

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:

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 # 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
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(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 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
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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
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