



## **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 CITY OF FRANKLIN and shall be considered confidential.

It shall be the right of any individual regardless of race, age, gender, sexual orientation, religious or political affiliation to apply for local welfare assistance.

Each application will be reviewed with the applicant in order to make a determination regarding the applicant's eligibility for assistance. If the applicant does not agree with the decision of the Welfare Director regarding the determination of eligibility based on the current Welfare Guidelines of the CITY OF FRANKLIN, the applicant may request a Fair Hearing within five (5) days of the date of such written decision.

YOU, THE 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.

All questions must be answered fully. Failure to complete any part of this application may delay processing the request for assistance. Blank spaces will be considered an omission of information. Applicants must comply with any requests for information by the Welfare Director necessary for determination and investigation of applicant's eligibility for assistance. Failure to comply with requests may result in withdrawal of the application for assistance, denial of assistance requested, or suspension pursuant to RSA 165:1-b.

\* If a question on this form is unclear to you, discuss it with the welfare official.



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

Welfare Department:

Phone: 934-3404

Fax: 934-7413

To the Applicant:

Notes:

**FOR RENTAL ASSISTANCE:** You must contact the Code Enforcement Officer, Chuck Bodien, at (603) 934-5680, to schedule an inspection of your residence. The inspection must have been done **PRIOR** to you scheduling an interview with the Welfare office.

**RENTAL RATES PAID AT THE RATE OF 1/2 OF THE RENT UP TO A CAP OF \$500.00 PER MONTH. THE TENANT WILL PARTICIPATE IN THEIR HOUSING EXPENSES ALONG WITH THE CITY. Note the City does not issue Security deposits{CAP does, ten day+ process} or First month's rent.**

**IF YOUR UTILITIES HAVE BEEN SHUT OFF:** Please be advised that if your PSNH service has been shut off and if you are eligible for assistance with this month's current charges, PSNH is demanding that you make a new payment arrangement for the remainder of the bill and that you make the **FIRST PAYMENT ON THIS ARRANGEMENT IMMEDIATELY EITHER BY CREDIT CARD OR BY A CASH PAYMENT MADE AT HANNAFORD FOOD AND DRUG STORE BEFORE THEY WILL TURN YOUR SERVICE BACK ON.**

**If you are requesting any assistance from the Franklin Welfare Department, you will need to complete this application. Please follow the directions below:**

1. All adults in the household **MUST** sign all the forms and come to the interview unless working.
2. The landlord's form must be completed only by the landlord. Do not fill in the top and then give it to your landlord to sign the bottom.
3. All disabled adults living at your address not receiving Social Security disability benefits or APTD benefits must have the Disability Verification Form completed by their physician.
4. Any recently unemployed adult living at your address must have the employment termination form completed and must have the unemployment benefit form completed by the Unemployment Office in either Concord or Laconia.
5. Any adult that has just started a job and who does not have a paycheck yet, must have the New Employment form completed.
6. You will need the last 4 weeks of paychecks for each working adult or the Income Verification form completed for each working adult. **If you are self employed or have a business you will need to complete either form 433A or 433B. Please ask for a copy of this form.**
7. If you have been working and are now disabled, please have the employment disability benefits form completed by your employer.
8. **Please read page two of the application (Verification Required for Application) and bring all requested verifications of assets, living expenses, and identification to the appointment.**

*Once you have gathered all the information,  
Call the Welfare office for an appointment at (603) 934-3404  
Between the hours of*

*8:00 a.m.-12:00 p.m. on Tuesday or Thursday;  
Or, between 12:00 p.m. and 4:00 p.m. MONDAY and FRIDAY.*

*All requested information for the application for assistance refers to the City of Franklin adopted welfare guidelines.*

*DURING THE SUMMER THE WELFARE OFFICE IS CLOSED-  
ASK FOR JUDIE MILNER EXT. 6 FOR ASSISTANCE ON WEDNESDAYS  
OR YOU COULD CALL 211 FOR HELP AS WELL.*



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WELFARE APPLICATION

Welfare Department:

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## RESPONSIBILITIES OF EACH APPLICANT AND RECIPIENT

At the time of initial application, and at all times thereafter while you are receiving assistance, the applicant/recipient has the following responsibilities:

