FORM B

AUTHORIZATION FOR THE RELEASE OF INFORMATION – DHHS

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

Type of Information	**Purpose for Requesting this Information**
Date of DFA application(s), type(s) of assistance applied for, date of eligibility determination, expected date of benefit issuance, amount of cash grant (if applicable) and/or the reason my case closed or my application was denied	Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance
Date my Medicaid case opened and my Medicaid Identification Number(s)	Processing of Medicaid reimbursements if/when, during the time my Medicaid application was pending, the local welfare administrator makes an expenditure on my behalf for an item covered by Medicaid
Date of any sanction of my cash assistance grant	Determining countable household income also called "deeming"
Reason for any sanction of my cash assistance grant	Helping me to remove the sanction

I understand that I have the option to provide any or all of the requested information myself.

I understand that any use of the above information inconsistent with these purposes is forbidden.

I understand that the local welfare administrator may not release information provided under this authorization to any other person without my written permission.

This authorization shall expire 180 days from the date it is signed.

_____ _____
Signature Date

If the signature above is not that of the person to whom the requested information pertains, the relationship of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

_____ _____ _____
Relationship to You Witness Date

FORM D

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

I/We, _____, authorize any relative, physician, lawyer, banker, employer, insurance company, mental health professional, school official or other person or organization having information concerning my/our circumstances to furnish such information to the Municipal Welfare Department. I/We also authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth and Families, Division of Adult and Elderly, New Hampshire Legal Assistance, any City/Town Welfare Department, shelter, Department of Employment Security, Veteran's Administration and Fuel Assistance, or any non-profit agency to release information from their files to the Municipal Welfare Department.

_____ _____

Applicant Signature Date

_____ _____

Spouse or Co-applicant Signature Date

_____

Signature of person completing form (if not applicant); Relationship to applicant

_____

Date

FORM E

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

(Francestown Public Assistance Administration)

I understand that as part of the administration of the general assistance program, a municipal welfare official may verify information I have provided on my application for assistance and any other information that would affect my eligibility. My signature below authorizes Francestown, New Hampshire welfare official, to obtain information from regarding factors relevant to my application for general assistance benefits.

This authorization shall expire one year from the date it is signed.

A photocopy of this signed authorization may be used in place of an original.

_____ _____

Applicant Date

_____

Welfare Official

FORM F

REQUIRED VERIFICATIONS

Applicant Name: _____ Date: _____

Social Security Number: _____ D.O.B.: _____

Address: _____ Phone: _____

YOUR APPOINTMENT IS SCHEDULED FOR: _____

You must provide the following verification/documentation at this appointment or assistance may be delayed or denied:

_____ Completed Application Form A

_____ Rental Verification Form J and copy of any written lease agreement

_____ Last four weeks pay-stubs or other proof of net wages for all adult members of household

_____ Last four weeks receipts or other proof of bills paid or currently due, utility disconnect notices

_____ Employment verification Form I from your employer

_____ Employment termination Form I from your last employer

_____ You have applied for / are receiving Social Security benefits

_____ You have applied at the HHS District Office for:

- ❑ Emergency Food Stamps
- ❑ Food Stamps
- ❑ TANF
- ❑ Title XX Daycare
- ❑ APTD/MA
- ❑ OAA
- ❑ TANF Emergency Assistance

_____ You have applied for / are receiving Fuel Assistance benefits

_____ Verification of injury or illness Form H

_____ You have applied for / are receiving Unemployment Compensation

_____ If available, picture ID (Adults); Birth certificate/SS card (minors)

_____ Vehicle registration

_____ Savings and checking account, liquid asset statements, bankbooks

_____ Statement child support payments received / Child support court-ordered payments made

_____ Statement from room-mate(s) regarding division of expenses

Other: understand that failure to provide the indicated information may result in delay and/or denial of my request for assistance, and I understand that if approved for assistance I may be required to do a job search and participate in workfare.

