APPLICATION INSTRUCTION SHEET

1. Any person who is poor and unable to support him/herself is entitled to Assistance providing they meet eligibility requirements set out in the Town's Welfare Guidelines.

2. WELFARE GUIDELINES: Guidelines are available for review at the Town Hall during regular business hours

3. Each applicant and each adult living with the applicant, whether related or not must complete an application and provide information necessary to determine eligibility.

4. An application for assistance may be picked up at the Town Hall during regular work hours. The application may be picked up before the appointment and completed to the best of the applicant's ability. An applicant must make an appointment to meet with the Welfare Officer to go over the application, the verifying documents (See page 2) and to determine applicant's eligibility.

5. EMERGENCY ASSISTANCE – An applicant who requires emergency assistance to avoid the loss of a necessity or when there is an imminent threat to life or health, should notify their Welfare Officer immediately. In case of emergency during non-working hours, contact the Allenstown Police Department.

6. Recipients are entitled to Assistance in the full amount by which their basic living expenses exceed their income and resources, not to exceed the Welfare Guidelines.

7. VERIFICATION: An applicant is required to verify factual information. Each applicant receives a list (Page 2) of items which must be verified. A good faith effort to obtain verification documents that are unavailable due to circumstances beyond the control of the applicant will satisfy this requirement and will not result in a delay in the processing of an application. If you are unable to obtain the requested verification, such as by a sworn statement signed by you.

8. EMPLOYMENT: Applicants are not required to be employed as a precondition to obtaining assistance; however, continued assistance may be conditioned on participation in a work program as well as meeting job search requirements. Continuing aid may be denied for failure to accept suitable employment.

9. HOME VISITS: As part of the general Assistance program you may be asked to participate in a home visit. The home visit is used to assist the Welfare Officer to determine all of the services needed to help an applicant and to verify eligibility information.

10. DETERMINATION: a decision will be made on each completed application within five (5) working days.

11. APPEAL: If an applicant is denied assistance in whole or in part, he/she has the right to request a fair hearing within five (5) working days of receipt of the Notice of Decision.
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
___ Loan Disclosure, including, but not limited to: student and personal loans, and income tax
___ 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
BASIC NEEDS POLICY

PER COMMUNITY SERVICE GUIDELINES, IT IS THE APPLICANT / RECIPIENT'S RESPONSIBILITY TO UTILIZE ANY AVAILABLE BENEFITS OR RESOURCES TO REDUCE THE NEED FOR GENERAL ASSISTANCE.

COMMUNITY SERVICE DEPARTMENT WILL DIRECT THE APPLICANT / RECIPIENT TO APPLY FOR OTHER RESOURCES AND WILL REQUIRE AN APPLICANT / RECIPIENT TO USE FURTHER RESOURCES TO MEET BASIC NEEDS, IN ORDER TO REDUCE THE NEED AND DEPENDANCY ON GENERAL ASSISTANCE.

* WHILE WORKING WITH ALLENTOWN WELFARE, YOU ARE REQUIRED TO USE YOUR EARNED OR UNEARNED RESOURCES FOR BASIC NEEDS ONLY. THESE ARE RENT, FOOD, NON-FOOD HYGIENE ITEMS, UTILITIES OR PRESCRIPTIONS.

* THE COST OF PUBLIC TRANSPORTATION WILL BE ALLOWED IF NEEDED FOR WORK OR MEDICAL APPOINTMENTS OR OTHER APPOINTMENTS NECESSARY TO MEET CONDITIONS OF ASSISTANCE.

* PAYMENT OF TELEPHONES ARE NOT ALLOWED UNLESS A MEDICAL NOTE FROM A LICENSED PHYSICIAN THAT THE ABSENCE OF A TELEPHONE CREATES AN UNREASONABLE RISK TO HEALTH AND SAFETY.

