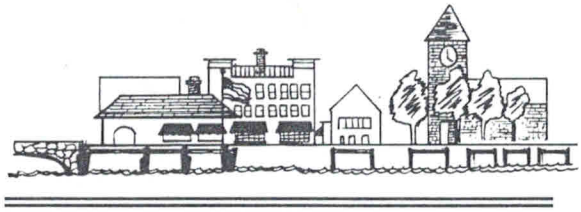

Town of
Wolfeboro
www.wolfeboronh.us

WELFARE DIRECTOR
Amy Capone-Muccio

Welfare Department
Application for Assistance

REQUIRED DOCUMENTATION CHECKLIST: All information necessary is required to complete the application process

[ ] Picture ID (adults) Birth Certificate/Social Security cards (children)
[ ] Vehicle registration(s)
[ ] Form A- Application for Assistance completed and signed
[ ] Form B- Authorized for Release of Information from DHHS (if applicable)
[ ] Proof of ALL household income in the past 30 days, from the date of application. Pay stubs or other or other proof of net wages for last 30 days.
[ ] Bank statements for all checking and savings accounts and statements for any other liquid asset accounts.
[ ] Form D –Applicant's Authorization to Furnish Information (all applicants)
[ ] Receipts or other proof of bills/expenses paid in the last 30 days.
[ ] Form H- Employment verification from your employer if applicable.
[ ] Written Agency Verification of any of the following programs: WIC FS TANF/EAP MA/APTD TITLEXX HUD FAP WC HEALTHLINK/COMMCARE SS/SSI MEDICATION CONNECTION CAP 2-1-1 other _____
[ ] Form G-Medical Release and/or Report (if applicable)
[ ] Physician's statement of inability to work such as verification of injury of illness (if applicable)
[ ] Documentation of application to the Department of Employment Security for the following: Work registration_____ Unemployment Compensation_____ Potential benefit amount $_____
[ ] Eviction paperwork (if applicable)
[ ] Lease/Rental Agreement (singed by the tenant(s) and landlord(s) or property manager
[ ] Mortgage statement/agreement
[ ] Form T Social Security Administration Consent for Release of Information
[ ] Form U Unemployment Compensation and Release form
[ ] Form V Child Support Release Form
[ ] Form W Client Self-Declaration of Off Jobs or Other Undocumented Self Employment
[ ] Copy of latest IRS Income Tax Return or signed Form 4506-T-Requst of Transcript of Tax Return

South Main Street Post Office Box 629 Wolfeboro, New Hampshire 03894
(603) 569-8151 Fax (603) 569-8167

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INCORPORATED 1770

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BASIC NEEDS POLICY

Per the TOWN OF WOLFEBORO Welfare guidlines, it is the applicant/recipient's responsibility to utilize any available benefits or resources to reduce the need for general assistance. This department will direct the applicant/recipient to apply for all other resources and also will require the applicant/recipient to use current resources to meet basic needs in order to reduce the need for general assistance.

While working with this department, you will be required to use your earned or unearned resources for basic needs only. These are:

Rent/Mortgage	Diapers
Food	Utilities
Non-food hygiene products	Prescriptions

The cost of public transportation will be allowed if needed for work or medical appointments or other appointments made in order to meet conditions of assistance.

Following are examples of what may be UNALLOWABLE expenses in determining eligibility:

Telephone	Insurance Payments
Credit Card Payments	Bail Payments
Loan Payments	Repayment of personal loans
Cable & Internet	Restaurant/Fast Food
Miscellaneous Payments	Tobacco/Alcohol Products

As a condition of assistance, you will be required to first use all available resources, as directed, to meet your basic needs. Unaltered, dated receipts for these expenses are required. Should you choose to use your resources for other than basic needs as outlined above and/or in your written decision from this department, those amounts will be considered available to you, and assistance will be reduced accordingly, a sanction or denial may be issued.

I/We have read and reviewed the Basic Needs Policy with my/our Welfare Director.

Applicant:	Co-Applicant:
_____	_____
Signature: _____	Signature: _____
Date: _____	Date: _____

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THIS APPLICATION IS A LEGAL DOCUMENT

Please read carefully before completing this application for assistance. Once submitted to the department for consideration, the application and related material become the property of the TOWN OF WOLFEBORO and shall be considered confidential.

