

Application For Assistance

Date of Application _____ Referred by _____

Reason for Request _____

Assistance Requested _____

General Information:

Name _____ Date of Birth _____

Address _____

Telephone _____ SS# _____ US Citizen? Yes No

Marital Status _____ Rent or Own _____ How Long at This Address _____

Spouse/Co-Applicant Name _____ SS# _____

Spouse Address (if not same as applicant) _____

Have you applied for local assistance before? _____ When? _____

Where? _____ Under what name? _____

List below all persons living in your household, Provide picture ID, SS Card or Birth Certificate for **"Everyone"** living in the 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	Date of Residence

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? _____

If Home Owner: Mortgage Amount _____ Date last paid _____ Owed _____

Bank/Mortgage Co _____ Address _____

Education / Training / Employment

	Special Training or Skills	Military Service	What Branch	How Long
Applicant:	_____	_____	_____	_____
Co Applicant:	_____	_____	_____	_____

Applicant Work History:

Are you employed now? _____ Employer _____ Position _____

When began work? _____ All household income past 30 days _____
(Documentation Needed)

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

Name	Employer	Pay	wk/bwk	Dates of Employment	Reason for Leaving
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If unable to work please provide a Dr note which should include your current ability to work with the extent and duration of the disability.

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 including current bank statements and printouts:

Cash on hand (all household combined) _____ Certificates of Deposit (CD's) _____
Savings Bonds _____ Mutual Funds _____ Annuities _____ Stocks _____
Trust Funds _____ Retirement Accounts _____ Insurance Policies _____
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 Payments (explain) _____
Do you or any member have a lawsuit pending? _____ Who? _____
Please give details _____
Lawyers Name/Address _____

Motor vehicles owned by you and all household members:

Owner	Auto Make	Model	Year	Value	Payments	Insurance
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Household Income

Provide Documentation of any benefits or income received or applied for by you or any household member:

Name	Date Applied	Date Last Received	Monthly Amount
ANB (Aid to the needy blind)			
APTD			
Child Support			
Disability (Employer)			
Food Stamps			
Fuel Assistance			
Gift/Loans			
Healthlink/Community Care			
Insurance			
Maternity Benefits			
Medicaid			
Medication Connection			
NH Healthy Kids			
OAA (Old Age Assistance)			
Prenatal Care			
Retirement			
School Loans/Grants			
Severance Pay			
Social Security			
SSDI (SS Disability)			
SSI (Supplemental Security)			
TANF			
Unemployment			
Vacation Pay			
Veteran's Pension			
Vocational Rehabilitation			
WIC (Woman/Infants/Children)			
Worker's Compensation			
Other			

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

Name	Agency Name	Contact Person

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.) Bring receipts.

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 _____	_____
Credit Card _____	Lot Rent _____	_____

List unplanned, emergency or irregular periodic expenses during the last 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 _____

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 _____

Liability for Support Information

Please provide following details:

Your Father _____ Address _____

Your Mother _____ Address _____

Co-Applicant Father _____ Address _____

Co-Applicant Mother _____ Address _____

You or your co-applicant's adult children _____

Certification 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-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 understand that if I am assisted the municipality may place a lien against any property settlement or civil judgment for personal injuries (except any worker's compensation settlement) which I receive within six years of receiving municipal assistance. RSA 165:25-a.

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.

I understand that an investigation will be conducted in order to verify facts and statements presented by the applicant and that this investigation may take place prior, during, and subsequent to the applicant's receipt of welfare assistance.

Applicant or Person Completing Form Signature

Date

Spouse or Co-Applicant Signature

Date

Welfare Official

Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION – DHHS

I, _____, the undersigned, understand that from time to time,
Print Your Name
 the local welfare administrator for _____ may require certain information about
Town/City

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 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 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

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

Authorization for release of information

I, _____ of the CITY OF LACONIA in the COUNTY OF BELKNAP, being an applicant for assistance, do hereby authorize and request any relative, physician, lawyer, banker, employer, insurance company, fraternal order, or any other person or organization having information concerning my circumstances to furnish such information to the Welfare Director. I also authorize the Laconia Welfare Department to release information to other welfare and social service agencies involved in servicing my case.

Applicant Signature

Date

Signature of person completing app if
Not applicant

Co-Applicant Signature

Date

Relationship

Date _____

TOTAL INCOME RECEIVED IN THE LAST 30 DAYS (if no income, see next page):

\$ _____

In the past 30 days I, _____, have approximately spent my income on the following items listed below:

_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$

Expense Total \$ _____

X _____
(Client Signature)

Date _____

To Whom It May Concern,

I, _____, have had no income for the past 30 days. Income is defined as any and all monetary benefits received, to include gifts, refunds, loans, other state, local or federal benefits received, or any money received by me at all.

