Town of Stratford
Welfare Assistance Application Package
welfare@stratfordnh.gov.

Following is the package required to apply for welfare assistance in the Town of Stratford.

- You must **complete and sign all forms**, including all releases and authorizations.
- **All** members of your household—children, yourself, spouse, significant other, relatives, other residents—should be listed, along with their incomes, as appropriate, and proofs; all **adult members must sign**.
- You must supply all the **required documentation** listed in the application (both proofs and bills).
- The date of the application will be the date you have fully completed the application plus supplied the required documentation.

The welfare officer has five working days to respond to your request once it is completed and final (all required documents provided, form completed and signed as appropriate). If you re-apply 30+ days after a previous application, you must start the process all over again and supply all the information again.

Omitting information or providing false information is grounds for denial of your application (such as failing to note that you have previously applied here, in other towns, or to the state).

If you qualify for assistance and you own property, a lien will be placed against your property.

Keep Form C – This details your rights.

FORM C
Town of Stratford

NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF STRATFORD

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) working days after you received your decision.

5. You have a right to have a hearing to present your case.

6. You have a right 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 making 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 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.

FORM G
Town of Stratford

INTAKE FORM

(to be completed at the time of each request for assistance)

DATE:_____

NAME:_____
Last First Middle Maiden

ADDRESS:_____
Street / # / Apartment Town

HOW LONG AT THIS ADDRESS?_____TELEPHONE:_____

WHAT TYPE OF ASSISTANCE ARE YOU REQUESTING AT THIS TIME?_____
_____

NAMES AND AGES OF ALL HOUSEHOLD MEMBERS:_____
_____
_____

LIST ALL SOURCES AND AMOUNTS OF HOUSEHOLD'S EARNED AND UNEARNED INCOME. THIS INCLUDES CASH, SAVINGS AND CHECKING ACCOUNTS:
_____
_____

INDICATE ANY CHANGES IN YOUR PERSONAL SITUATION SINCE YOUR LAST VISIT.
_____
_____
_____

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 a crime.

_____
SIGNATURE

FORM A
Town of Stratford
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:

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

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

LANDLORD: Name_____Telephone_____

Address_____

IF HOME-OWNER: Mortgage Amount _____Date last paid_____Owed_____

Bank/Mortgage Co_____Address_____

3. Education / Training / Employment

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

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:

Name	Employer	Pay	Weekly/ Biweekly	Employment Dates	Reason for Leaving

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)_____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:

Owner	Auto Make	Model	Year	Value	Payments	Insurance

5. Household Income

Indicate 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				
Gifts/Loans				
Maternity Benefits				
Medicaid				
OAA (Old Age Assistance)				
Retirement				
Severance Pay				
Social Security				
SSDI (SS Disability)				
SSI (Supplemental Security)				
TANF				
Unemployment				
Vacation Pay				
Veteran's Pension				
Vocational Rehabilitation				
WIC(Women/Infants/Children)				
Worker's Compensation				
Other: [ ]				

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

Name	Agency Name	Contact Person

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_____	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_____	Other_____
Credit Card_____	Lot Rent_____	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 Reparis_____	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 Date

_____ _____

Spouse or Co-applicant Signature Date

_____ _____

Signature of person completing form (if not applicant) Date

FORM B

Town of Stratford

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

FORM D
Town of Stratford

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 E
Town of Stratford

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION
(specific agency/individual)

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 ________, town/city of _____ welfare official, 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

____
Welfare Official

FORM F

Town of Stratford

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

_____ 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

FORM H

Town of Stratford

MUNICIPAL WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#:_____ **dob:**_____

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 from date of my signature below:

_____ _____

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 Municipality 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(s) 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 / Signature **Date**

Thank you for taking the time to complete this form.
Please contact the Municipal Welfare Department if you have any questions.

FORM I

Town of Stratford

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

Town of Stratford

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: 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: $_____Back rent owed: $_____

_____

(if back rent is owed, please attach accounting of months and amounts)

For IRS reporting, landlord's Tax ID or Social Security # <u>must</u> be provided:

Tax ID #:_____**OR** Social Security #:_____

CHECK IS TO BE MADE PAYABLE TO: (PLEASE PRINT)

_____ _____

Landlord's Name Telephone / Fax Numbers

_____

Landlord Address

_____

Name of Manager or other Representative

_____ _____

Landlord Signature Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I,_____, the undersigned, understand that from time to time the
Print Your Name
local welfare administrator* for **Stratford** may require certain information about assistance I am apply 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 administrator* for the specific purposes outlined below.

Type of Information	Purpose for Requesting this Information
Date of DFA application(s), type(s0 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 proved 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 for 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;
- Any use of the above information inconsistent with these purposes is forbidden;
- The local welfare administrator* may not release information provided under this authorization to any other person without my written permission.

* Local welfare administrator includes the appointed welfare officer, the Board of Selectmen, and their assistant.

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 Signature Date