1. To provide accurate, complete and current information concerning needs and resources and the whereabouts and circumstances of relatives who may be responsible under RSA 165:19.
2. To notify the Welfare Official within 72 hours when a change in needs or resources may affect eligibility for continuing assistance.
3. To keep all appointments as scheduled and to return all information that is needed within the specified time frames so that once assistance is granted, no lapse of benefits such as TANF, APTD, Food Stamps occurs.
4. To notify the Welfare Director within 72 hours of a change of address and any change in the members of the household.
5. To diligently search for employment and provide verification of application for employment when requested, following a determination of eligibility for assistance.
6. To accept employment when offered, following a determination of eligibility for assistance.
7. To provide a doctors statement if any work eligible adult in the household claims an inability to work due to medical problems.
8. To participate in the welfare work program if physically and mentally able, following a determination of eligibility for assistance.
9. To keep appointments as scheduled for Franklin City Welfare knowing that if you are more than 15 minutes late you will be considered a no show and may not be eligible for rescheduling for 7 calendar days from your missed appointment date.
10. To diligently work towards independence of local welfare assistance through employment of other forms of public assistance or by banking available assets for moving into affordable housing.
11. It is the responsibility of the food voucher recipient to follow the list of allowable foods and non food products printed on the food voucher and not to purchase or attempt to purchase items not listed. Misuse of the food voucher will be grounds for suspension.
12. To apply for and utilize immediately, but no later than seven (7) days from initial application, any benefits or resources, public or private, that will reduce or eliminate the need for general assistance.

A RECIPIENT'S ASSISTANCE MAY BE TERMINATED OR SUSPENDED FOR FAILURE TO FULFILL ANY OF THESE RESPONSIBILITIES WITHOUT REASONALBE JUSTIFICATION.

**Any person may be denied or terminated from General Assistance or prosecuted for a criminal offense, which, by means of intentionally false statements or intentional misrepresentation or by impersonation or other willfully fraudulent act or device, obtains or attempts to obtain any assistance to which he/she is not entitled.**

These responsibilities have been read and I believe that I understand my responsibilities when applying for General Assistance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(18)



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

*Welfare Department:*

*Phone: 934-3404*

*Fax: 934-7413*

1.1.2014 updated

Name \_\_\_\_\_ Date \_\_\_\_\_

Service \_\_\_\_\_

### VERIFICATIONS REQUIRED FROM APPLICANTS FOR ASSISTANCE

*You will need to bring the following documentation with you for your appointment. A decision will not be made until all documentation requested has been supplied.*

1. **PROOF OF IDENTIFICATION FOR EACH HOUSEHOLD MEMBER.** This can be a birth certificate, social security card or pictured identification.
2. **PROOF OF RESIDENCE.** The attached rental form must be completed by the landlord.
3. **PROOF OF INCOME.** You need to verify in writing all income received in the household during the past 4 weeks. This is done by paycheck stubs, Social Security Grant Letters, State Welfare decision letters, Workman's Comp. check stubs, Unemployment check stubs, child support, and pension grant letter, etc.
4. **UTILITY VERIFICATION.** Bring in your current months electric, gas and water bills.
5. **VERIFICATION OF PENDING AID.** Proof of your application to State Welfare, Social Security, Workers' Comp., Unemployment, Fuel Assistance, Short Term Disability, Etc.
6. **PROOF OF PERSONAL PROPERTY.** This would be vehicle registration, house deed, trailer deed, stocks, bonds, and any other assets.
7. **PROOF OF CASH RESOURCES.** Current savings and checking account statements for all household members, including children.
8. **DISABILITY VERIFICATION.** If you are unable to work, you will need to prove this by having the medical form completed by your physician.
9. **RSA 165:19.** You need to provide a statement from your parents that they cannot afford to assist you with your financial need at this time.

