Town of Epsom
Welfare Department
1598 Dover Road
Epsom, NH 03234

Welfare Phone: 736-5507
Selectmen's Office Phone: 736-9002

Your appointment is scheduled for:

Monday Tuesday Wednesday Thursday Friday

_____ **at** _____
DATE TIME

If you will be late for your appointment, please call and notify this office **as soon as possible**. You may have to be rescheduled. If you need to reschedule this appointment or have questions, please call.

You will need to be prepared to present your completed application and required documentation at the time of your appointment. Failure to provide completed application and documentation may result in a delay and/or denial of your request for assistance.

THIS APPLICATION IS A LEGAL DOCUMENT. Please read carefully before completing this application for assistance. Once submitted to the department for consideration, the application and related material become the property of the Town of Epsom and shall be considered confidential. ****If a question on this form is unclear to you, discuss it with the welfare official**

REQUIRED VERIFICATIONS

Every applicant must provide the following documentation/verifications at their appointment:

Completed Application (if your application is not completed, you may be rescheduled)

Photo ID plus a 2nd form of identification such as a social security card or birth certificate required for all adult household members. **I-94** card if applicable.

Minor household members will need 2 forms of identification: social security card, birth certificate, or Medicaid/Insurance card.

Landlord Verification Form completed by the landlord, rental office, or authorized agent for the landlord.

A **30-day** activity report on all checking and savings accounts in the household, 401K, Retirement.

Your state issued debit card for child support. If you pay child support, bring in receipts showing amount of support paid.

Last **4 weeks** of pay-stubs or proof of net wages. If you do not have 4 weeks of pay stubs, provide a statement from the employer that includes date of hire, start date, hourly rate, hours per week, pay schedule, contact name and phone number.

Last **4 weeks** of receipts and proof of bills paid.

All pages of bills, any disconnect notices, eviction papers (demand for rent/notice to quit or writ)

Vehicle registration if you own a vehicle (car, motorcycle, etc.).

EBT card (if you, the co-applicant or any household members have one).

Medicaid cards for applicant, co-applicant and any household members.

If you are **unemployed**, verification that you have applied for or are receiving Unemployment Compensation.

Documentation of divorce, custody/child support and/or restraining orders.

If you share a house/apartment with a roommate(s), statement outlining division of expenses.

Other: _____

Provide the following verifications if it applies to your situation:

Verification that you have applied for, or are receiving Social Security Benefits.

A medical verification from treating physician of illness or injury.

A copy of your lease or rental agreement.

Verification from State Welfare if you applied for, or receive, any of the benefits listed below. For verification we need DHHS issued paperwork which documents all benefits received.

Other: _____

The applicant and/or co-applicant are responsible *at each appointment* for providing full and accurate information regarding your household income and expenses, household members, current address, details of your current situation and any changes in regards to this information.

Failure to provide required verifications/documentation may result in a delay and/or denial of your request for assistance.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES

The Town of Epsom Welfare Department provides temporary emergency assistance to Town residents for the basic necessities of life when all other resources have been exhausted. Assistance is rendered in voucher form only.

Department of Health & Human Services (State Welfare) is located at 40 Terrill Park Drive, Concord; phone 271-6200. State welfare programs are listed below. Currently, you can walk in between the hours of 8AM – 4 PM, Monday through Friday, to make an appointment. You may also apply at NH Easy Gateway to Services.

ANB – Aid to the Needy Blind

APTD – Aid to the Permanently & Totally Disabled

Child Care

Child Support

TANF – Temporary Assistance to Needy Families

Food Stamps

Emergency Food Stamps

Healthy Kids Program

Medicaid

OAA – Old Age Assistance

Town of Epsom, NH **Application for Assistance**

Date of Application _____ **Referred By** _____

GENERAL INFORMATION:

Name _____ Date of Birth _____

* _____

*List any other names you or the co-applicant have used or been known by

Address _____

Telephone _____ Social Security # _____

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

Spouse/Co-Applicant Name _____

Spouse/Co-Applicant Date of Birth _____ Social Security # _____

Spouse/Co-Applicant Telephone _____

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 other persons living in your household: (Use 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

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 _____ Do you have a housing subsidy? ❑Yes ❑No

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? _____

EDUCATION/TRAINING/EMPLOYMENT:

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

APPLICANT WORK HISTORY:

Are you currently employed? ❑Yes ❑No*

Employer _____ Position _____

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

*If you are currently unemployed state reason _____

Former Employer _____ Position _____

Date last worked _____ Date/Amount of last check _____

Are you able to work now? ❑Yes ❑No If No, why _____

Other than your current employer, list two most recent jobs for yourself and household members over the age of 18:

Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving
Name	Employer	Pay	Employment Dates	Reason for Leaving

HOUSEHOLD ASSETS:

Provide information regarding 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:

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:

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 any household member:

	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	$	Rent-to-Own	$
Child Support Paid	$	Fuel Oil	$	School Loan	$
Gasoline	$	Gas-Bottled/Natural	$	Storage	$
Car Insurance	$	Medical Insurance	$	Telephone	$
Car Payment	$	Laundry	$	Other	$
Condo Fee	$	Loan	$	Other	$
Child Care	$	Lot Rent	$	Other	$
Credit Card	$	Mortgage	$	Other	$

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	$

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

Your Father _____ Address _____ Phone _____
❑ Deceased

Your Mother_____ Address _____ Phone _____
❑ Deceased

Co-Applicant:

Father _____ Address _____ Phone _____
❑ Deceased

Mother_____ Address _____ Phone _____
❑ Deceased

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

Name_____ Address _____ Phone _____

Name_____ Address _____ Phone _____

Name_____ Address _____ Phone _____

Name_____ Address _____ Phone _____

Name_____ Address _____ Phone _____

CURRENT MEDICAL INFORMATION:

Are you or anyone in the household under the care of a physician for any reason? ❑ Yes ❑ No If yes, provide the following information:

Patient's Name	Doctor's Name & Address	
Telephone	Date of Last Visit	Date of Next Visit

Illness/Disability/Condition being treated: _____

Patient's Name	Doctor's Name & Address	
Telephone	Date of Last Visit	Date of Next Visit

Illness/Disability/Condition being treated: _____

Patient's Name	Doctor's Name & Address	
Telephone	Date of Last Visit	Date of Next Visit

Illness/Disability/Condition being treated: _____

List prescription medications currently prescribed to your or household members:

_____ for the treatment of _____

_____ for the treatment of _____

_____ for the treatment of _____

_____ for the treatment of _____

Have you served in the Military? ❑ Yes ❑ No Discharge: _____
Month Year

If you answered yes to the above question, are you eligible for medical care through the Veteran's Administration? ❑Yes ❑ No

CERTIFICATIONS/SIGNATURES/RELEASE OF INFORMATION:

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, after 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 Administrator immediately upon receipt of any money from or upon the settlement of such claim. I understand that if I am assisted, Welfare Administration may place a lien against any property settlement or civil judgment for personal injuries (except any workers' 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 NH DHHS cash on my EBT and/or debit card and if I fail to comply with NH DHHS 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 Municipal Welfare Department. 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, any 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 Epsom Municipal Welfare Department.

I also waive my right to privacy and confidentiality contained in my file and/or any information received by the Town of Epsom Welfare Dept and authorize the Epsom Welfare Dept 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

AUTHORIZATION FOR THE RELEASE OF INFORMATION - DHHS

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

LANDLORD VERIFICATION FORM

In order to determine assistance for:_____
It is necessary to have the following information completed by the Property Owner / Authorized Agent.

Name(s) on Lease: _____

All other household members: _____

Address of Rental: _____

Rental Amount: $ _____ Per: ___ Month ___ Week ___ Bi-Weekly

Security Amount: $ _____ Paid by: ___ Check ___ Cash ___ Money Order

Is the tenant responsible for the full amount of rent? ❑Yes ❑ No* Tenant's responsibility*: _____

Date of Occupancy: _____ Date Rent Last Paid: _____ $ _____

Current Rent Due: $ _____ Indicate any utilities included in rental amount:
___ Heat ___ Gas ___ Electric ___ Hot Water
Past Rent Due: $ _____ ___ Water Only

Damage / Late Fees: $ _____ Number of Bedrooms: _____

Total Due: $ _____ Number of Demands for Rent / Eviction Notices issued in the last 12 months: _____

Property Owner(s) Name(s): _____

Address: _____ Phone: _____

AND

If this property is managed by an authorized Business or Agency, please complete the following:

Business / Agency Name: _____

Address: _____ Phone: _____

Contact Name: _____ Email: _____

IMPORTANT INFORMATION

Checks will be made payable to the person(s) as listed on line 1 of the W9; if the checks are to be payable to a business/agency, complete line 2 of the W9 (leave line 1 blank). Checks will be mailed to the address entered on the W9.

_____ _____

Signature* Date

___ Property Owner ___ Authorized Agent

* Falsification of information is a prosecutable offense pursuant to RSA 641:3