It shall be the right of any individual regardless of race, age, gender, sexual orientation, religious or political affiliation to apply for local welfare assistance.

Each application will be reviewed with the applicant in order to make a determination regarding the applicant's eligibility for assistance. If the applicant does not agree with the decision of the Welfare Director regarding the determination of eligibility based on the current Welfare Guidelines of the TOWN OF WOLFEBORO, the applicant may request a Fair Hearing within five (5) days of the date of such written decision.

YOU, THE APPLICANT, ARE RESPONSIBLE AT EACH APPOINTMENT FOR PROVIDING FULL AND ACCURATE INFORMATION REGARDING YOUR HOUSEHOLD INCOME AND EXPENSES, HOUSEHOLD MEMBERS, CURRENT ADDRESS, DETAILS OF YOUR CURRENT SITUATION AND ANY CHANGES IN REGARDS TO THIS INFORMATION.

All questions must be answered fully. Failure to complete any part of this application may delay processing the request for assistance. Blank spaces will be considered an omission of information. Applicants must comply with any requests for information by the Welfare Director necessary for determination and investigation of applicant's eligibility for assistance. Failure to comply with requests may result in withdrawal of the application for assistance, denial of assistance requested, or suspension pursuant to RSA 165:1- b.

* If a question on this form is unclear to you, discuss it with the welfare official.

APPLICATION FOR ASSISTANCE

Date of Application _____ Referred By _____

Assistance Requested _____

Reasons for Request _____

1. General Information

Applicant

Name: _____ Date of Birth: _____

Current Address _____

Mailing Address, if different _____

Home Phone _____ Rent or Own? ____ How long at this address? _____

Type of Housing: _ House _ Apt _ Mobile Home Other: _____

Household Composition: # 18 & Over ___ # under 18 ___ # of Bedrooms ___

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

Street	Town/City	State	Dates of Residence
_____	_____	_____	_____
_____	_____	_____	_____

Cell Phone:_____ Work Phone:_____ Social Security#_____

E-Mail Address: _____ Marital Status: _____

Education: _ High School Diploma _ Less than HS Diploma _ GED _ Some College
_ 2 Year Associates _ 4 Year Bachelor _ Graduate Studies

Citizenship: _ United States _ Other: _____

Ethnicity: _ White/Caucasian _ Other: _____

Special Training/Skills: _____

Currently employed? _ Full Time _ Part Time _ Self Employed _ Unemployed

Have you applied for local assistance before? _ Yes _ No When? _____

Where? _____ Under What Name? _____

Actively serving in the U.S. Military? _ Yes _ No If YES, Branch _____

U.S. Veteran? _ Yes _ No Discharge Date: Month ____ Year ____
Discharge Status: _ Honorable _ Dishonorable _ Other

Do you have Medicare or Medicaid? (circle one) ID Number: _____

Other Insurance:_____ EBT Card # _____

Spouse/Co- Applicant

Name: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Social Security# _____

E-Mail Address: _____ Marital Status: _____

Education: _ High School Diploma _ Less than HS Diploma _ GED _ Some College
_ 2 Year Associates _ 4 Year Bachelor _ Graduate Studies

Citizenship: _ United States _ Other: _____

Ethnicity: _ White/Caucasian _ Other: _____

Special Training/Skills: _____

Currently employed? _ Full Time _ Part Time _ Self Employed _ Unemployed

Have you applied for local assistance before? _ Yes _ No When? _____

Where? _____ Under What Name? _____

Actively serving in the U.S. Military? _ Yes _ No If YES, Branch _____

U.S. Veteran? _ Yes _ No Discharge Date: Month ____ Year ____
Discharge Status: _ Honorable _ Dishonorable _ Other

Do you have Medicare or Medicaid? (circle one) ID Number: _____

Other Insurance: _____ EBT Card # _____

Other Household Members: List all persons living in your household

Full Name	Relation	Birth Date	Social Security #	Health Insurnace

If children listed have a biological parent not residing with you, list information on each child's biological parent. (Do not list yourself under Parent's Name)

Parent's Full Name	Relationship	Birth Date	Social Security #

2. Employment History

Applicant

Employer_____ Position _____

Date you started work:_____ Date & Amount of last paycheck:_____

Pay Period Frequency: _ Daily _ Weekly _ Bi-Weekly _ Monthly _ Quarterly

If you are currently unemployed, state reason: _____

Former Employer_____ Position _____

Date last worked:_____ Date & Amount of last paycheck:_____

Are you able to work now? _ Yes _ No If NO, why not?_____

List two most recent jobs before current:

Employer	Pay	Employment Dates	Reason for Leaving

Spouse/Co- Applicant

Employer_____ Position _____

Date you started work:_____ Date & Amount of last paycheck:_____

Pay Period Frequency: _ Daily _ Weekly _ Bi-Weekly _ Monthly _ Quarterly

If you are currently unemployed, state reason: _____

Former Employer_____ Position _____

Date last worked:_____ Date & Amount of last paycheck:_____

Are you able to work now? _ Yes _ No If NO, why not?_____

List two most recent jobs before current:

Employer	Pay	Employment Dates	Reason for Leaving

Work History for Other Household Members over 18: List two most recent jobs

Name	Employer	Pay	Employment Dates	Reason for Leaving

3. Housing Information

Rent $ _____ per (month/week) Date last paid _____ Date Due _____

Currently have: _ Demand for Rent/Notice to Quit _ Landlord/Tenant Writ

Total Rent Owed _____

Do you have a housing subsidy? _ Yes _ No If YES, how much? _____

Utilities Included: _ Heat _ Electric _ Gas _ Water/Sewer _ Other _____

LANDLORD: Name _____ Telephone _____

Address _____

IF HOME-OWNER:

Mortgage Payment: _____ Date last paid _____ Date Due _____

Bank/Mortgage Co _____ Telephone _____

Address _____

Do you have a foreclosure notice? _ Yes _ No

4. Household Assets

Provide account information & current balances held by all household members:

Household Member	Bank/Credit Union	Savings Acct. #	Savings Balance	Checking Acct. #	Checking Balance

Provide current value of the following assets held by all household members:

Asset	Value	Household Member
Cash on Hand (household combined)		
Certificates of Deposit (CDs)		
Retirement		
401K		
Life Insurance (Cash Value)		
Investments		
Time Share		
Real Estate		

List Properties and Locations (other than primary residence): _____

_____

Motor vehicles owned by you and all household members:

Owner	Auto Make/Model	Year	Value	Payments	Insurance

5. Claims/Settlements/Income due to you or any household member

IRS Refund:_____ Date Rec:_____ Insurance Claim:_____ Date Rec:_____

Retroactive disability check:_____ Date Rec:_____

Retroactive Unemployment or Worker's Compensation check:_____ Date Rec:_____

Inheritance:_____ Date Rec:_____

Other Lump Sum Payment (explain):_____

Do you currently have an attorney pursuing any civil suit, workers compensation claim, a social security denial, etc? _ Yes _ No If YES, complete the following, and briefly explain the details of the situation:

Attorney Name _____ Phone number _____

Address _____

6. Household Income/Benefits

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

Income:	Household Member	Amount	Date Last Received
ANB (Aid to the Needy Blind)			
APTD (Aid to Perm/Totally Disabled)			
Child Support			
Charities/Churches			
Disability (STDA/LTDA - Work)			
Gifts/Loans			
Income Tax Refund			
Maternity Pay/Benefits			
OAA (Old Age Assistance)			
Retirement Benefit			

Income (continued):	Household Member	Amount	Date Last Received
Severance Pay			
Social Security (Retirement)			
SSDI (SS Disability)			
SSI (Supplemental Security)			
TANF			
Unemployment (DES)			
Veteran's Pension			
Worker's Compensation			
Other: _____			
Other: _____			

Benefits:

Child Care Assistance			
Food Stamps			
Fuel Assistance			
Medicaid			
WIC (Women/Infants/Children)			
Other: _____			
Other: _____			

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

Name	Agency Name and Phone#	Contact Person

7. Household Expenses

List actual or estimated regular expenses. (Not all expenses are allowable to be included in you eligibility determination, but all should be listed to show your financial situation.)