1c



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

Welfare Department:

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I AUTHORIZE AND REQUEST ANY RELATIVE, LAWYER, BANKER, INSURANCE CO., LOCAL WELFARE OFFICE, OR ANY OTHER ORGANIZATION OR PERSON HAVING INFORMATION CONCERNING MY ELIGIBILITY FOR ASSISTANCE TO FURNISH SUCH INFORMATION TO THE WELFARE DIRECTOR. I HAVE THE RIGHT TO A REVIEW IF I AM NOT SATISFIED WITH THE DECISION. I AUTHORIZE THE SECURITY OFFICE, SCHOOL PERSONNEL, COMMUNITY ACTION PROGRAM, OR ANY PERSON OR ORGANIZATION TO SUPPLY ANY INFORMATION NEEDED IN ORDER TO CONDUCT WELFARE BUSINESS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### INCOME TAX REFUND

PLEASE BE ADVISED THAT IF YOU ARE REQUESTING ASSISTANCE FROM THIS OFFICE, ALL INCOME TAX REFUNDS WILL BE CONSIDERED INCOME AND MUST BE USED FOR ALLOWABLE EXPENSES SUCH AS RENT, UTILITIES, MEDICATIONS, MEDICAL BILLS, AND CHILD CARE. BUDGETS IN THIS OFFICE WILL INCLUDE ALL INCOME AND ASSISTANCE WILL BE DETERMINED FROM THE HOUSEHOLD BUDGET.

YOU ARE REQUIRED TO PROVIDE THIS OFFICE WITH A COPY OF YOUR INCOME TAX RETURN PAPERWORK. YOU MUST IMMEDIATELY NOTIFY THIS OFFICE OF ANY REFUND PAYMENT. NOT DOING SO WILL BE CONSIDERED FRAUD AND WILL BE PROSECUTED ACCORDINGLY.

I (WE) HAVE READ AND UNDERSTAND THE ABOVE. I (WE) WILL PROVIDE A COPY OF MY/OUR INCOME TAX PAPERWORK WITHIN 7 DAYS OF WHEN I FILE. I WILL KEEP RECEIPTS OF WHAT THE MONEY HAS BEEN SPENT ON TO PROVIDE TO THE CITY OF FRANKLIN IN THE EVENT THAT I NEED ASSISTANCE AGAIN IN THE FUTURE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(10)

# APPLICATION FOR ASSISTANCE

Date of Application \_\_\_\_\_ Referred By \_\_\_\_\_

Assistance Requested \_\_\_\_\_

Reasons for Request \_\_\_\_\_

## I. General Information

### Applicant

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Address \_\_\_\_\_

Mailing Address, if different \_\_\_\_\_

Home Phone \_\_\_\_\_ Rent or Own? \_\_\_\_\_ How long at this address? \_\_\_\_\_

Type of Housing:  House  Apt  Mobile Home  Other: \_\_\_\_\_

Household Composition: # 18 & Over \_\_\_\_\_ # under 18 \_\_\_\_\_ # of Bedrooms \_\_\_\_\_

If at current address less than 12 months, list past 12 month's addresses:

Street	Town/City	State	Dates of Residence
--------	-----------	-------	--------------------

\_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security# \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Education:  High School Diploma  Less than HS Diploma  GED  Some College  
 2 Year Associates  4 Year Bachelor  Graduate Studies

Citizenship:  United States  Other: \_\_\_\_\_

Ethnicity:  White/Caucasian  Other: \_\_\_\_\_

Special Training/Skills: \_\_\_\_\_

Currently employed?  Full Time  Part Time  Self Employed  Unemployed

Have you applied for local assistance before?  Yes  No When? \_\_\_\_\_

where? \_\_\_\_\_ Under what Name? \_\_\_\_\_

Actively serving in the U.S. Military?  Yes  No If YES, Branch \_\_\_\_\_

U.S. Veteran?  Yes  No Discharge Date: Month \_\_\_\_\_ Year \_\_\_\_\_

Discharge Status:  Honorable  Dishonorable  Other

Do you have Medicare or Medicaid? (circle one) ID Number: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ EBT Card # \_\_\_\_\_

**Spouse/Co- Applicant**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security# \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Education:  High School Diploma  Less than HS Diploma  GED  Some College  
 2 Year Associates  4 Year Bachelor  Graduate Studies

