Welfare Administrator 16 School Street Allenstown, NH 03275



Application for Burial/Cremation Assistance

1. General Information for the departed:

Date of Application:	e of Application: Name of Funeral Home/Cremation Service:			
Name of departed:	uding middle initial & maiden name if applica	Date of Birth:		
Address:		If different mailing address also		
Telephone:	Social Security numbe	er:US Citizen?		
Marital Status:	Rent or Own?	How long at this address?		
Spouse		SS#		
Spouse address (if not sat	me as applicant)			
What emergency help do	you request:			
·				
Has the departed applied	for local assistance in any city/town b	efore? 🗆 Yes 🗆 No 🗖 Not Known		
When?	Where?	Under what name?		
-	s living in the departed's home?			
Full N	vame	Relationship		

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Has the departed e	ever served in the milita	ry?	Veteran?		
Was the departed	receiving benefits?	How	much?	Dates served:	
Branch:	Does t	the departed ha	ave an Honorable	e Discharge?	
Departed/Imm	ediate Family Memb	er Assets:			
	er, mother, stepfather		son, daughter,	husband or wife (RSA	A 165:19)
Bank Accounts?	🗌 Yes 🔲 No				
Provide information	on regarding accounts h	eld by the den	arted and all imm	nediate adult family me	mhers
	0 0	Savings 1	<u>Savings</u>	Checking	/110015.
<u>Name</u>	Bank/Credit Union	Acct.#	Balance	Balance	
Any current valu	e of assets held by the	departed and	l all immediate	family members?	Yes
Cash on hand: (all	household combined)		Certifi	cates of Deposit (CD's)):
Savings Bonds:	Mutual Fi	unds:	Annuit	ies: Stock	:s:
Trust Funds:	Retiremen	nt Funds:	Insurar	nce Policies: (cash valu	ue)
401K: Prop	perty other than primary	residence:		Location:	
	ase list)				
T					
Any claims/settle	ments due to the depa	rted or any in	nmediate family	members? Yes	🗆 No
IRS Refund:	Insurance C	Claim:	Retro	active disability check:	
		a .	CI 1	Inheritance: _	

Has the departed or any immediate family members in the line of father, mother, stepfather, stepmother, son, daughter, husband or wife consulted a lawyer regarding a possible lawsuit?

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4. Does the departed or any immediate family members have Unearned Income? Yes No

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

	Name &Household Members Name	Date Applied	Date Last Received	Monthly Amount
ANB (Aid to the Needy Blind)				
APTD (Aid to the Permanent & Total Dis	sabled)		<u> </u>	
Disability (Employer-short or long	term)			
Gifts/Loans				
Medicaid				
Retirement				
Severance Pay				
Social Security (Retirement)				
SSDI (SS Disability)				
SSI (Supplemental Security)				
TANF				
Unemployment				
Veteran's Pension				
Worker's Compensation				
Other:				

4. <u>Liability for Support Information</u> (Must complete this section do not leave blank)

Please provide the following information for all immediate family members in the line of *father*, *mother*, *stepfather*, *stepmother*, *son*, *daughter*, *husband* or *wife*, whether or not they reside in the departed's household. RSA 165:19

Name	Address	Phone #	Income Source	Average Monthly Income

1. <u>Certifications /Signatures/ Release of Information:</u>

I understand I may be required to provide financial information to determine immediate family members ability to assist with the need, in the line of father, mother, stepfather, stepmother, son, daughter, husband or wife, whether or not they reside in the departed's household. Should a relation refuse to render such financial information when requested, such person or persons could be summoned to appear in court for determination of ability to assist. RSA 165:19

I understand that immediate family members may be required to repay any assistance provided, if returned to an income status, and/or receive available financial resources, including income tax refund(s), which enables reimbursement without financial hardship. RSA 165:20-b.

I understand that if assisted, the municipality may place a lien against any property settlement or civil judgment for personal injuries (except any workers compensation settlement), received within six years of receiving municipal assistance. RSA 165:28-a.

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 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 immediate family 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 crimes of Unsworn Falsification RSA 641:3, Theft by Deception RSA 637:4 and/or Identity Fraud 638:27, which can result in imprisonment.



Release of Information



I/We _____authorize any relative, physician, lawyer, banker, landlord, insurance company, mental health professional, school official or other person or organization having information concerning my/our circumstances to furnish such information to Allenstown NH Welfare. I/We also authorize the IRS, Social Security Administration, any State or County Division of Health & Human Services, Division of Children Youth and Families, Division of Adult & Elderly, NH Legal Assistance, City/Town Welfare Department, Homeless Shelter, Department of Employment Security, Veteran's Administration and Fuel Assistance, or any non-profit agency to release information from their files to Allenstown NH Welfare.

I also waive my right to privacy and confidentiality contained in my file and/or any information received by Allenstown NH Welfare and authorize to release such information to other agencies to the extent that such release is made to further my application for, or receipt of, assistance from that agency.

This authorization shall expire 180 days from the date it is signed.



Signature of person completing form

Relationship to departed

Date