Town of Farmington, NH
Welfare Office
Phone: (603) 755-3100 Fax: (603) 755-9934

Application for Assistance

(Please answer each question)

Date _____

Have you ever applied for Farmington welfare before? Yes___ No___ If yes, When? _____ Under What Name_____

Name _____ Maiden Name _____

Address_____ Referred By_____

City_____State_____ ZIP_____ Contact Phone Number _____

Spouse/Cohab/Roommates_____ Relationship_____

Have you ever applied or received assistance from any other city, town, or state welfare office? Yes____ No____ If yes, provide details:
Where? _____ When? _____ What type of assistance?
_____

LIST EVERYONE WHO LIVES IN THE HOUSEHOLD, BEGIN WITH YOURSELF ON THE FIRST LINE

Full Name	Relationship	Marital Status	Birth date	Age	Social Security Number
	self				

LIST YOUR ADDRESSES FOR THE LAST YEAR, BEGIN WITH YOUR PRESENT ADDRESS

Street Address Room or Apt. #	Town / City / State	From (Month / Date / Year)	To (Month / Date / Year)

LIST YOUR PARENTS & THE PARENTS OF YOUR SPOUSE, ROOMMATE OR COHAB

Your Name_____ **Spouse, Roommate or Cohab Name** _____

Father _____ Address_____ **Father** _____ Address _____

City/State _____ City/State _____

Phone Number(s)_____ Phone Number(s) _____

Employer_____ Employer_____

Mother_____ Address_____ **Mother**_____ Address _____

City/State _____ City/State _____

Phone Number(s)_____ Phone Number(s) _____

Employer_____ Employer_____

SERVICE RECORD

Name & Rank at Discharge	Branch of Service	Dates of Service	Type of Discharge	Reason for Leaving

Are you or anyone in the household serving in the National Guard or Reserves? Yes___ No___ Name_____

List the date of last National Guard or Reserves pay _____ Amount _____

PLEASE LIST CURRENT & LAST EMPLOYERS FOR YOURSELF & ALL HOUSEHOLD MEMBERS

Employee's Name	Employer	Weekly Wage	Last Date Paid	Dates of Employment	Reason for Leaving

MEDICAL, ACCIDENT OR INJURY INFORMATION

Is anyone in your household unable to work? Yes____ No____ Name(s) _____

Check Reason: Non Work-Related Accident____ Non Work-Related Illness____ Work-Related Accident_____ Work-Related Illness_____

Date of Injury, Accident or Illness _____ Date Workers Comp Claim Filed _____

Name & Address of Employer _____ Phone number _____

_____

Doctor's Name, Address, Phone Number_____ Date able to return to work _____

PROPERTY

List all property & vehicles bought, sold or transferred within the last year

Descripton/Address_____Date_____ Price_____ Bought____ Sold ____

Descripton/Address_____Date_____ Price_____ Bought____ Sold ____

Do you or any other household member own any real estate? Yes___ No___ Name of owner(s) _____

Address of property_____ Multi or single family? _____

Mortgage holder name/address/phone & fax #'s. _____

Rental income property? _____ Purchase date _____ Purchase price _____

Payment _____ Date of last payment _____ Foreclosure pending?_____

LIST ALL VEHICLES OF ALL HOUSEHOLD MEMBERS INCLUDING BOATS, MOTORCYCLES, ATV's, ETC.

Year	Model	Registered To				
_____	_____	_____	Own_____	Rent_____	Lease_____	Borrow_____
_____	_____	_____	Own_____	Rent_____	Lease_____	Borrow_____

LIST INCOME TAX INFORMATION FOR ALL HOUSEHOLD MEMBERS

Name	Date Filed	Date Tax Refund Rec'd	Amount of Refund

LIST ALL ASSETS FOR YOURSELF & ALL OTHER HOUSEHOLD MEMBERS

Do you or any other household members, including children have any bank accounts? Yes___ No___If yes, provide information on all personal and/or business accounts owned singly or jointly.

Name	Name of Bank / Credit Union	Savings Acct.	Balance	Checking Acct.	Balance

Have you or any other household member closed a bank or credit union account within the last 6 months? Yes___ No___
If so, who? _____ When? _____ What type of account? _____
Which bank?_____ Bank location _____

Do you or any other household member have or cashed in any of the following within the last year? Yes___ No___ If yes, list each amount

Trust funds_____ Certificates of Deposit (CDs) _____ Mutual funds _____ Retirement account_____ Savings Bonds _____
Stocks_____ 401 K _____ Profit Sharing_____ Annuities _____ other (give details)_____

LIST IF YOU OR ANY OTHER HOUSEHOLD MEMBER HAS APPLIED FOR, OR ARE CURRENTLY RECEIVING INCOME OR BENEFITS FROM THE FOLLOWING SOURCES:

	Name	Date Applied	Date Last Received	Amount
ANB (Aid to Needy Blind)				
Boarders in your household				
Cash available or set aside				
Disability – State/APTD				
Disability – Short Term _____ Long Term ____				
Fuel Assistance: Rent ____ Heat ___ Elect____				
Help from friends, relatives, employers, coworkers				
Child Support				
Medicaid				
OAA (Old Age Assistance)				
Retirement Pension				
Severance Pay				
SS_____ SSD_____ SSI_____				
TANF____ Relative Payee____				
Unemployment				
Vacation Pay__ Earned Time__ Sick Time__				
Veteran's Pension				
WIC (Women, Infants & Children)				
Worker's Compensation				
Food Stamps				

PAYEE INFORMATION

Do you have a payee for any of your benefits? Yes___ No___ Which benefits? _____

Payee Name _____

Are you a payee for anyone else? Yes___ No___ Benefits for which you are payee _____

His/her Name _____

Are you compensated for your payee services? Yes_____ No_____ Amount_____ Date last received _____

CHILD SUPPORT INCOME (Request additional sheet of paper if necessary)

1. Child's Name _____ DOB_____
   Amount last received _____ Date last received _____ Next Due _____
2. Child's Name _____ DOB_____
   Amount last received _____ Date last received _____ Next Due _____
3. Child's Name _____ DOB_____
   Amount last received _____ Date last received _____ Next Due _____

CHILD SUPPORT PAYMENTS YOU OR SOMEONE IN HOUSEHOLD MUST MAKE (Request additional sheet of paper if necessary)

1. Support Provider's Name _____Child's _____ DOB _____
   Relation to Child_____ Name, of person receiving support payments _____
   Amount Last Paid_____ Date Last Paid_____ Court ordered? Yes___ No___
2. Support Provider's Name _____Child's _____ DOB _____
   Relation to Child_____ Name, of person receiving support payments _____
   Amount Last Paid_____ Date Last Paid_____ Court ordered? Yes___ No___
3. Support Provider's Name _____Child's _____ DOB _____
   Relation to Child_____ Name, of person receiving support payments _____
   Amount Last Paid_____ Date Last Paid_____ Court ordered? Yes___ No___

LIST ALL HOUSEHOLD EXPENSES, DATE LAST PAID & THE AMOUNT DUE (Provide complete information)

Basic Expenses	**Amount**	**Frequency**	**Date Last Paid**	**Name on Bill**	**Amount Due**
Rent/Mortgage		Wk___ Mo___			
Food		Wk___ Mo___			
Diapers		Wk___ Mo___			
Gasoline for vehicles(s)		Wk___ Mo___			
Household Supplies		Wk___ Mo___			
Gas		Wk___ Mo___			
Electric		Wk___ Mo___			
Oil		Wk___ Mo___			
Prescriptions		Wk___ Mo___			
OTHER EXPENSES					
Cable		Wk___ Mo___			
Car Payments		Wk___ Mo___			
Court Fees, Fines, etc.		Wk___ Mo___			
Credit Cards		Wk___ Mo___			
Personal Loans		Wk___ Mo___			
Rent to Own Items		Wk___ Mo___			
Tabacco		Wk___ Mo___			
Telephone		Wk___ Mo___			
Cell Phone		Wk___ Mo___			
Internet Connection		Wk___ Mo___			
Other		Wk___ Mo___			

ASSISTANCE REQUESTED (Be specific) _____

_____

_____

_____

REASON FOR REQUEST_____

_____

_____

_____

_____

_____

Have you or any other members of your household ever been convicted of a felony? Yes___ No___ If yes, who?_____

When? _____ Which city/town & state? _____

Are you or any member of your household a registered sex offender? Yes___ No___ If yes, who? _____

When? _____ Which city/town & state? _____

Are you or any other members of your household presently on parole or probation? Yes___ No___ If yes, who?_____

Which city/town & state? _____ Name of Parole/Probation Officer? _____

Phone No. _____ Provide details _____

READ CAREFULLY BEFORE SIGNING

I/We understand that:
I/We, the undersigned, agree to repay the Town of Farmington for any assistance granted pursuant to RSA 165; any misrepresentation of information pursuant to RSA 641:3 used in determining eligibility would terminate all aid from the Town of Farmington for up to one year; all information supplied by me / us is subject to investigation and verification. Any change in my status must be reported to the Welfare Office within 3 working days and failure to do so may result in suspension of my/ our assistance. I/We may request a fair hearing if I am/We are not satisfied with any decision regarding my / our assistance.
I/We must do so in writing to the welfare official within 5 working days. My / Our signature(s) below constitute(s) the granting of my / our authority for the Town of Farmington to obtain verification and/or proof from all sources concerning my / our household's circumstances.

