

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ give the Town of Loudon Welfare Office or their representatives my permission to contact the following: (Including but not limited to) Any relative, physician, lawyer, banker, employer, insurance company, fraternal order, or any other person or organization having information concerning my circumstances and request that they provide such information to the Welfare Director.

I also waive my right to privacy and confidentiality contained in my welfare file and/or any information received by the Town of Loudon Welfare Office and authorize the Welfare Office to release such information to other agencies to the extent that such release is made to further my application for/or receipt of assistance or benefits from that agency.

Applicant's Signature

Spouse's Signature

Date

Witness

**AUTHORIZATION OF RELEASE OF INFORMATION RELEVANT TO
TOWN OF LOUDON WELFARE WORK PROGRAM**

I, _____, hereby authorize the Town of Loudon to conduct a background investigation as part of the placement process in Loudon's Welfare Work Program. I understand this investigation may include contact with my former employers, landlords or leasing agents, social welfare agencies, financial institutions and family members. I further understand such investigation will include a criminal records check.

I release the Town of Loudon from any liability for information exchanged or received by the Town, provided that this information is made solely for the purpose of investigating my eligibility for assistance and participation in the Loudon Welfare Work Program.

Applicant's Signature

Spouse's Signature

Witness

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, the undersigned, understand that from time to time, the local welfare administrator for the **Town of Loudon** 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 **Town of Loudon 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

RESPONSIBILITY OF EACH APPLICANT AND RECIPIENT

At the time of initial application, and at all times thereafter, the applicant has the following responsibilities:

1. To provide accurate, complete and current information concerning his/her needs and resources and the whereabouts and circumstances of relatives who may be responsible under R. S. A. 165:19.
2. To notify Welfare Official within 72 hours when a change in needs or resources may affect eligibility for continuing assistance.
3. Within one week of application, to apply for and utilize any benefits or resources, public or private, that will reduce or eliminate the need for General Assistance.
4. To keep appointments as scheduled.
5. To notify the Welfare Official within 72 hours of a change of address and change in members of the household.
6. To diligently search for employment and provide verification of application for employment when requested.
7. To accept employment when offered.
8. To provide a doctor's statement if the applicant claims an inability to work due to medical problems.
9. To participate in the welfare work program if physically and mentally able.

An applicant shall be denied assistance if he/she fails to fulfill any of these responsibilities without a reasonable justification.

Any person may be denied or terminated from general assistance who, by means of intentionally false statements or intentional misrepresentation or by impersonation or other willfully fraudulent act or device obtains or attempts to obtain any assistance to which he/she is not entitled.

I have read and understand the above and/or have been offered to have the above explained to me.

Applicant's Signature

Spouse's Signature

VERIFICATION DOCUMENTATION REQUIRED FROM APPLICANTS
FOR GENERAL ASSISTANCE

Applicant(s): _____ Date: _____

IN ORDER TO APPLY FOR GENERAL WELFARE ASSISTANCE, THE FOLLOWING INFORMATION MUST BE BROUGHT IN AT THE TIME OF YOUR INTERVIEW. FAILURE TO PROVIDE THE REQUIRED VERIFICATIONS WILL DELAY THE PROCESSING OF YOUR APPLICATION, AND MAY ULTIMATELY RESULT IN A DENIAL OF ASSISTANCE.

1. Proof of identification (Picture ID, License, Birth Certificate, Social Security Card).
2. Divorce Decree (original and any court ordered amendments) or Marriage License.
3. Proof of children (Birth Certificates and Social Security Cards).
4. Proof of residency (CURRENT rent receipts and/or lease, **notarized statement from the person with whom you reside).
5. Residence/Shelter expenses: Complete the Budget Worksheet enclosed and provide documents as proof of all expenses listed.
6. Proof of income: Last four pay stubs, Court-ordered support payments, aid received from any other source including social Security, Veterans Administration, Trusts, State Aid, Etc.
7. Proof that you have applied for all available aid for which you might be eligible from any other source.
8. Proof of personal property: Car, Motorcycle, Trailer, House, Boat, Snowmobile, Electronics Equipment (TV's, VCR's, Cameras, etc), Appliances.
9. Proof of cash resources, including last four months bank statements (Checking and/or Savings).
10. Copy of last Federal Income Tax reporting form.
11. Proof of Lay-off (Notarized statement from former employer).
12. Proof of registration with local Employment Security Office (Date stamped employment card).