_____ _____

Welfare Staff signature Applicant signature

FORM H

MUNICIPAL WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#: _____ **dob:** _____

I hereby request the release by a doctor, hospital or clinic to the Municipal Welfare Department, or its authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization. A photocopy of this signed release may be used in place of an original, in effect for six months from date of my signature below:

_____ _____
APPLICANT SIGNATURE **DATE**

TO THE PHYSICIAN OR CLINIC:

The person named above has indicated that he/she is currently unable to work and is in treatment with you. New Hampshire General Assistance laws require able-bodied welfare applicants to seek and retain work as a condition of continued assistance, with the goal of minimizing the period of assistance necessary. The Municipality also may require welfare recipients to work in any capacity that the recipient is able in exchange for assistance. For these reasons, will you please briefly respond to these questions:

What is the condition(s) for which you are treating this person? _____

What is the nature and extent of this individual's limitations? _____

Is this person disabled? No ❑ Yes ❑ (If yes, please clarify below)

❑ Temporarily ❑ Permanently ❑ Partially ❑ Totally

Date incapacity began: _____ Expected to end: _____

When will this individual be capable of returning to work? What type of work would be suitable for this individual? Please describe any limitations: _____

_____

_____

Medications Prescribed: _____

_____ _____
Physician Name / Signature **Date**

FORM I

EMPLOYMENT VERIFICATION FORM

To Employer _____ Date _____

Address_____

Phone _____

For the purpose of administration of municipal assistance, the following information is required for:

_____
[name of employee]

Date of Hire _____ _____ Date starting/started work _____Hourly Pay Rate _____

Full/part time _____ Hours per week_____ Paid ❑ weekly ❑ biweekly ❑other ____

Date of first/most recent paycheck_____ Net amount_____

==========

If_____ is no longer employed by your company:

Date of termination/separation_____ Date/net amount of last paycheck _____

Reason for termination/separation _____

_____ _____
Signature and Title of immediate supervisor or person completing form Date

I, _____, authorize the release of information regarding my employment to the welfare official of the town/city of _____.

Signature: _____

FORM J

RENTAL VERIFICATION FORM

THIS FORM MUST BE COMPLETED BY THE LANDLORD

Tenant's Name: _____ Date: _____

Address: _____

(Number/Street) (Apt. #) (City) (State)

Number of adults in apartment: _____ Number of children in apartment: _____ _____

List of people in apartment:

_____

_____

_____

Occupancy date: _____ Security Deposit: Amount: $_____ Date paid: _____

Rent amount: $_____; paid ❑ monthly ❑ weekly ❑ other _____

If subsidized rent, please list tenant portion: $_____

Rent Includes: ❑ All utilities ❑ No Utilities ❑ Hot Water ❑ Heat ❑ Electric

Type of Heat: ❑ Electric ❑ Oil ❑ Gas ❑ Other _____

Date last rent was paid: _____ Amount Paid: $ _____ Back rent owed: $ _____

(if back rent is owed, please attach accounting of months and amounts)

For IRS reporting, landlord's Tax ID or Social Security # <u>must</u> be provided:

Tax ID #: _____ **OR** Social Security #: _____

Failure to provide the correct Tax ID or Social Security # may subject payments to backup withholding.

CHECK IS TO BE MADE PAYABLE TO: (PLEASE PRINT)

