Town of Stratford

Welfare Assistance Application Package

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.

Town Office – 922-5533 or stratfordnh@gmail.com or call a selectmen if closed.

The posted office hours are Monday through Thursday 9-3:30. Other hours may be available by appointment.
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:

______________________________________________________________________________________

______________________________________________________________________________________

_____________________________________

SIGNATURE

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.
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:**

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Social Security #</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

   **If at your current address less than 12 months, please list past 12 month’s addresses:**

<table>
<thead>
<tr>
<th>Street</th>
<th>Town/City</th>
<th>State</th>
<th>Dates of Residence</th>
</tr>
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<tbody>
<tr>
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</table>
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**

<table>
<thead>
<tr>
<th>Highest Grade</th>
<th>G.E.D. or Diploma</th>
<th>Special Training or Skills</th>
<th>Military Service</th>
</tr>
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<tbody>
<tr>
<td>Attended</td>
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</table>

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:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Employer</th>
<th>Pay</th>
<th>Weekly/Biweekly</th>
<th>Employment Dates</th>
<th>Reason for Leaving</th>
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</table>
4. **Household Assets:**

Provide information regarding accounts held by you and all household members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Bank/Credit Union</th>
<th>Savings Acct. #</th>
<th>Savings Balance</th>
<th>Checking Acct. #</th>
<th>Checking Balance</th>
</tr>
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<tbody>
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</table>

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:**

<table>
<thead>
<tr>
<th>Owner</th>
<th>Auto Make</th>
<th>Model</th>
<th>Year</th>
<th>Value</th>
<th>Payments</th>
<th>Insurance</th>
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</tbody>
</table>
5. **Household Income**

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Applied</th>
<th>Date Last Received</th>
<th>Monthly Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANB (Aid to the Needy Blind)</td>
<td>___________</td>
<td>_________________</td>
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<tr>
<td>APTD</td>
<td>___________</td>
<td>_________________</td>
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<tr>
<td>Child Support</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Disability (Employer)</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Food Stamps</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Fuel Assistance</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Gifts/Loans</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Maternity Benefits</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Medicaid</td>
<td>___________</td>
<td>_________________</td>
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<tr>
<td>OAA (Old Age Assistance)</td>
<td>___________</td>
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<tr>
<td>Retirement</td>
<td>___________</td>
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<tr>
<td>Severance Pay</td>
<td>___________</td>
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<tr>
<td>Social Security</td>
<td>___________</td>
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<td>SSDI (SS Disability)</td>
<td>___________</td>
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<td>______________</td>
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<tr>
<td>SSI (Supplemental Security)</td>
<td>___________</td>
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<tr>
<td>TANF</td>
<td>___________</td>
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<tr>
<td>Unemployment</td>
<td>___________</td>
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<tr>
<td>Vacation Pay</td>
<td>___________</td>
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<tr>
<td>Veteran’s Pension</td>
<td>___________</td>
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<tr>
<td>Vocational Rehabilitation</td>
<td>___________</td>
<td>_________________</td>
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<tr>
<td>WIC (Women/Infants/Children)</td>
<td>___________</td>
<td>_________________</td>
<td>______________</td>
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<tr>
<td>Worker’s Compensation</td>
<td>___________</td>
<td>_________________</td>
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<tr>
<td>Other: [ ]</td>
<td>___________</td>
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</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency Name</th>
<th>Contact Person</th>
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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? __________ 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, the local welfare administrator for ______________________________ 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:

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Purpose for Requesting this Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance</td>
</tr>
<tr>
<td>Date my Medicaid case opened and my Medicaid Identification Number(s)</td>
<td>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</td>
</tr>
<tr>
<td>Date of any sanction of my cash assistance grant</td>
<td>Determining countable household income also called “deeming”</td>
</tr>
<tr>
<td>Reason for any sanction of my cash assistance grant</td>
<td>Helping me to remove the sanction</td>
</tr>
</tbody>
</table>

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 signor 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
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.

__________________________________   ___________________
Assistant          Date

______________________________________   ___________________
Welfare Official
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 # must 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
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.

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Purpose for Requesting this Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Basic administration of my local welfare assistance case, including verification of information proved by me for determining eligibility for local welfare assistance</td>
</tr>
<tr>
<td>Date my Medicaid case opened and my Medicaid Identification Number(s)</td>
<td>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</td>
</tr>
<tr>
<td>Date for any sanction of my cash assistance grant</td>
<td>Determining countable household income also called “deeming”</td>
</tr>
<tr>
<td>Reason for any sanction of my cash assistance grant</td>
<td>Helping me to remove the sanction</td>
</tr>
</tbody>
</table>

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.

________________________  __________________________  __________________________
Relationship to You        Witness Signature          Date