

TOWN OF OSS�PEE
Application for Assistance
REQUIRED VERIFICATIONS

Applicant Name: _____ Date: _____

Social Security Number: _____ D.O.B: _____

Co-Applicant Name: _____ Date: _____

Social Security Number: _____ D.O.B: _____

Physical Address: _____ Phone: _____

Mailing Address: _____ Cell: _____

YOU MUST PROVIDE THE FOLLOWING VERIFICATIONS/DOCUMENTS AT TIME OF APPOINTMENT OR ASSISTANCE MAY BE DELAYED OR DENIED.

- Completed Application
- Rental Verification and copy of any written lease agreement.
- Last four (4) weeks receipts or other proof of bills paid or currently due, Utility disconnect notices.
- Last four (4) weeks pay stubs or other proof of net wages for all adult members living in the residence.
- Employment verification from your employer.
- Employment termination from your last employer.
- You have applied at DHHS district office for /are receiving Social Security Benefits.
 - Emergency Food Stamps Food Stamps TANF
 - Title XX Daycare APTD/MA OAA
 - TANF Emergency Assistance SSI SSDI
- You have applied for /are receiving Unemployment Compensation.
- You have applied for /are receiving Fuel Assistance Benefits.
- Verification of injury or illness -
- If available, picture ID (Adults); Birth Certificate(s)/SS Card(s) (Minors)
- Vehicle registration(s).
- Savings and Checking account(s), liquid asset statement(s), Bankbook(s)
- Statement child support payments received/Child support court-ordered payments made.
- Statement from room-mate(s) regarding division of expenses
- NH Housing Benefit

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, participate in workfare and meet any/all compliance requirements on my Notice of Decision within the stated time frame.

Applicant Signature

Co-Applicant Signature

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 1**

Date of Application: _____ Referred by: _____

1. GENERAL INFORMATION

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Physical Address: _____

Mailing Address: _____

Telephone: _____ Cell: _____ SS #: _____ U.S. Citizen: _____

Telephone: _____ Cell: _____ SS #: _____ U.S. Citizen: _____

Marital Status: _____ Rent or Own: _____ How long at this address: _____

Spouse/Co-Applicant Name: _____ SS #: _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 2**

2. Housing Information:

Rent Amount: _____ per (mo/wk) _____ Date last paid _____ Date due: _____

Do you have current: Demand for Rent Notice to Quit Landlord/Tenant Writ

Total rent owed: _____ Do you have a housings subsidy?: _____

Utilities included: Heat Electric Gas Water/Sewer Other

LANDLORD: Name: _____ Telephone: _____

Address: _____

IF HOME OWNER: Mortgage Amount _____ Date last paid _____ Owed _____

Bank/Mortgage Co. _____ Address: _____

3. Education/Training/Employment

	<u>Highest Grade Attended</u>	<u>G.E.D. or Diploma</u>	<u>Special Training /Skills</u>	<u>Military Service</u>
Applicant:	_____	_____	_____	_____
Spouse/Co-Applicant:	_____	_____	_____	_____

Applicant Work History:

Are you employed now: _____ Employer: _____ Position: _____

When began work: _____ Date & Amount of most recent check: _____

Are you employed now: _____ If no, Reason _____

Date last worked: _____ Employer: _____ Date/Amt 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:

<u>Name</u>	<u>Employer</u>	<u>Pay/Hr</u>	<u>Pay/Wk</u>	<u>Paid Weekly Or Biweekly</u>	<u>Employment Dates</u>	<u>Reason for Leaving</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 3**

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 (Supplemental SS Disability)	_____	_____	_____	_____
SSI (Supplemental Security)	_____	_____	_____	_____
TANF	_____	_____	_____	_____
Unemployment	_____	_____	_____	_____
Vacation Pay	_____	_____	_____	_____
Veteran's Pension	_____	_____	_____	_____
Vocational Rehabilitation	_____	_____	_____	_____
WIC (Women/Infants/Children)	_____	_____	_____	_____
Worker's Compensation	_____	_____	_____	_____
New Hampshire Housing Benefit	_____	_____	_____	_____
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>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 4**