_____ _____

Landlord's Name Telephone / Fax Numbers

_____

Landlord Address

_____

Name of Manager or other Representative

_____ _____

Landlord Signature Date

FORM K

BUDGET WORKSHEET

Name _____ Date _____

A. Available assets and income:

_____ _____ mo/wk
_____ _____ mo/wk
_____ _____ mo/wk
_____ _____ mo/wk

A. Total available income: _____

B. Allowable Expenses:

	Actual Expenses	Allowed Expenses	Ineligible Expenses
Rent/Board/Mortgage	_____ mo/wk	_____ mo/wk	_____
Electric	_____ mo/wk	_____ mo/wk	_____
Gas	_____ mo/wk	_____ mo/wk	_____
Fuel Oil	_____ mo/wk	_____ mo/wk	_____
Water/sewer	_____ mo/wk	_____ mo/wk	_____
Cooking fuel	_____ mo/wk	_____ mo/wk	_____
Telephone	_____ mo/wk	_____ mo/wk	_____
Food	_____ mo/wk	_____ mo/wk	_____
Personal & Household	_____ mo/wk	_____ mo/wk	_____
Medical/Prescription	_____ mo/wk	_____ mo/wk	_____
Transportation	_____ mo/wk	_____ mo/wk	_____
Childcare/Daycare	_____ mo/wk	_____ mo/wk	_____
Car payment	_____ mo/wk	_____ mo/wk	_____
Gasoline	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____

B. Total Allowed Expenses: _____ _____

C. Eligibility: [A. Income (-) B. Expenses**]:**_____

(If A is greater than B, applicant is ineligible. If A is less than B, applicant is eligible.)

Assistance will be provided as follows:

_____ $ _____
_____ $ _____
_____ $ _____

Note: This form should accompany a Notice of Decision. The welfare official should use discretion in accepting actual expenses relative to employment, work search, medical needs, etc.

FORM M

WORKFARE PROGRAM
REPORTING SLIP

In accordance with RSA 165:31, any recipient of general assistance may be required to work for the municipality at any available job that is within the capacity of the recipient. As a condition of continuing eligibility for assistance, you are required to participate in the workfare program as described below. Any failure to participate as required may result in suspension of assistance.

Recipient Name_____ Total hours owed _____

Work site assigned _____ Supervisor _____

First date to report _____ Daily shift, from_____to_____

(dates and shift may change with permission of welfare official)

TO BE COMPLETED BY WORK SITE SUPERVISOR

Form to be returned on a weekly basis.

Date	Weekday	# Hours Assigned	# Hours Time In	Time Out	Worked	Supervisor Initials
_____	Sunday	_____	_____	_____	_____	_____
_____	Monday	_____	_____	_____	_____	_____
_____	Tuesday	_____	_____	_____	_____	_____
_____	Wednesday	_____	_____	_____	_____	_____
_____	Thursday	_____	_____	_____	_____	_____
_____	Friday	_____	_____	_____	_____	_____
_____	Saturday	_____	_____	_____	_____	_____

TOTAL HOURS WORKED _____

Supervisor signature_____ **Date** _____

Recipient/workfare participant certification:

I understand that failure to fully comply with the workfare program, without just cause, may result in denial of further assistance. I further understand that workfare is for the purpose of working off hours in exchange for assistance granted and that no actual wages will be paid to me.

_____ _____

Recipient/workfare participant signature Date

FORM N

EMPLOYMENT SEARCH RECORD

NAME:_____

[In order to remain eligible for assistance, you are required to do a job search of 3-5 contacts daily. Use this form to list each employer you contact.]

	DATE	EMPLOYER	PHONE NUMBER	JOB OR TYPE OF WORK	TYPE OF CONTACT Visit/Phone/ Mail/Resume	PERSON CONTACTED	TIME OF DAY	RESULTS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

FORM O

FAIR HEARING REQUEST

I, _____hereby request a fair hearing to review the decision dated_____ regarding my application for general assistance. I ❑ want / ❑ do not want my current assistance to continue until my appeal has been decided. I understand that if I lose my appeal, I will be obligated to repay the assistance provided to me during the time the appeal is being decided.

_____ _____

(applicant signature) (date)

In order to be eligible for a fair hearing, this form must be completed and returned to the Welfare Office within five (5) working days of your receiving your notice of decision. Within seven (7) working days of receipt of this notice by the Welfare Official a hearing will be scheduled. You will be notified in writing of the place, date and time of the hearing.