Expense	Monthly Expense	Any Amounts Past Due	Comments
Auto Fuel			
Auto Insurance			
Auto Loan			
Auto Registration/Inspection			
Auto Repairs			
Bank Fees			
Condo Assoc Fee			
Child Care			
Child Support Paid			
Credit Card			
Dental Care			
Diapers/Wipes			
Driver's License			
Electric			
Food			
Legal Fees/Fines			
Loan (Used for _____)			
Oil Heat			
Propane (Used for _____)			
Natural Gas (Used for _____)			
Health Insurance			
Home Repairs			
Home/Renter Insurance			
Laundry			
Medical Expenses			
Mortgage			
Prescritions			
Rent (Including _____)			

Expense (Continued)	Monthly Expense	Any Amounts Past Due	Comments
Rent - Option to Own			
Rent - MH Lot			
Storage Unit			
Taxes (Income/Property)			
Telephone (Landline/Cell)			
Telephone (Cable/Internet)			
Transportation (Bus/Cab)			
Water/Sewer Bill			
Other:			
Other:			
Other:			
Other:			

8. Extended Payment Arrangements

Do you or any household members currently have an EXTENDED PAYMENT ARRANGEMENT with an electric or fuel company? _ Yes _ No If YES, complete the following:

Utility Company Name	Amount	
	$	(Circle one) weekly biweekly monthly
	$	(Circle one) weekly biweekly monthly
	$	(Circle one) weekly biweekly monthly
	$	(Circle one) weekly biweekly monthly

9. Other Assistance

Has any other organization(s) or individual helped you pay any of your bills in the last four (4) weeks? _ Yes _ No If YES, complete the following:

Organization/Individual's Name	Bill Paid	Amount	Date Assisted
		$	
		$	
		$	
		$	
		$	

10. Criminal Information

Have you or any member of your household ever been convicted of a felony or misdemeanor which has not been annulled? _ Yes _ No
If YES, complete the following:

Name	Date	Town/City/State	Detail of Conviction

Are you or household member presently on parole or probation? _ Yes _ No
If YES, complete the following:

Name	Court	Parole/Probation Officer Name & Phone Number

11. Liability for Support Information

Parents/step-parents, spouse or grown children may be called upon to assist in time of need. Provide the following information:

APPLICANT:	Name	Address	Phone #
Father			
Mother			
Spouse, if not living with you:			

CO-APPLICANT:	Name	Address	Phone #
Father			
Mother			
Spouse, if not living with you:			

Adult Children:

List name, address and phone # of any adult children not living with you:

12. 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 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)

I understand that my parents/step- parents, spouse or grown children may be called upon to assist me when in need of relief if they can do so without financial hardship to themselves. (RSA 165:19)

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) and/or Theft by Deception. (RSA 637)

Authorization to Release or Exchange Information *

I/ We authorize any relative, physician, attorney, banker, employer, insurance company, landlord/shelter staff or any other person(s) or organization(s) having information concerning my circumstances to furnish such information to the TOWN OF WOLFEBORO Welfare Director. The Social Security Administration, the Division of Health & Human Services and the Department of Employment Security may release information in their files to this office. I/ we authorize the TOWN OF WOLFEBORO Welfare to release information as requested to the Division of Health & Human Services, Social Security Administration, Department of Employment Security, school personnel, attorney, physician, landlord, other town welfare offices, or any agencies providing supportive services regarding medical, housing/shelter, or financial assistance.

Applicant	Co- Applicant
_____	_____
Print Name	Print Name
Signature:_____	Signature:_____
Date:_____	Date:_____

_____ _____ _____

Signature of person completing form (if not the applicant) | Print Name | Date

** The above authorization to release or receive information is in effect for as long as the applicant is currently seeking assistance from the TOWN OF WOLFEBORO Welfare Director or up to six (6) months after assistance has ended.*

TOWN OF WOLFEBORO
PO BOX 629
WOLFEBORO, NH 03894
(603) 569-8151 fax: (603) 569-8167
welfaredirector@wolfeboronh.us

AUTHORIZATION FOR RELEASE OF INFORMATION

I/We, the undersigned, understand that from time to time, the local Welfare Director of the TOWN OF WOLFEBORO may require certain information about assistance I am applying for or receiving from the NH 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 Director for the specifc purposes outlined below:

Type of Information	Purpose for Requesting this Information
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.	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 Number(s).	Processing of Medicaid reimbursements if/when, during the time my Medicaid application was pending, the local wefare 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.

Applicant:	Co-Applicant:
_____	_____
Signature: _____	Signature: _____
Date: _____	Date: _____

If the signature(s) above is/are not that of the person(s) 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(s) in these matters with DFA must be provided upon DFA request.