* CAR PAYMENTS, INSURANCE PAYMENTS, CREDIT CARD PAYMENTS, BAIL PAYMENT, LOAN PAYMENTS, REPAYMENT OF PERSONAL LOANS AND OTHER MISCELLANEOUS PAYMENTS WILL BE CONSIDERED UNALLOWABLE EXPENSES.

* AS A CONDITION OF ASSISTANCE APPLICANTS ARE REQUIRED TO MAKE USE OF ALL AVAILABLE RESOURCES, TO MEET BASIC NEEDS.

* DATED RECEIPTS FOR BASIC NEEDS ARE REQUIRED FOR FURTHER SERVICE, OR ASSISTANCE WILL BE REDUCED, DENIED OR A SANCTION MAY BE ISSUED.
FORM A
ALLENSTOWN
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:

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Social Security #</th>
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</thead>
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</tbody>
</table>

INSURANCE COVERAGE: __________________________

If at your current address less than 12 months, please list past 12 month's addresses:

<table>
<thead>
<tr>
<th>Street</th>
<th>Town/City</th>
<th>State</th>
<th>Dates of Residence</th>
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<tbody>
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</table>
2. Housing Information:

Rent amount __________________ per (month/week) ______________ Date last paid ______________ Date due ______________

Do you have a current: □ Demand For Rent □ Notice to Quit □ Landlord/Tenant Writ

Total rent owed __________________ Do you have a housing subsidy? ______________

Utilities Included: □ Heat □ Electric □ Gas □ Water/Sewer □ Other

Number of Bedrooms ______________

LANDLORD: Name __________________________ Telephone __________________________

Address __________________________

IF HOME-OWNER: Mortgage Amount ______________ Date last paid ______________ Owed ______________

Bank/Mortgage Co __________________________ Address __________________________

3. Education / Training / Employment

<table>
<thead>
<tr>
<th>Applicant:</th>
<th>G.E.D. or Diploma</th>
<th>Special Training or Skills</th>
<th>Military Service</th>
</tr>
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<tr>
<th>Spouse/Co-Applicant:</th>
<th></th>
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</thead>
</table>

Applicant Work History:

Are you employed now?________ Employer __________________ Position __________________

When began work ______________ Date/Amount of most recent check __________________

Are you unemployed now? _______ Reason __________________

Date last worked ______________ Employer __________________ Date/Amount last check __________________

Are you able to work now? _______ If not able, why not? __________________

Current and two most recent jobs of yourself and all household members aged 18 & older:

<table>
<thead>
<tr>
<th>Name</th>
<th>Employer</th>
<th>Pay</th>
<th>Weekly/Biweekly</th>
<th>Employment Dates</th>
<th>Reason for Leaving</th>
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</table>
4. **Household Assets:**

Provide information regarding accounts held by you and all household members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Bank/Credit Union</th>
<th>Savings Acct. #</th>
<th>Savings Balance</th>
<th>Checking Acct. #</th>
<th>Checking Balance</th>
</tr>
</thead>
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</table>

Provide current value of any assets held by you and all household members:

- Cash on hand (all household combined)
- Certificates of Deposit (CD's)
- Savings Bonds
- Mutual Funds
- Annuities
- Stocks
- Trust Funds
- Retirement Accounts
- Insurance Policies (cash value)
- 401k
- Property other than primary residence
- Location
- Other Investments
- Motorcycles/Boats/Snowmobiles/ATV's/RV's

Other Assets (please list)

Claims/settlements/income due to you or any household member:

- IRS Refund
- Insurance Claim
- Retroactive disability check
- Retroactive Unemployment or Worker's Compensation check
- Inheritance

Other Lump Sum Payment (explain)

Have you or any household member consulted a lawyer regarding a possible lawsuit?:

Lawyer Name/Address

Reason

Do you or any household member have a lawsuit pending?:

Who?

