form C**

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 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.



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**MUNICIPAL WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT: Form H**

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 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)



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EMPLOYMENT VERIFICATION FORM: Form I

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



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RENTAL VERIFICATION FORM: Form J

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

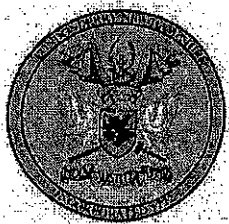
Telephone / Fax Numbers

Landlord Address

Name of Manager or other Representative

Landlord Signature

Date



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APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION:
FORM D

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

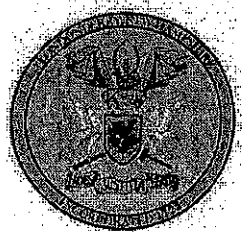
Date

Spouse or Co-applicant Signature

Date

Signature of person completing form (if not applicant); Relationship to applicant

Date



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NOTICE OF PROPERTY LIEN: Form R

TO: Register of Deeds for the County of _____
RE: Lien on Real Property pursuant to RSA 165:28 and any and all acts in Amendment thereof for aid given by the municipality of _____

DESCRIPTION OF PROPERTY: Land and Building(s) located at No. _____ Street, City/Town of _____ being Assessor's Map(s) and Lot(s) No. and/or Volume and Page No. _____

RECIPIENT: _____ of the City/Town of _____ in the County of _____, State of New Hampshire

BE IT KNOWN: that the City/Town of _____ has expended funds for and on behalf of the above-named recipient for which funds the City/Town is entitled to a Lien and hereby asserts a Lien pursuant to RSA 165:28 and any and all acts in amendment thereof.

CITY/TOWN OF _____ **STATE OF NEW HAMPSHIRE**
_____, ss.
(County)

BY: _____ **DATE:** _____
Director of Welfare/Human Services

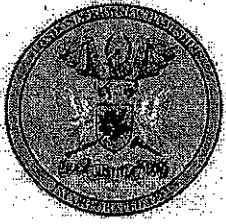
Subscribed and sworn to before me:

(Notary Public)

My commission expires: _____

NOTE: Lien is valid even without acknowledgement/Signature of recipient.

NOTE: County Register of Deeds requires 1-3" top margin with 1" all other margins (margins displayed are not in conformity) -- no less than 10 pitch in Times New Roman or Arial (Sample is Times New Roman 12 pitch which is acceptable).



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BUDGET WORKSHEET: Form K

Name _____ Date _____

A. Available assets and income:

Table with 2 columns: Description, Mo/wk. Includes 4 rows for listing assets and income.

A. Total available income: _____

B. Allowable Expenses:

Table with 4 columns: Expense Category, Actual Expenses, Allowed Expenses, Ineligible Expenses. Lists various expenses like Rent, Electric, Gas, etc.

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:

Table with 2 columns: Description, Amount. Shows dollar amounts for assistance.

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.

APPENDIX C

ADOPTED ETHICS RESOLUTION ON RESPONSIBILITY FOR PERSONS WHO CHANGE THEIR RESIDENCE WHILE, OR AS A RESULT OF, APPLYING FOR LOCAL WELFARE

(Adopted by New Hampshire Local Welfare Administrators Association)

I. "Dumping" is hereby declared to be an unethical practice. For purposes of this resolution, "dumping" consists of attempting to end, or avoid acquiring, a local welfare financial responsibility by encouraging, persuading or pressuring a client:

- A. not to establish, or to discontinue, a residence in the town which he/she has applied for assistance, or
- B. to establish a residence in another town.

II. In order to avoid "dumping" the following standards should be observed:

A welfare administrator should not encourage, direct, or knowingly allow a client who has applied for assistance in his/her town to apply for assistance in another town without making a good faith effort to contact the welfare administrator in that other town to explain why the person is coming to the other town. This applies whether or not the welfare administrator has accepted initial financial responsibility for the person (i.e. treat him/her as a resident) unless:

- A. he/she has an established place of abode (specific address, place to sleep) in another town which he/she intends to return to (even for just one night – i.e., hasn't moved out of yet), or
- B. he/she has NO established place of abode ANYWHERE, (i.e., any prior specific address was in some other town and has been abandoned) AND has a specific intent to go somewhere else rather than staying in the town for any time.

(Even when an applicant falls into A. or B. above, some temporary, non-resident assistance may be necessary, depending on the circumstances, in order to send the person on his/her way.)

III. Where a town has accepted initial financial responsibility under paragraph II above, the welfare administrator should not grant any assistance, which he/she knows, will be used so as to help establish the recipient's residence in another town, unless:

- A. a good faith effort is made to explore local resources, after which it is discovered that none within reason is available, or
- B. unless the client has indicated an intent to move to another town for some non-welfare-related reason.

In either case the welfare administrator who has accepted initial financial responsibility should contact the official of the other town and offer to pay up to one month's assistance following the move if necessary.

Towns must avoid "special" treatment. If a town never pays security deposits, the town must not pay security deposits in special instances to establish a client's residence elsewhere. The sending town should pay actual allowable shelter costs as determined by the receiving town's guidelines.

APPENDIX C

IV. Residency

According to RSA 126-A:43-h, persons receiving emergency housing (shelter) shall continue to maintain their legal residence as it existed at the time of entering the emergency housing facility. When a person leaves the originating shelter of their own free will, the liability no longer remains the responsibility of the original town. A person does not gain or lose residency while in a shelter, hospital or treatment center.

Persons who are sanctioned by local welfare, and arrive in another community, are not the liability of the community where the sanction originated. However, arrangements may be made between the two communities to have the sanction resolved.