_____ _____ _____

Relationship to You Witness Date

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FAIR HEARING REQUEST PROCEDURE

You have the right to request a fair hearing within five (5) working days of receipt of a notice of denial or suspension of benefits, or a decision which you wish to challenge. To review this decision, the fair hearing will be conducted by an impartial hearings officer. You will have an opportunity to review the contents of your welfare file prior to your hearing and present your case to the hearings officer, who will render a decision within seven (7) working days of the hearing. You may request that your assistance continue until the decision has been rendered.

Please complete and sign the form below to request a fair hearing, and return the form to the municipal office.

FAIR HEARING REQUEST

I/We, _____, request a Fair Hearing to
(Print your Name or Names of Co-Applicants)

review the decision of _____ concerning the request for assistance
(Date of Decision)

from the TOWN OF WOLFEBORO.

I/We __ want / __ do not want (check one) assistance to continue until the hearing decision.

I/We understand that if I/we lose the hearing, I/we will owe the amount of assistance granted to me/us from the date of the disputed decision to the date of the Fair Hearing decision. I/We have received and read the 'Fair Hearings' section of the General Assistance Guidelines.

_____ _____
Applicant Signature Co-Applicant Signature

_____
Address

_____
Date

TOWN OF WOLFEBORO
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EMPLOYMENT CONTACT WORK SEARCH

For: _____

DATE	** TYPE OF CONTACT	COMPANY NAME AND ADDRESS	COMPANY PHONE#	CONTACT PERSON (Name/Title)	POSITION APPLIED FOR	INTERVIEW (Yes or No)	**SEARCH RESULTS	CONTACT PERSON SIGNATURE
4/1/2010	Telephone	A New Hampshire Company Main St, Concord	555-1212	Mr.Smith, Human Resource Manager	Salesperson	Yes	Hired	

** TYPE OF CONTACT: i.e. Visit, Telephone, Mail, Electronic
(If applying electronically, you must provide proof of submission.)

** SEARCH RESULTS: i.e. Applied, Interviewed, Hired, Not Qualified

Under New Hampshire Law RSA 165:1- b and the TOWN OF WOLFEBORO Welfare Guidelines, applicants for general assistance are required to diligently search for employment and accept said employment when offered. You are required to provide the TOWN OF WOLFEBORO Welfare with an accurate and complete record of 5 employment opportunities by __/__/____. All sections of this form must be completed (see example above). Incomplete or illegible Contact Work Search forms will not be accepted as valid. The Welfare has the authorization to contact potential employers listed on this sheet for verification purposes. Providing false information shall result in suspension of assistance under RSA 165:1- b and may result in criminal charges.

Signature of this document signifies understanding of and consent to the above referenced laws/requirements.

_____ _____
Signature of Applicant Date

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EMPLOYMENT VERIFICATION FORM

I, _____, authorize the release of information regarding my employment to the TOWN OF WOLFEBORO.

Signature: _____ *Date:* _____

This form is to be completed by the employer / former employer or it shall not be accepted as valid.

Name of Employee: _____ SS#: ___-___-____

Employer Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Starting Date of Employment: _____ Hourly Pay Rate: $_____

Type of Position: ___ Full-Time ___ Part-Time ___ Temporary

Please indicate time frame expected to work: _____

Frequency of Pay: ___ Weekly ___ Bi-Weekly ___ Other: _____

Paid By: ___ Check ___ Direct Deposit

Please list the last four (4) Pay Periods and Amounts of Pay:

Date: _____ Amount: $_____

Date: _____ Amount: $_____

Date: _____ Amount: $_____

Date: _____ Amount: $_____

Employment Status: ___ Still Employed ___ Terminated/Separated

If termination/separation, please indicate date of last employment: _____

If termination/separation, please indicate reason for termination/separation:

___ Layoff
___ Voluntary Resignation
___ Dismissed with Cause
___ Temporary Leave (Medical or other personal leave)
___ Retired
___ Other: _____

Does this employee receive any of the following through his/her employment:

___ Credit Union Acct.
___ Medical Insurance
___ Life Insurance
___ Sick Pay
___ Retirement Plan (i.e.: 401K, IRA, etc.)
___ Short-Term Disability
___ Long-Term Disability
___ Other: _____

_____ _____
Authorized Company Signature Print Name

_____ _____ _____
Phone # E-mail Date

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LIABILITY OF RELATIVE FORM

This form and the attached Financial Statement must be completed by each relative as outlined in RSA 165:19 below.