X _____
(Client Signature)

WORK PROGRAM

JOBS REQUIRE THE FOLLOWING:

Raking, mowing, sweeping, shoveling, moderate lifting, pushing/pulling, clerical work, sitting, typing, filing, etc.

Are you able to perform any of these functions: _____

If not, why? _____

Do you have any physical or medical limitations that would restrict your capability to perform any of the above or similar tasks?

APPLICANT SIGNATURE

DATE

CO-APPLICANT SIGNATURE

DATE

(SEE OTHER SIDE)

ONE MUST NOT VOLUNTARILY LEAVE A JOB WITHOUT GOOD CAUSE

Public assistance applicants who voluntarily leave a job without good cause, within sixty days of applying for local welfare and having received local assistance within the past 365 days, may be disqualified from receiving assistance for 90 days from the date of voluntary quit. Such sanction shall not affect applicants who are responsible for supporting minor children within their household or those mentally or physically unable to work.

Any sanctioned applicant must have received prior notice that a voluntary job quit without good cause may result in a temporary eligibility cut-off. Likewise, they must receive a written application and a notice of decision. RSA 165:1-d.

I understand that quitting a job voluntarily, or not reporting to work without good cause, leading to employment termination, may result in a potential 90-day period of local public assistance ineligibility.

APPLICANT

DATE

CO-APPLICANT

DATE

WELFARE OFFICIAL

DATE

(SEE OTHER SIDE)

CITY OF LACONIA-WELFARE DEPARTMENT
Notice of Work Program Requirements

Name: _____ Date: _____

1. Under state law and the Welfare Guidelines of this City, any recipient of assistance may be required to work for this City at any available job that is within his/her capacity and to search for work. This work requirement will be imposed only after there has been a determination of eligibility for assistance and such assistance has been authorized. A recipient will not be required to work more hours than necessary, at no less than the minimum hourly wage, to reimburse the City for assistance received.
2. Participation in the City work program will not be required as a condition of continuing eligibility for assistance if the recipient can prove they are unable to participate due to any of the following circumstances:

Is a parent who must care for children under 5 and adequate day care facilities are not available;

Has a mental or physical disability certified by a physician and are incapable of participating in city work relief, as determined by the City Welfare Specialist;

Has a documented medical appointment or illness that cannot be scheduled at non-workfare hours;

Must remain at home because of illness or disability (certified in writing by a physician) to another member of the family;

Has a documented conflicting job interview that cannot be scheduled at non-workfare hours;

Has a documented conflicting interview at a service or welfare agency that cannot be scheduled at non-workfare hours;

Does not possess the materials or tools to perform the task and the City fails to provide them;

Lacks transportation where it is reasonably necessary for participation in the work program.

6. General assistance may be suspended for failure to comply with City Welfare Guidelines relating to appropriate participation in a work program. While employed by the work program, you will be expected to perform all legitimate tasks assigned to you in a reasonable and proficient manner, and conduct yourself in a manner consistent with any employment. Foul language, insubordination, fighting, theft, use of alcohol or drugs, or disrespect towards your supervisor, other town officials or employees, or citizens will not be tolerated. Failure to keep the agreed working hours (except for the reasons listed above), or failure to fulfill your obligations relative to this work program, will likely result in suspension of public assistance eligibility.

I have read and understand these requirements:

SIGNATURE: _____ DATE: _____

NOTICE OF WORK PROGRAM REQUIREMENT (GENERAL)

As a recipient of public assistance you are required to work for this City. In doing so, you will be subject to the following:

1. You will be allowed no more than one break a day, no longer than 10 minutes;
2. You will report "on time" to the job and leave on time. You are not to leave early without prior authorization from the Department Supervisor;
3. You will be courteous to customers as well as employees;
4. You will do the job. You are here to participate in the work program;
5. Any information that is confidential, you will keep confidential. You must act within the scope of your duties.
6. You are not an employee of the City of Laconia and the work you perform does not create an employee/employer relationship.

I have reviewed and understand these General Requirements of the City of Laconia Workfare Program.

APPLICANT

WELFARE OFFICIAL

DATE



WELFARE DEPARTMENT

Required Documentation

Must bring all information listed below at time of interview

- All Household Income** in the past 30 days, from the date of your scheduled appointment.

- Receipts** or other proof of bills paid in the last 30 days.

- Verification** that you have applied for any of the following programs:
WIC ES TANF/EAP MA/APTD TITLE XX HUD FAP WC HEALTHLINK/COMM CARE SS/SSI
MEDICATION CONNECTION FUEL ASSISTANCE ELECTRIC DISCOUNT

- Doctor's note** if you are unable to work.