Citizenship:  United States  Other: \_\_\_\_\_

Ethnicity:  White/Caucasian  Other: \_\_\_\_\_

Special Training/Skills: \_\_\_\_\_

Currently employed?  Full Time  Part Time  Self Employed  Unemployed

Have you applied for local assistance before?  Yes  No When? \_\_\_\_\_

where? \_\_\_\_\_ Under what Name? \_\_\_\_\_

Actively serving in the U.S. Military?  Yes  No If YES, Branch \_\_\_\_\_

U.S. Veteran?  Yes  No Discharge Date: Month \_\_\_\_\_ Year \_\_\_\_\_  
 Discharge Status:  Honorable  Dishonorable  Other

Do you have Medicare or Medicaid? (circle one) ID Number: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ EBT Card # \_\_\_\_\_

**Other Household Members: List all persons living in your household**

Full Name	Relation	Birth Date	Social Security #	Health Insurance
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If children listed have a biological parent not residing with you, list information on each child's biological parent. (Do not list yourself under Parent's Name)

Parent's Full Name	Relationship	Birth Date	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**2. Employment History**

**Applicant**

Employer \_\_\_\_\_ Position \_\_\_\_\_

Date you started work: \_\_\_\_\_ Date & Amount of last paycheck: \_\_\_\_\_

Pay Period Frequency:  Daily  Weekly  Bi-weekly  Monthly  Quarterly

If you are currently unemployed, state reason: \_\_\_\_\_

Former Employer \_\_\_\_\_ Position \_\_\_\_\_

Date last worked: \_\_\_\_\_ Date & Amount of last paycheck: \_\_\_\_\_

Are you able to work now?  Yes  No If NO, why not? \_\_\_\_\_

List two most recent jobs before current:

Employer	Pay	Employment Dates	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____

**Spouse/Co- Applicant**

Employer \_\_\_\_\_ Position \_\_\_\_\_

Date you started work: \_\_\_\_\_ Date & Amount of last paycheck: \_\_\_\_\_

Pay Period Frequency:  Daily  Weekly  Bi-weekly  Monthly  Quarterly

If you are currently unemployed, state reason: \_\_\_\_\_

Former Employer \_\_\_\_\_ Position \_\_\_\_\_

Date last worked: \_\_\_\_\_ Date & Amount of last paycheck: \_\_\_\_\_

Are you able to work now?  Yes  No If NO, why not? \_\_\_\_\_

List two most recent jobs before current:

Employer	Pay	Employment Dates	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____

**Work History for Other Household Members over 18: List two most recent jobs**

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

**3. Housing Information**

Rent \$ \_\_\_\_\_ per (month/week) Date last paid \_\_\_\_\_ Date Due \_\_\_\_\_

Currently have:  Demand for Rent/Notice to Quit  Landlord/Tenant Writ

Total Rent Owed \_\_\_\_\_

Do you have a housing subsidy?  Yes  No If YES, how much? \_\_\_\_\_

Utilities Included:  Heat  Electric  Gas  Water/Sewer  Other \_\_\_\_\_

LANDLORD: Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

**IF HOME-OWNER:**

Mortgage Payment: \_\_\_\_\_ Date last paid \_\_\_\_\_ Date Due \_\_\_\_\_

Bank/Mortgage Co \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Do you have a foreclosure notice?  Yes  No

**4. Household Assets**

Provide account information & current balances held by all household members:

Household Member	Bank/Credit Union	Savings Acct. #	Savings Balance	Checking Acct. #	Checking Balance
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Provide current value of the following assets held by all household members:

Asset	Value	Household Member
Cash on Hand (household combined)	_____	_____
Certificates of Deposit (CDs)	_____	_____
Retirement	_____	_____
401k	_____	_____
Life Insurance (Cash Value)	_____	_____
Investments	_____	_____
Time Share	_____	_____
Real Estate	_____	_____

List Properties and Locations (other than primary residence): \_\_\_\_\_



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

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**RENTAL VERIFICATION FORM**

**TO THE CLIENT – Take this form to your landlord and have him/her completely fill out the whole form. Do not fill out any of this form yourself.**

**TO THE LANDLORD - Please complete this form and return to your tenant. This form is used to document who is living in the household. *Intentional misrepresentation of household content to assist in Welfare Fraud would be considered a Falsification of an Unsworn Document and will be prosecuted under penalty of law.***

