

**TOWN OF GRAFTON, NEW HAMPSHIRE
DOCUMENTATION REQUIRED FROM APPLICANTS
TEL: 603-523-7140**

Name: _____ Today's Date: _____

Address: _____ Telephone: _____

APPOINTMENT: _____ Welfare Official: _____

The following checked off information or anything else applying to **all your household** must be brought in at the time of your appointment in order for you to apply for Welfare from the Town of Grafton. A good faith effort to obtain information, which may not be immediately available due to location or other circumstances beyond your control, will not delay processing of your application. Failure to provide required documentation might delay processing of your application.

_____ **PROOF OF INCOME of last 30 days** from any source for current month (pay stubs, wage verification form, Terminated Employment Documentation, child or alimony support payments, Worker's Compensation documentation, Social Security benefits, State Cash Assistance, Unemployment compensation, affidavit from family and friends providing assistance, etc.)

_____ **RESIDENCE/SHELTER EXPENSES** current rent receipts, mortgage book or statement, (breaking payment into principal, interest and escrow amounts), & utility bills (Electric, water, heating bill and phone).

_____ **PERSONAL EXPENSES VERIFIED** from the last 30 days expenses of prescriptions, daycare expenses (if working), required car repair bills, car registration and inspection.

_____ **PROOF OF PERSONAL OR REAL PROPERTY** vehicle registration, house, trailer, motorcycle etc and loan payment books/statements.

_____ **PROOF OF CASH and RESOURCES** Food Stamps, Medical Assistance, affidavit of cash on hand, current statements for savings/checking accounts, and checkbook, current balance of checking or savings accounts, credit union accounts, CD, IRA, 401K, Life insurance with cash value, etc

_____ **DOCTOR'S STATEMENT** if unable to work (Extent of disability and duration)

_____ **DOCUMENTATION OF APPLICATION TO STATE OR FEDERAL AGENCIES.** Application for Cash Assistance, Emergency Food Stamps, Food Stamps, Medical, or Child Care to State Welfare at the Claremont District Office 17 Water St, Claremont, NH 03743 Phone 603-542-9544.

_____ **DIVORCE DECREE OR MARRIAGE LICENSE**

_____ **PROOF OF IDENTIFICATION** picture ID, birth certificate and social security card

_____ **PROOF OF CHILDREN** picture IDs, birth certificates and/or social security cards

_____ **AFFIDAVIT** signed by you indicating that immediate financial assistance is not available from responsible relatives per State Law RSA 165:19. (attached to application)

_____ **TERMINATION or SANCTION NOTICE** from previous welfare office (state or city/town)

_____ **DOCUMENTATION OF EMERGENCY** Demand of Rent, Notice to Quit, Disconnect of Electric or Heat, or Prescriptions and MD Medical Necessity of Prescription Need Form.

_____ **OTHER** _____



Application for General Assistance

Town of Grafton

7 Library Road
Grafton, N. H. 03240

Date of Application Received:	Official reviewing Application:
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PLEASE PRINT. FILL IN ALL AREAS OR INDICATE IF SOMETHING DOES NOT APPLY.

Household Address Information

Street Number	Street Address	Apt./Unit #	Length of Time at Residence
City		State	ZIP Code
Phone: ()	Cell Phone: ()	Cell Phone: ()	

Applicants (Household Members 18 yrs old or older)

Name (first, initial, last)	Age	Date of Birth	Social Security Number	Marital Status
				<input type="checkbox"/> Single; <input type="checkbox"/> Married; <input type="checkbox"/> Divorced; <input type="checkbox"/> Separated (List Date)
				<input type="checkbox"/> Single; <input type="checkbox"/> Married; <input type="checkbox"/> Divorced; <input type="checkbox"/> Separated (List Date)
				<input type="checkbox"/> Single; <input type="checkbox"/> Married; <input type="checkbox"/> Divorced; <input type="checkbox"/> Separated (List Date)
				<input type="checkbox"/> Single; <input type="checkbox"/> Married; <input type="checkbox"/> Divorced; <input type="checkbox"/> Separated (List Date)

Other Household Members (Less than 18 yrs. old)

Names (first, initial, last)	Age	Date of Birth	Social Security #	Relationship to Applicants	Medical Coverage

List last addresses for past two years, starting with most recent residence.

Town/City/ State	Street Address	From	To	If not entire household, who?

