Town of Gilsum
650 Route 10
PO Box 67
Gilsum, NH 03448

603-357-0320

O.W.A.

You must complete all items in this application.
Failure to complete this application in its entirety is grounds for denial of assistance.
You must produce any information the Welfare Officer requests from you if it applies to your eligibility.

Official Welfare Application

TOWN OF GILSUM 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 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? Wher

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)

I understand that my immediate relations are responsible for my support. The Town of Gilsum Welfare Officer may contact them requesting their assistance in supporting me. (RSA 165:19)

_____ _____

Applicant Signature Date

_____ _____

Spouse or Co-applicant Signature Date

_____ _____

Signature of person completing form (if not applicant) 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 the Town of Gilsum 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 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

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

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.

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 Gilsum 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 Gilsum Welfare Department.

_____ _____

Applicant SignatureDate

_____ _____

Spouse or Co-applicant Signature Date

_____

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

_____

Date

Form D
Town of Gilsum
Welfare Department

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 all Town of Gilsum welfare officials, 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 E

Town of Gilsum – Welfare Department

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 and denied any assistance.

_____
SIGNATURE

GILSUM WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#: _____ dob: _____

I hereby request the release by a doctor, hospital or clinic to the Gilsum 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 Gilsum Welfare Department, PO Box 67, Gilsum, NH 03448, 603-357-0320 if you have any questions.

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