

Town of Hillsborough, NH

Application for Assistance

Date of Application _____

Referred By _____

GENERAL INFORMATION:

Name _____ Date of Birth _____

Address _____ (_____)
Mailing Address _____ How long at this address? _____

Telephone _____ Social Security # _____

Marital Status _____ Rent or Own _____ United States Citizen Yes No

Spouse/Co-Applicant Name _____

Spouse Address (if not the same as applicant) _____

Assistance Requested _____

Reason for Request _____

If you have a Rep Payee, provide name & phone: _____

Have you applied for local assistance before? _____ When? _____

Where? _____ Under what name? _____

List below all persons living in your household: (Use an additional sheet if necessary)

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 Residency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RENTAL HOUSING INFORMATION:

Rent Amount _____ per week or month Date Last Paid _____ Due Date _____

Do you have a current Demand for Rent* Notice to Quit* Landlord/Tenant Writ*

* Total Rent Owed _____ For What Months? _____

Do you have a housing subsidy? Yes No If YES, What Kind? _____

Utilities Included: Heat Electric Gas Water/Sewer Other _____

Landlord Name _____ Telephone _____

Address _____

IF YOU ARE A HOME OWNER: Mortgage Amount _____ Date Last Paid _____

Bank/Mortgage Co. _____ Telephone _____

Address _____ Do you have a foreclosure notice? _____

Are you currently in process for a modification? _____ With Whom? _____

Do you have a Mortgage Cousellor? _____ If yes, Who? _____ Phone: _____

Name and Address of Agency: _____

EDUCATION/TRAINING/EMPLOYMENT:

	Highest Grade Attended	GED/ Diploma	Special Training or Skills	Military Service
Applicant	_____	_____	_____	_____
Spouse/Co-Applicant	_____	_____	_____	_____

CURRENT EMPLOYER:

Applicant

Co-Applicant

Employer _____ Position _____

Date you started work _____ Date AND Amount of last check _____

CURRENT EMPLOYER:

Applicant

Co-Applicant

Employer _____ Position _____

Date you started work _____ Date AND Amount of last check _____

LIST ANY OTHER EMPLOYERS FOR ANY OTHER MEMBERS OF THE HOUSEHOLD:

Name	Employer	Pay	Employment Dates	Reason for Leaving

HOUSEHOLD ASSETS:

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

Name	Bank/Credit Union	Savings Acct #	Balance	Checking Acct #	Balance

Provide current value of any assets held by you and all household members: (all must be filled in)

Cash on Hand (combined household)	\$ _____	Annuities	\$ _____
Certificates of Deposit (CD's)	\$ _____	Stocks	\$ _____
Savings Bonds	\$ _____	Trust Funds	\$ _____
Mutual Funds	\$ _____	Retirement	\$ _____
Insurance Policies (cash value)	\$ _____	401K	\$ _____
Property other than primary residence	\$ _____	Location _____	
Other Investments	\$ _____	Motorcycles/Boats/ATV's, etc.	\$ _____
Other Assets (please list)	_____		

Claims/Settlements/Income due to you or any household member: (all must be filled in)

IRS Refund	\$ _____	Retroactive Unemployment or Worker's Compensation	\$ _____
Insurance Claim	\$ _____	Inheritance	\$ _____
Retroactive Disability	\$ _____	Other Lump Sum Payment	\$ _____

Do you (the applicant) have a lawsuit pending? Yes No

Lawyer Name/Address: _____

Nature of Lawsuit: _____

Does any household member have a lawsuit pending? Yes No Who? _____

Lawyer Name/Address: _____

Nature of Lawsuit: _____

Motor vehicles owned by you and all household members:

Owner	Make	Model	Year	Value	Auto Payment	Insurance Yes/No	Insurance Payment

HOUSEHOLD INCOME:

Indicate any benefits or income received or applied for by you or anyone in your household:

	Name	Date Applied	Date Last Received	Amount
ANB (Aid to the Needy Blind)				
APTD				
Child Support				
Disability (Employer)				
Food Stamps				
Fuel Assistance				
Gifts/Loans				
Maternity Benefits				
Medicaid				
OAA (Old Age Assistance)				
Retirement				
Severance Pay				
Social Security				
SSDI				
SSI				
TANF				
Unemployment				
Vacation Pay				
Veteran's Pension				
Vocational Rehabilitation				
WIC				
Worker's Compensation				
Other _____				