Housing Payment Information

Pay rent Own home Lease with option to buy Number of Bedrooms:

Amount of Rent or Mortgage \$ How often paid: Monthly Weekly or Other: When due: Rent Assistance Amount if None ; \$;

Housing cost includes: Electric Heat Water Escrows for taxes and insurance Other

Landlord / Mortgage Company Information

Landlord OR Mortgage Co.	Address	City	State	Are they a Relative?
				<input type="checkbox"/> No, not a relative. <input type="checkbox"/> Parent; <input type="checkbox"/> Adult Child Other relative: <input type="text"/>

Do you currently have? Notice to Quit Demand for Rent Writ of Possession Foreclosure or Forbearance

If you have any of the above, When was the above received? When is the date of action?

General Assistance Application for Town of Grafton, NH

Non Household Relatives Responsible for Assistance per State Law 165:19

Applicant:	Mother's Name: (first and last)	Address:	City:	State:	Employment	If deceased give date:
Applicant:	Father's Name: (first and last)	Address:	City:	State:	Employment	If deceased give date:
Applicant:	Mother's Name: (first and last)	Address:	City:	State:	Employment	If deceased give date:
Applicant:	Father's Name: (first and last)	Address:	City:	State:	Employment	If deceased give date:

Additional Adults or Children's Parent or Spouse *Not Listed As Part of Household*

Applicant/ Child:	Parent's or Spouse's (Name)	Address:	City:	State:	Employment	If deceased give date:
Applicant/Child	Parent's or Spouse's (Name):	Address:	City:	State:	Employment	If deceased give date:

List All Children That Reside Outside of Household. IF NONE check here.

Applicant	Child's Name (first & last)	Address	City	State	Employment	Date of Birth

Work History of All Household Members for last 2 years.

Applicant	Employer	Position	Wage or Salary	Employment Dates	Reason for Leaving
				to	

Military Service Record of All Household Members IF NONE check here.

Veteran	Military Branch	Benefits	Dates Served	Status
			to	Honorably Discharged: <input type="checkbox"/> Active : <input type="checkbox"/>
			to	Honorably Discharged: <input type="checkbox"/> Active : <input type="checkbox"/>

List Educational Background For All Adult Household Members

Applicant:	Grade last attended	Degree:	Types of Training and Skills

If there are any circumstances that keep any household member from being Employed Full Time, please explain.

List All Assets and Accounts of Household Members:

If No Checking or Saving Accounts check here.

Name of Account Holder	Bank/Credit Union Name	Checking Account Number	Checking Balance Today	Saving Account Number	Saving Balance Today

All Household Members Cash on Hand Total is:

\$

If no cash available check here.

Household Asset Type	If None check box	Account Name or Property Address	Account Number	Account or Property Owner	Balance or Value
Certificates of Deposit (CD)	None <input type="checkbox"/>				
Savings Bonds	None <input type="checkbox"/>				
Mutual Funds	None <input type="checkbox"/>				
Stocks or Bonds	None <input type="checkbox"/>				
Retirement Accounts (IRA, 401K, 457, etc.)	None <input type="checkbox"/>				
Property other than main housing.	None <input type="checkbox"/>				
Motorcycle, Boat, ATV, RV, Snowmobile	None <input type="checkbox"/>				
Annuities	None <input type="checkbox"/>				
Trust Fund	None <input type="checkbox"/>				
Insurance Policy with cash value (whole life)	None <input type="checkbox"/>				
Other Assets	None <input type="checkbox"/>	Please List:			

Household Future Claims /Settlements or Income

Type	If None check box	Name it is under	Contact Name or Telephone #	Amount Expected	When Expected
IRS Refund	None <input type="checkbox"/>				
Insurance Claim	None <input type="checkbox"/>				
Retroactive Disability	None <input type="checkbox"/>				
Retroactive Unemployment	None <input type="checkbox"/>				
Inheritance	None <input type="checkbox"/>				
Other Lump Sum	None <input type="checkbox"/>	(explain)			

Is anyone in your Household represented by any Lawyer or have consulted a lawyer regarding a lawsuit?

Lawyer Name	Address	Telephone #	Applicant

Give details or reason or **Check NONE** :

Household Motor Vehicles

If NONE Check Box

Owner	Auto Make	Model	Year	Value	Payment Amt.	Frequency
						Week <input type="checkbox"/> Month <input type="checkbox"/>
						Week <input type="checkbox"/> Month <input type="checkbox"/>
						Week <input type="checkbox"/> Month <input type="checkbox"/>

HAVE YOU APPLIED TO TOWN OR CITY WELFARE BEFORE?