13. Proof of Work Search. MINIMUM OF THREE (3) APPLICATIONS REQUIRED.

Complete enclosed work search form including name of place where applied, date, contact person, phone number. All persons 18 years of age or older residing with applicant(s) are required to participate in work search program. Younger members of the household who contribute substantially to household income are also required to participate. Additional forms are available upon request.

14. Doctor's statement if unable to work including extent of disability and anticipated duration of incapacity.

15. Proof that parents, stepparents, sons, daughters, and/or spouses cannot assist financially and the reasons why such assistance cannot be given. Statement must be ***notarized.**

16. Terminated notice from previous welfare (Town, City, County, State, and/or Federal).

17. Other: _____

Applicant's Signature

Spouse's Signature

Date

Welfare Administrator

*A Notary Public is available at the Town Office at no expense.

APPLICATION FOR AID
FROM THE TOWN OF LOUDON WELFARE DEPARTMENT

Name: _____ S.S. #: _____

Address: _____

How many years at this address: _____ Telephone #: _____

Date of Birth: _____ Age: _____ Are you a U. S. Citizen: Yes _____ No _____

Currently Employed: Yes _____ No _____ Net pay per week: _____

Employer Name: _____ Telephone #: _____

Employer's Address: _____

Dates of Employment: From _____ To _____ Job Title: _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Legal Separation _____

Last full grade of School completed: _____ Do you have a GED: _____

Number in household: _____ (List below all persons living with you)

Name	Relationship to Applicant	DOB & Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What type of assistance are you requesting: _____

Reason assistance is needed: _____

Have you ever received welfare assistance before: Yes _____ No _____

Type of assistance received: _____ Agency: _____

Dates of assistance: _____

Resources of Household	Amount	Location
Cash	_____	_____
Savings	_____	_____
Checking	_____	_____
Child Support	_____	_____
Stocks/Bonds	_____	_____
Insurance/Pension	_____	_____
Other	_____	_____

Available Income:

Hourly wage: _____ Wages per week: _____

Hours worked per week: _____ Shift worked: 1 2 3

Do you expect a Tax Refund: Yes _____ No _____ When did you file for Refund: _____

Amount expected: _____ Other refunds and amounts expected: _____

Do you expect a settlement from any source: Yes _____ No _____ If yes, please give specifics: _____

Lawyer or Agency handling case: _____

Address: _____ Telephone #: _____

Monthly expenses: (Complete Budget Worksheet)

Name of Landlord: _____

Address: _____

*****Have Landlord complete Landlord/Tenant form*****

Family History

Name of Spouse, Estranged, or Ex-Spouse: _____

Address of the above: _____ Telephone #: _____

S.S. # of the above: _____ DOB: _____ Age: _____

Date and place of Marriage, Separation, Divorce: _____

In accordance with RSA 165:19 – “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”.

Please provide the following:

Applicants -

Father/Stepfather - Name: _____ Employer: _____

Address: _____ Telephone #: _____

Mother/Stepmother - Name: _____ Employer: _____

Address: _____ Telephone #: _____

Spouses –

Father/Stepfather - Name: _____ Employer: _____

Address: _____ Telephone #: _____

Mother/Stepmother - Name: _____ Employer: _____

Address: _____ Telephone #: _____

Please list the names, addresses, and telephone numbers of any children living outside the home.

Name	Address	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please use back of this form if more space is required

Please list the name, address, and telephone number of any brothers or sisters.

Name	Address	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

****Please use back of this form if more space is required****

Please list all your addresses for the last two (2) years.

<u>Street</u>	<u>Town</u>	<u>State</u>	<u>From</u> Month/Yr	<u>To</u> Month/yr
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Service Record:

Branch: _____ Dates served: _____ Type of discharge: _____

Veteran: _____ Benefits: _____ Claim #: _____

Work Record of Applicant's for the last year:

<u>Employer</u>	<u>Dates</u>	<u>Type of Work</u>	<u>Wages</u>	<u>Reason for leaving</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you own any property (i.e. mobile home, house, etc.): Yes _____ No _____

If yes, list addresses and/or location: _____

Pursuant to Section XIII of the Town of Loudon Welfare Guidelines:

The Town of Loudon may place a lien on property for services rendered, if applicable.

REIMBURSEMENT – AGREEMENT

I agree to reimburse the Town of Loudon for Welfare Assistance, if possible, at some future date. Such recovery of these expenses will be through a program of repayment per RSA 165:20-B.