ACCORDING TO THE CITY OF FRANKLIN WELFARE GUIDELINES – RENT ASSISTANCE WILL BE PAID ONLY ON HOUSING THAT MEETS THE CRITERIA SET FORTH BY THE CODE ENFORCEMENT OFFICE AND THE FIRE DEPARTMENT. AN INSPECTION WILL BE NECESSARY BEFORE RENT IS PAID. ELIGIBLE RENT WILL NOT BE PAID UNTIL THE APARTMENT HAS PASSED THE INSPECTION.

**If this is new housing for this tenant what income is this client(s) using to provide proof that he/she/they will be able to afford this housing on a monthly basis?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Apartment Address \_\_\_\_\_

Names of all people to be residing in this address:  
\_\_\_\_\_  
\_\_\_\_\_

Number of Bedrooms \_\_\_\_\_ Date Occupancy Began \_\_\_\_\_

Rent Amount \_\_\_\_\_ Per \_\_\_\_\_

Rent Includes: Heat \_\_\_\_\_ Electricity \_\_\_\_\_ Gas \_\_\_\_\_ Water \_\_\_\_\_

Amount of Deposit Paid \_\_\_\_\_ By Whom \_\_\_\_\_

Date Rent Last Paid \_\_\_\_\_ Amount Paid \_\_\_\_\_

Is there any governmental subsidy paid on the tenant's behalf? If yes, give amount, frequency and type.

Is there any back rent due? \_\_\_\_\_ How much? \_\_\_\_\_ What months? \_\_\_\_\_

Are you related in any way to the tenants? \_\_\_\_\_

If you are not incorporated, your social security number is needed for a 1099 tax form.

Social Security Number \_\_\_\_\_

Landlords Name \_\_\_\_\_

Landlords Address \_\_\_\_\_

Landlords Signature \_\_\_\_\_ Phone # \_\_\_\_\_

All information on this form is current to this date of: \_\_\_\_\_

5A

Motor vehicles owned by you and all household members:

Owner	Auto Make/Model	Year	Value	Payments	Insurance
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**5. Claims/Settlements/Income due to you or any household member**

IRS Refund: \_\_\_\_\_ Date Rec: \_\_\_\_\_ Insurance Claim: \_\_\_\_\_ Date Rec: \_\_\_\_\_

Retroactive disability check: \_\_\_\_\_ Date Rec: \_\_\_\_\_

Retroactive Unemployment or Worker's Compensation check: \_\_\_\_\_ Date Rec: \_\_\_\_\_

Inheritance: \_\_\_\_\_ Date Rec: \_\_\_\_\_

Other Lump Sum Payment (explain): \_\_\_\_\_

Do you currently have an attorney pursuing any civil suit, workers compensation claim, a social security denial, etc?  Yes  No If YES, complete the following, and briefly explain the details of the situation:

Attorney Name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

**6. Household Income/Benefits**

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

Income:	Household Member	Amount	Date Last Received
ANB (Aid to the Needy Blind)	_____	_____	_____
APTD (Aid to Perm/Totally Disabled)	_____	_____	_____
Child Support	_____	_____	_____
Charities/Churches	_____	_____	_____
Disability (STDA/LTDA - work)	_____	_____	_____
Gifts/Loans	_____	_____	_____
Income Tax Refund	_____	_____	_____
Maternity Pay/Benefits	_____	_____	_____
OAA (Old Age Assistance)	_____	_____	_____
Retirement Benefit	_____	_____	_____

Motor vehicles owned by you and all household members:

Owner	Auto Make/Model	Year	Value	Payments	Insurance
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**5. Claims/Settlements/Income due to you or any household member**

IRS Refund:\_\_\_\_\_ Date Rec:\_\_\_\_\_ Insurance Claim:\_\_\_\_\_ Date Rec:\_\_\_\_\_

Retroactive disability check:\_\_\_\_\_ Date Rec:\_\_\_\_\_

Retroactive Unemployment or Worker's Compensation check:\_\_\_\_\_ Date Rec:\_\_\_\_\_