NO

YES (complete below)

If Yes WHEN? _____ WHAT CITY /TOWN? _____ UNDER WHAT LAST NAME? _____

What assistance did you receive? _____

Did you ever receive a Sanction Notice or Warning? _____

General Assistance Application for Town of Grafton, NH

Household income and Resources	Check if None	Check if N/A	Amount Last Received	Date Last Received	How often do you receive this?	Name received under.	If Applied give date.
State Cash TANF (Temporary Assistance to Needy Families)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
State Cash APTD (Aid to Permanent & Total Disabled)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Food Stamps	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Fuel Assistance	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
State Old Age Assistance	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
State Aid to the Blind	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Child Support	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Employer Disability Pay	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Retirement or Pension	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
WIC supplement foods	<input type="checkbox"/> none	<input type="checkbox"/> N/A	For:				
SSDI (Disability)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
SSI (Supplemental)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Unemployment	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Severance Pay	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Veteran's Benefit	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Vocational Rehab.	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Trust /Annuity/Saving Bond	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Income Tax Return	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Workman's Compensation	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Wages (applicant)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Wages (2 nd applicant)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Wages (3 rd applicant)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Wages (minor over 14 yrs.)	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Boarder or Rental Income	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Self Employment	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Gifts or Loans	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Other:	<input type="checkbox"/> none	<input type="checkbox"/> N/A	\$				
Medical Insurance Coverage					Check here <input type="checkbox"/> if no coverage in household.		
Insurance or Assistance	Who is covered?		Start or Application Date	End Date	Cost	Co pay cost or deductible	

Household Basic Need Expenses	None	Monthly Estimate	Last Amount Paid	Last Date Paid	Amount behind.
Rent (Includes utilities <input type="checkbox"/>)	<input type="checkbox"/>				
Mortgage (Includes Tax & Ins.Escrows <input type="checkbox"/>)	<input type="checkbox"/>				
Food	<input type="checkbox"/>				
Electric Bill (includes heat <input type="checkbox"/>)	<input type="checkbox"/>				
Heat (natural gas <input type="checkbox"/> , propane <input type="checkbox"/> , oil <input type="checkbox"/>)	<input type="checkbox"/>				
Telephone/Cell phone	<input type="checkbox"/>				
Prescriptions Expenses	<input type="checkbox"/>				
Car Payment	<input type="checkbox"/>				
Car Gasoline	<input type="checkbox"/>				
Household cleaners, paper product, laundry & personal hygiene supplies.	<input type="checkbox"/>				
Child Care Expense for working hours.	<input type="checkbox"/>				
Rent Lot for Mobile Home	<input type="checkbox"/>				
Satellite	<input type="checkbox"/>				
Internet/Other: _____	<input type="checkbox"/>				

List any unplanned, emergency or irregular expenses that you have documentation for **in the last 30 days**. Such as Car registration, inspection, repairs; Drivers License; Water Bill, Transportation Costs; Taxes (Income or Property & Sewer); Home repairs or insurance; Medical or Dental Bills; Court ordered Fines or payments. (Will need documentation).

List Expense	Check if NONE <input type="checkbox"/>	Amount of Expense Paid	Date Expense Paid	Balance still owed

ASSISTANCE REQUESTED: _____

REASON FOR REQUEST: _____

Please initial each statement below showing that you have read and understand the statement. Please do not hesitate to ask any questions.

I understand that if our household receives assistance then our household members will be required to repay any assistance provided if we are returned to income status which enables us to reimburse the Town without financial hardship. (RSA 165:20-b) _____ (initials)

I understand that if our household receives assistance from the Town household adult members over 18 years may be required to participate in work program to re-pay my assistance and complete job search for full time work. (RSA 165:20-b) _____ (initials)

I understand that if our household receives assistance, the Town may place a lien against any real property in which any household member owns. For Real Estate a lien will be recorded with the Registry of Deeds and accrue a 6% interest starting one year after first assistance is given. After re-payment a lien is removed. (RSA 165:28) _____ (initials)

I understand that if assisted, the Town may place a lien against any property settlement or civil judgment for personal injuries which I receive with six years of receiving Town Assistance. (RSA 165-28-a) _____ (initials)

I understand that the Town reserves the right to investigate and pursue reimbursement from responsible relatives. (RSA 165:19) _____ (initials)

I understand that if anyone in my household obtains a job after we are assisted by any municipality and he/she later quits the job without good cause, we may be ineligible for local assistance from any municipality for a period of up to ninety days. (RSA 165:1-d) _____ (initials)

I understand that any changes in status of the above information must be reported to the Welfare Official within 3 working days. _____ (initials)

I understand that the information supplied in this application and verifications provided are subject to investigation. _____ (initials)

I further understand that my signature(s) below constitutes the granting of my authority for the Town of Grafton to obtain verification and / or proofs from appropriate sources having knowledge concerning our household circumstances. _____ (initials)

(THIS SECTION BELOW MUST BE SIGNED AND WITNESSED IN THE PRESENCE OF THE WELFARE OFFICIAL)

I hereby certify that the information I have provided on this application is complete to the best of my knowledge and belief and provides true information of my income, assets, resources, expenses and needs. I understand any false, misleading or omitting information or statements in my application shall result in termination of any assistance and prosecution per RSA 641:3.11 (a-c) which a person is guilty of a misdemeanor if with a purpose to deceive a public servant in the performance of his or her official function.