Applicant's Signature

Spouse's Signature

If you have a Lawsuit, Workman's Compensation claim, or aid from any other Social Service Agency now pending disposition, please list the name, address, and phone number of your Attorney, Insurance Company or any other Agency which may be handling this claim on your behalf.

Name: _____ Telephone #: _____

Address: _____

MISREPRESENTATION

I understand that any misrepresentation given on this application would cancel all aid from the Town of Loudon and may result in court action for recovery. I also understand if I am dissatisfied with the action taken on this application, I have the right to request a hearing.

Applicant's Signature

Spouse's Signature

Dear Landlord:

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

Name(s) on lease: _____

All other household members: _____

Address of rental: _____

Rent amount: \$ _____ Per: Month Week Bi-monthly

Circle which utilities are included in rental amount:

Heat Electricity Gas Water - or - No heat or utilities included

Date of occupancy: _____ Last date rent paid: _____ Amount paid: _____

Check payable to:

Landlord's Name (please print): _____

Mailing Address: _____

Tax I.D. # or S.S. # : _____

Telephone #: _____

Landlord's Signature: _____ Date: _____

****Failure to provide this information may result in 20% withholding of payment for tax purposes****

Please return to: Loudon Welfare Administrator
Town of Loudon
P O Box 7837
Loudon, NH 03307

Budget Worksheet

Name: _____

Date: _____

A. Available assets and income:

Amount:

_____	\$ _____ mo/wk

Total available income:

\$ _____

B. Allowable expenses:

	Actual Expenses	Allowed Expenses (For office use)
Rent/Board/Mortgage	\$ _____ mo/wk	\$ _____ mo/wk
Electricity	\$ _____ mo/wk	\$ _____ mo/wk
Heat	\$ _____ mo/wk	\$ _____ mo/wk
Water/Sewer	\$ _____ mo/wk	\$ _____ mo/wk
Cooking Fuel	\$ _____ mo/wk	\$ _____ mo/wk
Telephone	\$ _____ mo/wk	\$ _____ mo/wk
Food	\$ _____ mo/wk	\$ _____ mo/wk
Maintenance	\$ _____ mo/wk	\$ _____ mo/wk
Medical	\$ _____ mo/wk	\$ _____ mo/wk
Transportation	\$ _____ mo/wk	\$ _____ mo/wk
Other:	\$ _____ mo/wk	\$ _____ mo/wk
Other:	\$ _____ mo/wk	\$ _____ mo/wk
Other:	\$ _____ mo/wk	\$ _____ mo/wk
 Total Expenses	 \$ _____ mo/wk	 \$ _____ mo/wk

C. Eligibility: $A - B = +$ or $-$ \$ _____

(If A is greater than B, applicant is ineligible)

(If A is less than B, applicant is eligible for the difference)

Area(s) in which assistance will be rendered and amount.

_____	\$ _____ mo/wk
_____	\$ _____ mo/wk
_____	\$ _____ mo/wk

FAIR HEARING REQUEST

I, _____ request a fair hearing to review the decision concerning my claim for general assistance. I understand that I not be able to introduce new information at the hearing and that the fair hearing officers will be reviewing only that information and documentation which was provided as part of my application to the Welfare Administrator, and upon which the decision was made to deny my request for aid, or to determine that I was not eligible for the full amount of the aid I had requested. I want ____, I do not want ____, the level of assistance which I have been receiving continued until the hearing. I understand that if the Welfare Administrator's decision is upheld, I will be obligated to repay the assistance provided during the time of appeal.

Signature of client: _____ Date: _____

RETURN TO:

WELFARE ADMINISTRATOR
TOWN OF LOUDON
P.O. BOX 7837
LOUDON, NH 03307

Town of Loudon

Work Search Record

Client: _____

Date: _____

In order to comply with State Law RSA 165:1-b-II-c you are required to do a work search. You must comply by completing the list below.

Date	Employer	Telephone #	Type of work sought	Type of contact Visit – Telephone – Mail - Resume	Individual Contacted	Time of day	Results

APPLICANT MUST CONDUCT A MINIMUM OF 3 WORK SEARCHES PER DAY. FAILURE TO DO SO COULD JEOPARDIZE ELIGIBILITY FOR ASSISTANCE OR BE CAUSE FOR TERMINATION OF ASSISTANCE OR ELIGIBILITY.