Inheritance:\_\_\_\_\_ Date Rec:\_\_\_\_\_

Other Lump Sum Payment (explain):\_\_\_\_\_

Do you currently have an attorney pursuing any civil suit, workers compensation claim, a social security denial, etc?  Yes  No If YES, complete the following, and briefly explain the details of the situation:

Attorney Name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

**6. Household Income/Benefits**

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

Income:	Household Member	Amount	Date Last Received
ANB (Aid to the Needy Blind)	_____	_____	_____
APTD (Aid to Perm/Totally Disabled)	_____	_____	_____
Child Support	_____	_____	_____
Charities/Churches	_____	_____	_____
Disability (STDA/LTDA - work)	_____	_____	_____
Gifts/Loans	_____	_____	_____
Income Tax Refund	_____	_____	_____
Maternity Pay/Benefits	_____	_____	_____
OAA (Old Age Assistance)	_____	_____	_____
Retirement Benefit	_____	_____	_____

Income (continued):	Household Member	Amount	Date Last Received
Severance Pay	_____	_____	_____
Social Security (Retirement)	_____	_____	_____
SSDI (SS Disability)	_____	_____	_____
SSI (Supplemental Security)	_____	_____	_____
TANF	_____	_____	_____
Unemployment (DES)	_____	_____	_____
Veteran's Pension	_____	_____	_____
Worker's Compensation	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
<b>Benefits:</b>			
Child Care Assistance	_____	_____	_____
Food Stamps	_____	_____	_____
Fuel Assistance	_____	_____	_____
Medicaid	_____	_____	_____
WIC (Women/Infants/Children)	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

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

Name	Agency Name and Phone#	Contact Person
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**7. Household Expenses**

List actual or estimated regular expenses. (Not all expenses are allowable to be included in you eligibility determination, but all should be listed to show your financial situation.)

Expense	Monthly Expense	Any Amounts Past Due	Comments
Auto Fuel	_____	_____	_____
Auto Insurance	_____	_____	_____
Auto Loan	_____	_____	_____
Auto Registration/Inspection	_____	_____	_____
Auto Repairs	_____	_____	_____
Bank Fees	_____	_____	_____
Condo Assoc Fee	_____	_____	_____
Child Care	_____	_____	_____
Child Support Paid	_____	_____	_____
Credit Card	_____	_____	_____
Dental Care	_____	_____	_____
Diapers/Wipes	_____	_____	_____
Driver's License	_____	_____	_____
Electric	_____	_____	_____
Food	_____	_____	_____
Legal Fees/Fines	_____	_____	_____
Loan (Used for _____)	_____	_____	_____
Oil Heat	_____	_____	_____
Propane (Used for _____)	_____	_____	_____
Natural Gas (Used for _____)	_____	_____	_____
Health Insurance	_____	_____	_____
Home Repairs	_____	_____	_____
Home/Renter Insurance	_____	_____	_____
Laundry	_____	_____	_____
Medical Expenses	_____	_____	_____
Mortgage	_____	_____	_____
Prescriptions	_____	_____	_____
Rent (Including _____)	_____	_____	_____

Expense (Continued)	Monthly Expense	Any Amounts Past Due	Comments
Rent - Option to Own	_____	_____	_____
Rent - MH Lot	_____	_____	_____
Storage Unit	_____	_____	_____
Taxes (Income/Property)	_____	_____	_____
Telephone (Landline/Cell)	_____	_____	_____
Telephone (Cable/Internet)	_____	_____	_____
Transportation (Bus/Cab)	_____	_____	_____
Water/Sewer Bill	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

**8. Extended Payment Arrangements**

Do you or any household members currently have an EXTENDED PAYMENT ARRANGEMENT with an electric or fuel company?  Yes  No If YES, complete the following:

Utility Company Name	Amount				
_____	\$ _____	(Circle one)	weekly	biweekly	monthly
_____	\$ _____	(Circle one)	weekly	biweekly	monthly
_____	\$ _____	(Circle one)	weekly	biweekly	monthly
_____	\$ _____	(Circle one)	weekly	biweekly	monthly