Are you or any other household member working, volunteering and/or receiving assistance from any other agencies? Yes (Enter info below) No

Name	Agency	Contact Person
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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	\$ _____	Prescription	\$ _____
Bus/Cab	\$ _____	Electric	\$ _____	Rent	\$ _____
Cable/Internet	\$ _____	Food and Household	\$ _____	Rent-to-Own	\$ _____
Child Support Paid	\$ _____	Fuel Oil	\$ _____	School Loan	\$ _____
Car Gasoline	\$ _____	Propane (Metered/Tank)	\$ _____	Storage	\$ _____
Car Insurance	\$ _____	Medical Insurance	\$ _____	Telephone	\$ _____
Car Payment	\$ _____	Laundry	\$ _____	Other	_____ \$ _____
Condo Fee	\$ _____	Loan	\$ _____	Other	_____ \$ _____
Child Care	\$ _____	Lot Rent	\$ _____	Other	_____ \$ _____
Credit Card	\$ _____	Mortgage	\$ _____	Other	_____ \$ _____

If your income comes up short for the month or you have an emergency expense, which of the above expenses do you usually skip first? _____

Why? _____

List unplanned, emergency or irregular periodic expenses during the past 30 days:

Car Inspection	\$ _____	Drivers License	\$ _____	Medical	\$ _____
Car Registration	\$ _____	Fines/Court Payment	\$ _____	Water/Sewer	\$ _____
Car Repair	\$ _____	Home Repairs	\$ _____	Property Tax	\$ _____
Dental	\$ _____	Home/Rent Insurance	\$ _____	Other	\$ _____
Bail	\$ _____	Payday/Title Loan	\$ _____		

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? _____

Details _____

Town/City of Conviction _____ State _____ County _____

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: _____

LIABILITY FOR SUPPORT INFORMATION - RSA 165:19

Applicant:

Father _____ Address _____ Phone _____

Deceased

Mother _____ Address _____ Phone _____

Deceased

Co-Applicant:

Father _____ Address _____ Phone _____

Deceased

Mother _____ Address _____ Phone _____

Deceased

Applicant's/Co-Applicant's Adult Children:

Name _____ Address _____ Phone _____

CERTIFICATIONS/SIGNATURES/RELEASE OF INFORMATION:

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 Human Services Official immediately upon receipt of any money from or upon the settlement or civil judgment for personal injuries (except worker's compensation settlement) which I receive within six years of receiving municipal assistance. RSA 165:28-a

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 the information requested on this application. I hereby certify that all information I will provide in response to questions asked by the human services 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 recipient of Temporary Assistance for Needy Families (TANF) cash benefits and I fail to comply with TANF regulations, leading to a sanction and loss of income, the municipality may, under certain circumstances, disregard this decrease in my income. RSA 165:1-e



I/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 General Assistance staff. I/We also authorize the IRS, Social Security Administration, any State or County Division of Health & Human Services, Division of Children Youth and Families, Division of Adult & Elderly, NH Legal Assistance, and City/Town Welfare Dept, shelter, Dept of Employment Security, Veteran's Administration and Fuel Assistance, or any non-profit agency to release information from their files to the Town of Hillsborough General Assistance Staff.

I also waive my right to privacy and confidentiality contained in my file and/or any information received by the Town of Hillsborough General Assistance Dept and authorize the Department to release such information to other agencies to the extent that such release is made to further my application for, or receipt of, assistance from that agency.

X

Applicant Signature

Date

Signature of person completing app if not applicant

X

Co-Applicant Signature

Date

Relationship and Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION - DHHS



I, _____, the undersigned, understand that from time to time, the local welfare administrator for the Town of Hillsborough may require certain information about assistance I am applying for or receiving from the New Hampshire Department of Health and Human Services, Division of Family Assistance (DFA). When information cannot be provided by me personally, I hereby authorize DFA to release the following information to the local welfare administrator for the specific purposes outlined below:

Type of Information	Purpose for Requesting this Information
Date of DFA application(s), types(s), of assistance applied for, date of eligibility determination, expected date of benefit insurance, 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 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.

X _____
Applicant Signature

Date

X _____
Co-Applicant 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