I hereby certify that all the 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 or misleading information or withhold or omit information related to my receipt of assistance, now or in the future, the Town assistance shall be terminated and I shall be prosecuted for the crime of Unsworn Falsification. (RSA 641:3) .

Applicant Signature:		Date:	

Sworn before me this _____ day of _____ 20_____

Welfare Official



Town of Grafton
 7 Library Road
 Grafton, N. H. 03240

Signature Page for Adult Applicants:

 Applicant Name (print)

 Co-applicant Name (print)

 Spouse Name (print)

 Co-applicant Name (print)

Applicants Reimbursement Agreement

I/ We understand and agree to repay the Town of Grafton , NH for any assistance granted pursuant to RSA 165 at some future date when possible. Such recovery of these expenses shall be made through a repayment program per RSA 165:20-B.

 Applicant Signature Date

 Co-applicant Signature Date

 Spouse Signature Date

 Co-applicant Signature Date

Applicants Authorization to Furnish Information

I/ We authorize and request any relative, physician, lawyer, banking/lending/financial institution, check cashing service, employer, former employer, rental/leasing company, utility, insurance company, healthcare provider, mental health professional /provider, pharmacy, hospital, emergency care facility, ambulance service, funeral home/ crematorium, rent-to-own business, police, sheriff, State Police, fire department, tax preparer, accountant, Department of Homeland Security, Social Security Administration, any state or county division of Health and Human Services, Division of Children Youth and Families, Division of Adult and Elderly, NH Legal Assistance, any town, city, county, state or federal department, shelter, domestic violence or crisis organization, Department of Employment Security, Veteran's Administration, Southern NH Services, or any other public, religious or private organization providing assistance or help or any other person, business, organization or agency having information concerning my circumstances to furnish such information to the Grafton, NH Welfare Administrator for the purposes of my establishing application for general assistance.

 Applicant Signature Date

 Co-applicant Signature Date

 Spouse Signature Date

 Co-applicant Signature Date

Applicants Release of Information

I/We authorize the Town of Grafton, NH Welfare Department to release information to any relative, physician, lawyer, banking/lending/financial institution, check cashing service, employer, former employer, rental/leasing company, utility, insurance company, healthcare provider, mental health professional /provider, pharmacy, hospital, emergency care facility, ambulance service, funeral home/ crematorium, rent-to-own business, police, sheriff, State Police, fire department, tax preparer, accountant, Department of Homeland Security, Social Security Administration, any state or county division of Health and Human Services, Division of Children Youth and Families, Division of Adult and Elderly, NH Legal Assistance, any town, city, county, state or federal department, shelter, domestic violence or crisis organization, Department of Employment Security, Veteran's Administration, Southern NH Services, or any other public, religious or private organization providing assistance or help or any other person, business, organization or agency concerning my/our circumstances in the event that it should be necessary that such release is made to further my application for or receipt of assistance or benefits from that agency I agree to waive my right of privacy and confidentiality.

 Applicant Signature Date

 Co-applicant Signature Date

 Spouse Signature Date

 Co-applicant Signature Date

SELF DECLARATION AFFIDAVIT FOR RESPONSIBLE RELATIVES

To Grafton Town Welfare:

Let it be know that I, _____, do hereby state that I do not have any responsible relatives (Mother, Father, Father-in-law, Mother-in-law, Stepfather, Stepmother, Daughter or Son) that are able to assist me financially at this time in accordance with the law RSA 165:19.

The reasons they are financially unable to help are:

By signing below I understand that “a person is guilty of a misdemeanor if with a purpose to deceive a public servant in the performance of his official function he makes any written false statement which he does not believe to be true, or if he knowingly creates a false impression for pecuniary or other benefits by omitting information necessary to prevent statements therein from being misleading, or if he submits or invites reliance on any written which he knows to be lacking in authenticity.” NH State Law RSA 641:3.11

Applicant's Signature _____ Date _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

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 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 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