Please give details

Lawyer Name/Address

Motor vehicles owned by you and all household members:

<table>
<thead>
<tr>
<th>Owner</th>
<th>Auto Make</th>
<th>Model</th>
<th>Year</th>
<th>Value</th>
<th>Payments</th>
<th>Insurance</th>
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</table>
### 5. Household Income

Indicate any benefits or income received or applied for by you or any household member:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Name</th>
<th>Date Applied</th>
<th>Date Last Received</th>
<th>Monthly Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOB INCOME (net monthly)</td>
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<td>JOB INCOME (net monthly)</td>
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<td>APTD</td>
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<tr>
<td>Child Support</td>
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<tr>
<td>Disability (Employer)</td>
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<tr>
<td>Food Stamps</td>
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<tr>
<td>Fuel Assistance</td>
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<tr>
<td>Gifts/Loans</td>
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<tr>
<td>Maternity Benefits</td>
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<tr>
<td>Medicaid</td>
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<tr>
<td>OAA (Old Age Assistance)</td>
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<td>Retirement</td>
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<tr>
<td>Severance Pay</td>
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<tr>
<td>Social Security</td>
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<td>SSDI (SS Disability)</td>
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<td>SSI (Supplemental Security)</td>
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<td>TANF</td>
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<td>Unemployment</td>
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<td>Vacation Pay</td>
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<td>Veteran’s Pension</td>
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<td>Vocational Rehabilitation</td>
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<td>WIC (Women/Infants/Children)</td>
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<tr>
<td>Worker’s Compensation</td>
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<td>Other: [ ]</td>
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</table>

Are you or any other household member working, volunteering, and/or receiving assistance from any other agencies?

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency Name</th>
<th>Contact Person</th>
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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.)

Mortgage  Lot Rent  Electric  
Prescriptions  Food  Rent  
Child Support  Fuel Oil  Rent-To-Own  
Car Gasoline  Gas, Bottled  Car Insurance  
Gas, Natural  Car Payment  Health Insurance  
Telephone  Other  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 Repairs  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**

________________________________________________________________________

**Spouse or Co-applicant Signature**

________________________________________________________________________

**Signature of person completing form**

(if not applicant)

________________________________________________________________________

**Date**

________________________________________________________________________

**Date**

________________________________________________________________________

**Date**
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
FORM B

AUTHORIZATION FOR THE RELEASE OF INFORMATION – DHHS

I, _______________________________________, the undersigned, understand that from time to time, the local welfare administrator for ______________________________________ may require certain 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 outlined below:

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Purpose for Requesting this Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance</td>
</tr>
<tr>
<td>Date my Medicaid case opened and my Medicaid Identification Number(s)</td>
<td>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</td>
</tr>
<tr>
<td>Date of any sanction of my cash assistance grant</td>
<td>Determining countable household income also called “deeming”</td>
</tr>
<tr>
<td>Reason for any sanction of my cash assistance grant</td>
<td>Helping me to remove the sanction</td>
</tr>
</tbody>
</table>

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

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                                  Date
FORM I

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 __________
FORM J

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: ___________________________

__________________________

Number of bedrooms ______

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: $ ____________ Total rent currently owed: $ ____________

(if back rent is owed, please attach accounting of 3 months’ payment history)

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)

_____________________________________________ Telephone / Fax Numbers

_____________________________________________ Landlord’s Name

_____________________________________________ Landlord Address

_____________________________________________ Cell Phone

_____________________________________________ Name of Manager or other Representative

_____________________________________________ Landlord Signature

_____________________________________________ Date
<table>
<thead>
<tr>
<th>RESULTS</th>
<th>DAY</th>
<th>CONTACTED PERSON</th>
<th>MAIL/RESUME CONTACT TYPE</th>
<th>JOB OR TYPE</th>
<th>NUMBER</th>
<th>EMPLOYER NAME</th>
<th>DATE</th>
</tr>
</thead>
</table>

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.

NAME:

EMPLOYMENT SEARCH RECORD