This NH state law only applies when an individual is seeking municipal assistance (welfare). Relatives of such applicants hold a centain liability and this form is designed for relatives to identify what assistance they can provide, or not provide based on their current financial situation. The law is as follows:

165:19 Liability for Support - The relation of any poor person in the line of father, mother, stepfather, stepmother, son, daughter, husband, or wife shall assist or maintain such person when in need of relief. Said relation shall be deemed able to assist such person if his weekly income is more than sufficient to provide a reasonable subsistence compatible with decency and health. Should a relation refuse to render such aid when requested to do so by the county commissioner, selectman, or overseer of public welfare, such person or persons shall upon complaint of one of these officials be summoned to appear in the court. If, after hearing, it is found that the alleged poor person is in need of assistance, and that the relation is able to render such assistance, the court shall enter a decree accordingly and shall fix the amount and character of the assistance which the relation shall furnish. If the relation neglects or refuses to comply with the court order without good cause, as determined by the court at a hearing, or by refusing to work or otherwise voluntarily places himself in a position where he is unable to comply, he shall be deemed to be in contempt of court and shall be imprisoned not more than 90 nor fewer than 60 days. If a poor person has no relation of sufficient ability, the town or city in which he resides shall be liable for his support.

If you can provide assistance to this family, complete the following and return it to the address above. In order to be in compliance with the above statute, I __ am providing or __ will now begin to provide (check one) the following assistance to: _____.

(Fill in the dollar amounts for each category where applicable)

Rent $_____	Electric $_____	Fuel $_____	Car Gas $_____
Phone $_____	Other Utility $_____	Food $_____	Insurance $_____
Diapers $_____	Personal/Household $_____	Car Pmt(s) $_____	Other $_____

If you are unable to provide financial assistance, please complete the statement below and the attached Relative Financial Statement and return both to the address above.

I, _____, do hereby declare that I am
(Parent, Step-parent, son, daughter, husband, wife)

unable to provide support to the Applicant,_____,

for the reasons specifically cited below*. I attest to the validity of my statements, and recognize that I am bound to support the above named individual under state law when able to do so.

Please briefly describe any financial hardship which might preclude your ability to comply with the above (such as reduced work hours, illness, injury, etc.):

*_____

_____

_____

Signed:_____ Date:_____

Witness:_____

PLEASE COMPLETE THE ABOVE INFORMATION AND RETURN TO THE ADDRESS ABOVE. FAILURE TO PROVIDE THIS DOCUMENT MAY DELAY PROCESSING THE APPLICATION.

TOWN OF WOLFEBORO
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WOLFEBORO, NH 03894
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LIABILITY OF RELATIVE FORM

RELATIVE FINANCIAL STATEMENT TO BE COMPLETED WITH LIABILITY OF RELATIVE FORM

ELATIONSHIP TO APPLICANT (circle one)
Father Mother Step-Father Step-Mother Son Daughter Husband Wife

Your Name:_____ Employer:_____

Spouse:_____ Employer:_____

Address:_____

DEPENDENTS:

Name:_____ Age:___ Name:_____ Age:___

Name:_____ Age:___ Name:_____ Age:___

Name:_____ Age:___ Name:_____ Age:___

HOUSEHOLD INCOME AND ASSETS:

Gross Monthly Income $_____ Net Monthly Income $_____

Total Income Last Year $_____ Sources(s):_____

Savings Account Balance $_____ Checking Account Balance $_____

Stocks, Bonds, CDs $_____ Other $_____

Real or Personal Property $_____ Food Stamps $_____

Child Support $_____ per __Week __bi-weekly __monthly (check one)

MONTHLY HOUSEHOLD EXPENSES (Please list out of pocket expenses only):

Cable/Internet $_____ Child Support Paid $_____ Car Gas $_____

Car Insurance $_____ Car Payment $_____ Child Care $_____

Credit Card $_____ Electric $_____ Food $_____

Fuel Oil $_____ Natural Gas/Propane $_____ Health Insurance $_____

Life Insurance $_____ Loan $_____ Lot Rent $_____

Mortgage $_____ Prescriptions $_____ Rent $_____

Student Loans $_____ Telephone $_____ Home/Renter Ins. $_____

Medical $_____ Property Tax $_____ Water/Sewer $_____

Other $_____

I have read and understand the Liability of Relative Form attached including the requirements of RSA 165:19.