**9. Other Assistance**

Has any other organization(s) or individual helped you pay any of your bills in the last four (4) weeks?  Yes  No If YES, complete the following:

Organization/Individual's Name	Bill Paid	Amount	Date Assisted
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

**10. Criminal Information**

Have you or any member of your household ever been convicted of a felony or misdemeanor which has not been annulled? \_ Yes \_ No

If YES, complete the following:

Name	Date	Town/City/State	Detail of Conviction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you or household member presently on parole or probation? \_ Yes \_ No

If YES, complete the following:

Name	Court	Parole/Probation Officer Name & Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

**11. Liability for Support Information**

Parents/step-parents, spouse or grown children may be called upon to assist in time of need. Provide the following information:

APPLICANT:	Name	Address	Phone #
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse, if not living with you:	_____	_____	_____

CO-APPLICANT:	Name	Address	Phone #
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse, if not living with you:	_____	_____	_____

Adult Children:

List name, address and phone # of any adult children not living with you:

\_\_\_\_\_

\_\_\_\_\_



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

Welfare Department:

Phone: 934-3404

Fax: 934-7413

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

I, \_\_\_\_\_ the undersigned, understand that from time to time,  
Print Your Name  
the local welfare administrator for \_\_\_\_\_ Franklin, NH \_\_\_\_\_ may require certain information about 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, 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. New releases will need to be updated as needed.**

\_\_\_\_\_  
**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

10A

## 12. 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 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)

I understand that my parents/step- parents, spouse or grown children may be called upon to assist me when in need of relief if they can do so without financial hardship to themselves. (RSA 165:19)

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) and/or Theft by Deception. (RSA 637)

### **Authorization to Release or Exchange Information \***

I/ We authorize any relative, physician, attorney, banker, employer, insurance company, landlord/shelter staff or any other person(s) or organization(s) having information concerning my circumstances to furnish such information to the CITY OF FRANKLIN Welfare Director. The Social Security Administration, the Division of Health & Human Services and the Department of Employment Security may release information in their files to this office. I/ we authorize the CITY OF FRANKLIN WELFARE to release information as requested to the Division of Health & Human Services, Social Security Administration, Department of Employment Security, school personnel, attorney, physician, landlord, other town welfare offices, or any agencies providing supportive services regarding medical, housing/shelter, or financial assistance.

### **Applicant**

\_\_\_\_\_  
Print Name

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **Co- Applicant**

\_\_\_\_\_  
Print Name

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of person completing form  
(if not the applicant)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

*\* The above authorization to release or receive information is in effect for as long as the applicant is currently seeking assistance from the CITY OF FRANKLIN Welfare Director or up to six (6) months after assistance has ended.*



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

Welfare Department:

Phone: 934-3404

Fax: 934-7413

**RSA 165:1-b**

***As a recipient of General Assistance, you are required by New Hampshire State Law to apply for and utilize any benefits or resources, public or private that will reduce or eliminate your need for General Assistance.***

This means that if you are eligible to receive TANF, APTD, OAA, Food Stamps or Subsidized rent through HUD, or Unemployment Benefits, you must apply within seven days following your application for General Assistance. You must follow the requirements and fulfill your responsibilities of these programs. This also means that you are to keep all appointments for these programs so that once you are receiving benefits, they do not lapse. If you are having difficulties meeting your responsibilities you need to immediately contact your caseworker to make further arrangements to meet their requirements. If you are on HUD subsidized housing you will need to contact them immediately if you have a reduction in your income that is expected to last longer than 30 days.

The State of New Hampshire has also passed a voluntary quit bill that is in effect as of 08-10-95 which states that any person eligible for public assistance, who voluntarily terminated employment within the 60 day period before filing an application for assistance, shall be ineligible to receive assistance for 90 days from the date of the employment termination.