4. Household Assets:

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

Name	Bank/Credit Union	Savings Acct #	Savings Balance	Checking Acct #	Checking Balance
Provide Current value of any assets held by you and all household members:					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Cash on hand (all household combined) _____ Certificate 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:

<u>Owner</u>	<u>Auto Make</u>	<u>Model</u>	<u>Year</u>	<u>Value</u>	<u>Payments</u>	<u>Insurance</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 5**

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 _____	Prescriptions _____
Bus/Cab _____	Electric _____	Rent _____
Cable/Internet _____	Food _____	Rent-To-Own _____
Child Support Paid _____	Fuel Oil _____	School Loan _____
Car Gasoline _____	Gas Bottled _____	Storage _____
Car Insurance _____	Health Insurance _____	Telephone _____
Car Payment _____	Laundromat _____	Cell Phone _____
Condo Fee _____	Loan _____	Other _____
Child Care _____	Lot Rent _____	Other _____
Credit Card _____	Mortgage _____	Other _____

List unplanned, emergency or irregular periodic expenses during the past 30 days:

Car Inspection _____	Driver's 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 Co-applicant's adult children _____

9. Certifications and Signatures

I understand that if I receive assistance from the Town of Ossipee 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 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 Town of Ossipee 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 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 Town of Ossipee 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 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 Town of Ossipee, and I later quit the job without good cause, I may be ineligible for local assistance from the Town of Ossipee 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 Town of Ossipee 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 OSSIPEE – APPLICATION FOR ASSISTANCE
PAGE – 7**

AUTHORIZATION FOR THE RELEASE OF INFORMATION -DHHS

I, _____, the undersigned, understand that from time to time,
Print Your Name

the local welfare administrator for **OSSIPEE** 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:

Type of Information	Purpose for Requesting this Information
Date of DFA of assistance applied for, date of eligibility determination, expected date of benefit issuance, amount of cash grant (if applicable) the reason my case closed or my application was denied	Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance
Date my Medicaid case opened and my Medicaid Identification	Processing of Medicaid reimbursements during the time my Medicaid application was pending, the local welfare administrator makes an expenditure on my behalf for an item covered by Medicaid
Date of any sanction of my cash assistance grant	Determining countable household income also called "deeming"
Reason for any sanction of my cash assistance grant	Helping me to remove the sanction

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 Applicant

 Date

 Signature Co-Applicant

 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

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 8**

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 circumstances to furnish such information to the Ossipee Welfare Department. I/We also authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Services, Division of Children Youth and Families, Division of Adult and Elderly, New Hampshire Legal Assistance, any City/Town Welfare Department, Department of Employment Security, Veteran's Administration and Fuel Assistance, shelter, or any non-profit agency to release information from their files to the Ossipee Welfare Department .

Applicant Signature

Date

Spouse or Co-applicant Signature

Date

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

Date

**TOWN OF OSS�PEE – APPLICATION FOR ASSISTANCE
PAGE – 9**

**APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION
(Specific Agency)**

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, **Welfare Director** of **The Town of OSS�PEE** 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

Co-Applicant

Date

Welfare Official

MEDICAL RELEASE AND REPORT

APPLICANT NAME: _____ D.O.B.: _____

SOCIAL SECURITY NUMBER: _____

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 date of my signature below:

APPLICANT SIGNATURE

DATE

CO-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 Town of Ossipee 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 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: _____ Date: _____

Signature: _____

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 started work: _____ Hourly Pay Rate: _____

Full/part time: _____ Hours per week: _____ Paid Weekly bi/weekly 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 OSS�PEE – APPLICATION FOR ASSISTANCE

PAGE – 12

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: \$ _____ 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: \$ _____ # of months _____
(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 Number

Landlord Address

Name of Manager or other Representative

Landlord Signature Date

**TOWN OF OSSIPEE – APPLICATION FOR ASSISTANCE
PAGE – 13**

**NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE
FROM THE TOWN OF OSSIPEE**

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) 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 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 or to conduct a job search if you must search, if you must care for a child under the age of five (5), if you are disabled or ill, or if you must take care of a member of your family who is disabled or ill.