TOTAL MONTHLY INCOME $_____

TOTAL MONTHLY EXPENSES $_____

_____ _____ _____ _____

Signature Date Signature Date

TOWN OF WOLFEBORO
PO BOX 629
WOLFEBORO, NH 03894
(603) 569-8151 fax: (603) 569-8167
welfaredirector@wolfeboronh.us

Welfare

INTAKE FORM

Request Date: _____ Date of Birth | Soc.Sec.# | Cell Phone | Employed? Full/Part/Self/No

Applicant: _____

Co-Applicant: _____

Current Address: _____ Home Phone: _____

_____ Household Makeup: _____

Prior Address if less than 30 days at current address: _____ Homeless: __ Yes __ No

ASSISTANCE NEEDED: _____

REASON FOR SEEKING ASSISTANCE: _____

Number of Household Members

# of Adults _____ # of Children _____

Available Cash the Household has now: $_____

Complete the following if you are renting:	Complete the following if you own a home:
Rent Payment $_____ _ Monthly _ Weekly	Mortgage Payment $_____ _ Monthly _ Bi-Monthly
Do you have a Notice to Quit/Demand for Rent? _ Yes _ No	Do you have a foreclosure notice? _ Yes _ No
Do you have a Writ of Possesion from the Court? _ Yes _ No	Check Type of Home: _ House _ Condo _ Mobile Home
Landord/Property Manager Name and Telephone: _____	Lending Institution/Mortgage Holder & Account Number: _____

	Head of Household	Other Household Members
Has anyone in household applied to this office before?	__ Yes __ No	__ Yes __ No
If working, indicate TAKE HOME (NET) Pay	__Weekly __Bi-Weekly $_____	__Weekly __Bi-Weekly $_____
If NOT working, is it due to illnes and/or injury?	__ Yes __ No	__ Yes __ No
If no longer working, list date of last employment:	Date _____	Date _____
List benefits received by any household member:		
	APTD Cash $_____	APTD Cash $_____
	TANF $_____	TANF $_____
	SSA $_____	SSA $_____
	SSDI $_____	SSDI $_____
	SSI $_____	SSI $_____
	Workers Comp $_____	Workers Comp $_____
	Child Support $_____	Child Support $_____
	Unemployment $_____	Unemployment $_____
	Food Stamps $_____	Food Stamps $_____
	Other $_____	Other $_____

List Health Insurance Benefits for all household member:
Medicaid Ins# _____
Medicare Ins# _____
Other Ins Names and Numbers:
_____
_____
_____
_____

EBT Card # _____

RELEASE OF INFORMATION: I do hereby authorize and request any relative, physician, lawyer, banker, insurance company, or any other person or organization having information concerning my circumstances, to furnish such information to the TOWN OF WOLFEBORO Welfare. I also waive my right to privacy and confidentiality contained in my file and/or any information received by the TOWN OF WOLFEBORO Welfare and authorize the TOWN OF WOLFEBORO Welfare to release such information to other agencies to the extent that such release is made to further my request for, or receipt of, assistance from that agency. This authorization shall expire 180 days from the date it is signed.

Applicant Signature: _____ Date: _____

Co-Applicant Signature: _____ Date: _____

If you are completing this request in the absence of the applicant, assisting or representing the applicant, please provide the information below.

Your Name: _____ Contact #: _____

Agency or Relationship: _____

Case Technician: ACapone Your Next Appointment is: _____ at _____

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REQUEST FOR MEDICAL INFORMATION

I, _____, hereby authorize and request my physican to furnish such medical information concerning my circumstances to the TOWN OF WOLFEBORO.

Signature: _____ *Date:* _____

This form is to be completed by the physican or it shall not be accepted as valid.

APPLICANT/PATIENT INFORMATION

Name: _____

Address: _____

_____

Birth Date: _____

PHYSICIAN INFORMATION

Name: _____

Address: _____

_____

Telephone: _____

Diagnosis: _____

_____

_____

_____

Prognosis: _____

_____

_____

_____

Is patient able to work? __ Yes __ No Period of Disability: _____

__ Yes, with the following limitations: _____

_____

_____

_____

_____

Does patient have another appointment scheduled? _____ Date & Time: _____

_____ _____

Signature of Physician Date

OFFICIAL USE ONLY _____ Date: _____