My responsibilities to apply for and to utilize other kinds of public assistance as stated above have been discussed with me. I understand that failure to fulfill these responsibilities will cause me to be denied General Assistance. I have also read the information on the Voluntary Quit Legislation and have discussed any questions I might have with the Welfare Director.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

(12)



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

*Welfare Department:*

*Phone: 934-3404*

*Fax: 934-7413*

## **WELFARE WORKFARE PROGRAM**

When you are receiving General Assistance, you will be required to participate on the Workfare Program through the Welfare Department. If you have a medical problem that limits the type of duties you can perform, you will need a medical statement to verify them. If you are physically or mentally unable to participate on the workfare program, you will also need a medical statement to verify this. The medical statement should state the length of time you will need to be excused from the program and for what reason. It is expected that you schedule your job interviews and other appointments during the afternoons. If you are in need of being excused early, you need to advise your supervisor before you start the work morning. If you are sick on your scheduled day(s) of workfare, you must call your supervisor at (603) 934-4103 by 7:15 a.m. If you are absent from the workfare program for two consecutive days or longer you will need a doctor's statement explaining why.

Why you are on the Workfare Program, you will be expected to perform your duties in a courteous and respectful manner. That is, you are to show respect for the supervisor, and you are expected to do your duties as instructed. If you are dismissed from the Workfare Program for any reason (ex. See below) you will be suspended from receiving benefits for 7 days, and you will be expected to make up the missed work time before you can reapply for further benefits. If you are dismissed for a second time in the period of 6 months, the suspension period will be for 14 days and until the lost time has been made up. The workfare program runs from 7:00 a.m. to 12:00 p.m. each day. You are to report to work on time. If you are late you will not be able to participate for the morning and you will need to make up the time that is owed before you can continue to be eligible for any further welfare assistance. If you become employed and have not completed the workfare hours required, you can submit proof of your employment to the welfare office to be excused from completing the hours needed. Completion of a Criminal Record Release Form is required for participation on this program.

### **Examples of dismissal reasons:**

1. Use of foul language.
2. Showing disrespect to the Supervisor.
3. Refusal to perform the job as instructed.
4. Failure to report to work at 7:00 a.m.
5. Cause a disruption of the workflow.
6. Inappropriate behavior, such as intoxication through alcohol or drug use.

You currently need to complete \_\_\_\_\_ hours of workfare to repay the assistance you have been given. You are expected to work every day until either you have paid back the city for the assistance you have been given or you become employed and are no longer eligible for assistance.

The Workfare Program as stated above has been discussed with me and I agree to participate on the Workfare Program if requested. I am aware that willful non-compliance of the Workfare Program will result in disqualification for General Assistance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



CITY OF FRANKLIN, NEW HAMPSHIRE  
WELFARE APPLICATION

**Welfare Department:**

**Phone: 934-3404**

**Fax: 934-7413**

**WORKFARE PROGRAM**

I AGREE TO PARTICIPATE IN THE WORKFARE PROGRAM FOR THE FRANKLIN WELFARE DEPARTMENT. I UNDERSTAND THAT I WILL BE DENIED FURTHER GENERAL ASSISTANCE UNLESS I PARTICIPATE AS REQUESTED. IF I CLAIM GOOD CAUSE FOR REFUSAL TO PARTICIPATE, I MUST CONTACT THE WELFARE DIRECTOR AT 934-3404 PRIOR TO THE DATE THAT I AM SCHEDULED TO PARTICIPATE. IF I AM SICK, I REALIZE THAT I MUST CONTACT THE WELFARE DIRECTOR ABOUT MY ABSENTEEISM WITHIN TWO HOURS AFTER MY SCHEDULED WORK. IF I AM ABSENT FROM MY SCHEDULED WORKFARE FOR TWO DAYS IN A ROW, I REALIZE THAT I MUST PROVIDE A DOCTORS NOTE IN ORDER TO AVOID SUSPENSION.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**YOUR SUPERVISORS NAME WILL BE** \_\_\_\_\_

**PLACE TO REPORT TO WORK** \_\_\_\_\_

**SEE BELOW FOR DATE AND TIMES TO REPORT.**

**WORKFARE SCHEDULE**

Day/Date	Time to Report	Hours Due	Hours Worked	Supervisor's Signature
	7 am – 12 pm	5		
	7 am – 12 pm	5		
	7 am – 12 pm	5		
	7 am – 12 pm	5		
	7 am – 12 pm	5		

**TOTAL HOURS WORKED** \_\_\_\_\_ X \_\_\_\_\_ = \_\_\_\_\_