Applicant's Signature	**Date**	**Co-applicant's Signature**	**Date**
Spouse's Signature	**Date**	**Co-applicant's Signature**	**Date**

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION
I/We authorize any relative, physician, lawyer, banker, check cashing service, employer, former employer, insurance company, health care provider, mental health professional, pharmacy, hospital, emergency care facility, ambulance service, police, Sheriff, State Police, firefighter, EMT, Red Cross, Salvation Army or any persons or organizations concerning my/our circumstances to furnish such information to Farmington Welfare Office. I/We further authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth & Families, Bureau of Elderly & Adult Services, NH Legal Assistance, any City/ Town Welfare Department, shelter, Department

of Employment Security, Veteran's Administration, Community Action, or any non profit agency to release information from their files to the Town of Farmington Welfare Office.

Applicant's Signature	Date	Co-applicant's Signature	Date
Spouse's Signature	Date	Co-applicant's Signature	Date

APPLICANT'S RELEASE OF INFORMATION

I/We authorize the Town of Farmington Welfare Office to release information to any persons or organizations concerning my/our circumstances or to any State or County Division of Health and Human Services, Division of Children, Youth & Families, Social Security Administration, Internal Revenue Service, school administration, physician, Community Action, Red Cross, mental health professional, Bureau of Elderly & Adult Services, NH Legal Assistance, any City/Town Welfare Department, shelter, Department of Employment Security, Salvation Army, food pantries or any Town of Farmington departments connected with the administration of Welfare.

Applicant's Signature	Date	Co-applicant's Signature	Date
Spouse's Signature	Date	Co-applicant's Signature	Date

Cases will be held open for 6 month after last contact.

The Town of Farmington Welfare Office will be hold cases open for 6 months from the date of last in-person contact with this office. Returning clients must continue to comply with all the requirements of prior Notices of Decision; including but not limited to using all income for basic needs as detailed on prior Notices of Decision. Clients will be expected to provide written verification of all income and dated receipts for expenses for the weeks prior to their return date. Failure to comply may result in a delay or suspension of assistance.

Voluntary Quit Law.

Pursuant to the provisions of RSA 165:d voluntary termination of employment without good cause could lead to disqualification from receiving general assistance in the future.

RSA 641:3

The Town of Farmington Welfare Office may refer violations of RSA 641:3 to the appropriate authorities for prosecution RSA 641:3 provides.

Unsworn Falsification

A person is guilty of a misdemeanor if:

A. S/He makes a written false statement which he does not believe to be true, on or pursuant to a form bearing a notification authorized by law to the effect that false statements made therein are punishable; or
B. With a purpose to deceive a public servant in the performance of his official function s/he:
    1. Makes any written false statement which s/he does not believe to be true; or
    2. Knowingly creates a false impression in a written application for pecuniary or other benefit by omitting information necessary to prevent statements therein from being misleading.
    3. Submits or invites reliance on any writing which s/he know to be lacking in authenticity; or
    4. Submits or invites reliance on any sample, specimen, map, boundary mark, or their object which s/he know to be false.
C. No person shall be guilty under this section if s/he retracts the falsification before it becomes manifest that the falsification was or would be exposed.

I/We have read the above statements and certify that I/We fully understand them.

Applicant's Signature	Date	Co-applicant's Signature	Date
Spouse's Signature	Date	Co-applicant's Signature	Date

Applicant(s)/client(s) DO NOT sign the following until the conclusion of the intake interview.

I hereby certify that all notes and/or alterations written on my application by the caseworker(s) during this intake process accurately reflect my responses to questions and any additional information I provided. I further certify that all written and verbal information I have provided has been truthful and without omission to the best of knowledge.

Applicant's Signature	**Date**	**Co-applicant's Signature**	**Date**
Spouse's Signature	**Date**	**Co-applicant's Signature**	**Date**

I hereby certify _____ signed in front of me at the conclusion of the interview.

Welfare Officer Signature	**Date**	**Witness Signature**	**Date**

Requests. A request for a fair hearing is a written expression, by the applicant or recipient, or any person acting for him/her, to the effect that he/she wants an opportunity to present his/her case to a higher authority. When a request for assistance is denied or when an applicant desires to challenge a decision made by the welfare official relative to the receipt of assistance, the applicant must present a request for a fair hearing to the welfare official within five (5) working days of receipt of the notice of decision at issue. RSA 165:1-b, III.

Applicant's Signature	**Date**	**Co-applicant's Signature**	**Date**
Spouse's Signature	**Date**	**Co-applicant's Signature**	**Date**