- Verification** that you have applied to the Dept. of Employment Security for the following:
Work Registration _____ Unemployment Compensation _____ Potential Benefit Amt. \$ _____

- Eviction paperwork (If Any)**

- Resource Verification:** Be sure to provide a current printout for any item checked off below:
Checking _____ Savings _____ Child Support _____ Cash/Other _____

- Completed Landlord Form & W-9** (if applicable). Must be completed by the landlord only.

- Application**

- Picture ID and SS Card or Birth Certificate** for everyone living in the household.

Please complete & return the enclosed W-9 if box is checked off.

Fax (603) 737-1005

Dear Landlord:

In order to determine assistance for your tenant, it is necessary to have the following verification form completed and signed by you.

NAME(S) ON LEASE: _____

ALL OTHER HOUSEHOLD MEMBERS: _____

ADDRESS OF RENTAL: _____

RENT: \$ _____ PER MONTH WEEK BI-MONTHLY (please circle)

OF BEDROOMS _____ TOTAL # OF ROOMS _____

INCLUDES: HEAT ELEC GAS WATER NO UTILITIES INCLUDED

DATE OF OCCUPANCY: _____

SEC. DEP. PAID: _____ BY WHOM: _____ \$ _____

AMOUNT OF RENT PAID IN CURRENT MONTH: \$ _____

DATE RENT LAST PAID: _____ AMOUNT PAID: \$ _____

RENT PAID IN LAST 30 DAYS \$ _____ RENT PAID UNTIL: _____

MONTHLY/WEEKLY RENT DUE DATE: _____

PLEASE MAKE CHECK PAYABLE TO:

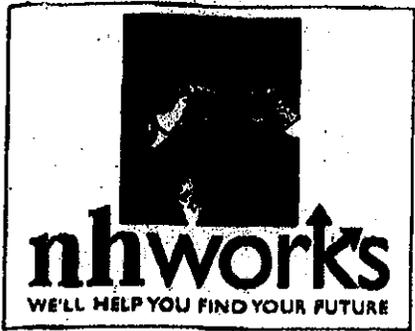
LANDLORD'S NAME (please print) _____

MAILING ADDRESS: _____

TELEPHONE # _____

LANDLORD'S SIGNATURE _____ DATE: _____

MANAGER'S NAME: (if there is one) _____



Employment Assistance & Skills Training Available at your local NH Works Career Center

**Are you having difficulty finding a job?
Do you feel that you need some extra help in finding the right job for you?
Come in and see what we have to offer!**

Employment Assistance

- | | |
|---|---|
| Job Listings | Employment Referrals |
| Job Search / Placement Assistance | Economic & Labor Market Information |
| One-on-one Employment Counseling | Career assessment – Skills & Aptitude |
| Workshops for resume & cover letter writing, interviewing techniques and using the internet as a job search tool. | Resource Center w/ fax, phone & computer to help with you with your job search. |

Skills Training

If you are not having success with your job search due to lack of updated skills or a change in the employment market, you may need occupational skills training. Individual Training Accounts and On-The Job Training are available to those who qualify. Please contact your Community Action Agency WIA Counselor at the numbers listed below.

NH Works locations / contacts:

Berlin	151 Pleasant Street	603-752-5500	Paul Lozier
Claremont	404 Washington Street	603-542-3394	Bill Ingalls
Concord	10 West Street	603-229-4428	Jean Donzello
Conway	518 White Mountain Highway	603-447-2214	Nicolle Bradbury
Keene	109 Key Road	603-357-5037	Betsy Chatman
Laconia	426 Union Avenue	603-528-9315	Melinda Wilson
Lebanon	85 Mechanic Street Suite 4	603-448-5873	Bill Ingalls
Littleton	646 Union Street	603-444-1065	Nicolle Bradbury
Manchester	300 Hanover street	603-656-6503	Ginny Haley / Mary McGee
			Mitch Cranmer
Nashua	6 Townsend West	603-594-8547	Dave Roberts / Maureen Griffin
Portsmouth	2000 Lafayette Road	603-559-9130	Fran Bishop
Salem	29 South Broadway	603-894-5107	Jane Sullivan
Somersworth	243 Route 108	603-742-4290	Cheri Trombley

All offices are open for business Monday – Friday from 8 a.m. – 4:30 p.m.

Website: www.nhworks.org

The Workforce Opportunity Council is a proud sponsor of the NH Works Program.
The partners of NH Works are Equal Opportunity Employers and comply with the Americans with Disabilities Act.
Auxiliary aids and services are available upon request.