Town of Barrington
Application for Aid

Introduction

Before you read and complete the enclosed application form, we want you to understand the types of assistance offered under Barrington General Assistance Guidelines.

1. We will allow for immediate basic expenses. Immediate basic expenses mean that the expense is necessary to provide a reasonable subsistence compatible with decency and health. Barrington General Assistance does not give cash payments, but uses a voucher system, and all payments will be made by check directly to the vendor, if the vendor's charges are within Barrington's expense guidelines for the service rendered. Barrington will not pay for back bills, you are expected to arrange payment with vendor's for any outstanding balances.

2. During the heating season, Clients are expected to monitor how much fuel is in their tank, and plan accordingly, as heating companies no longer have same day delivery. If you run out of fuel, you may have to wait for as much as several days for delivery even if you qualify for assistance. Property damage due to Client's improper monitoring of fuel levels will not be allowed.

3. The Barrington General Assistance Program does not pay for telephone services unless you present a statement from a qualified physician that specifies that your telephone is needed for emergency health reasons. If approved, only a very basic rate of $20 per month will apply.

4. Barrington will not pay any medical expenses or prescriptions unless there is an extreme emergency evidenced by a call from a medical professional, i.e. hospital emergency room. However, qualified medical expenses and prescriptions will be allowed when determining eligibility.

5. Barrington will not pay any personal debt. We will not allow any credit card payments, bank fees etc. Vehicle fuel allowance, and/or transportation allowance is considered on a case-by-case basis; however, we will not make any car payments.

6. Current receipts are required for all income and expenses at the time of Client and Case Worker appointments. Current is defined as happening in the 30 days prior to the appointment. Clients must bring all paperwork with them at the time of their appointment. Failure to do so will impact timeliness of eligibility decisions.

PLEASE NOTE: While we love and value children, it is not appropriate to bring them to Client and Case Worker appointments. Please make other arrangements for them. Failure to do so may require us to postpone your appointment.

Complete the attached application, and call 664-0155 for an appointment.

The application, when returned, must be accompanied by the following:

- The attached rental application related to your current residence, or a current mortgage statement or stub.
- If your parents, stepparents, or spouse cannot support you, you must bring a signed, notarized statement from them stating that they are unable to maintain you.
- If your landlord is a relative, you must provide a notarized statement of inability to support.
- If you are claiming a disability, you must provide the attached medical form signed by your doctor.
- Proof of all income for the household including the attached Employment Verification form with either a current wage statement for the past 4 weeks from your employer, or pay stubs, for the same period.
- All household bills and available receipts for the last 30 days.
- Notice of Decisions from any federal, state or local social service agency currently in effect.

Normally you will receive a decision at the time of your appointment, however in some cases that is not possible. Remember, we have 72 hours to verify information, and make a decision. We will provide you with a written decision that will outline what assistance we will provide, and what if any conditions you are required to meet to qualify for further assistance. If we deny your request for assistance, we will give you a written reason.

If you disagree with our action, you may request a fair hearing. Fair hearing requests must be submitted in writing within 5 days of receiving notice of our decision. A fair hearing will be scheduled within a reasonable length of time, and a written decision on your case will be sent to you within 7 working days after the hearing.

Before completing this application, you are also reminded of the following:

- Once we provide assistance, and it is determined that you are physically able to work, we may require you to work in our Work Fare program. If you refuse, your aid may be discontinued.
- If you own real property in Barrington, we will place a lien on that property for the amount of assistance given you. We are also entitled to lien property that you receive by will, inheritance, or civil judgments.
- If you have quit your job without good cause just prior to, or during the time we are assisting you, you will be ineligible to receive assistance for sixty days from the time of job separation.
- If you conceal or misrepresent facts pertaining to your income or expenses, your aid will be discontinued or denied, and you may be prosecuted for the crime of Unsworn Falsification (RSA 641:3)
- The Town of Barrington will deny you assistance if you refuse to apply for other assistance programs for which you may be eligible.
- If you refuse any reasonable assistance that we give you, you will be ineligible for further Town assistance at that time.

NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF Barrington, NH

You have the following rights:

1. You have a right to make a written application for assistance, even if the welfare officer tells you that you are not eligible.

2. You have a right to receive a prompt written decision telling you whether or not you will receive assistance each time you apply for assistance.

3. You have a right to have in writing the reason why you have been denied assistance or have been given only some of the assistance you requested.

4. You have a right to appeal any decision you do not agree with. You must appeal within five (5) working days after you received your decision.

5. You have a right to have a hearing to present your case.

6. You have a right have your assistance continued if you are already receiving assistance when you request a fair hearing.

7. You have a right to review the information in your file before your hearing.

8. You have a right to see the guidelines used by the welfare officer in making decisions on your application.

9. You have a right to be given a written notice of conditions before you are suspended from receiving assistance for failing to obey the guidelines.

10. You have a right to refuse to participate in municipal workfare program or to conduct a job search if you must care for a child under the age of five (5), if you are disabled or ill, or if you must take care of a member of your family who is disabled or ill.

RESPONSIBILITY OF EACH APPLICANT AND RECIPIENT

At the time of initial application, and at all times thereafter, the applicant has the following responsibilities:

1. To provide accurate, complete and current information concerning his/her needs and resources and the whereabouts and circumstances of relatives who may be responsible under RSA 165:19.

2. To notify Welfare Official within seventy two (72) hours when a change in needs or resources may affect eligibility for continuing assistance, a change in address or a change in members of the household.

3. Within one week of application, to apply for and utilize any benefits or resources, public or private, that will reduce or eliminate the need for General Assistance.

4. To keep appointments as scheduled.

5. To diligently search for employment and provide verification of application for employment when requested.

6. To accept employment when offered.

7. To provide a doctor's statement if the applicant claims an inability to work due to medical problems.

8. To participate in the welfare work program if physically and mentally able.

An applicant shall be denied assistance if he/she fails to fulfill any of these responsibilities without a reasonable justification.

REQUIRED VERIFICATIONS

Applicant Name:_____ Date: _____

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

Address: _____ Phone: _____

When application is complete, call for appointment, 603-664-9007: Date: Time:

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

_____ Completed Application Form
_____ Rental Verification Form or Current mortgage statement
_____ Last four weeks pay-stubs or other proof of net wages
_____ Last four week's receipts or other proof of bills paid or currently due
_____ Employment verification form from your employer
_____ Employment termination form 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
- ☐ Daycare ☐ APTD/MA
- ☐ TANF Emergency Assistance

_____ You have applied for / are receiving Fuel Assistance benefits
_____ Verification of injury or illness and/or Medical Release Form
_____ You have applied for / are receiving Unemployment Compensation
_____ Picture ID (Adults); Birth certificate/SS card (minors). Proof of dependents.
_____ Notice of Decision from other agencies, including state, city or county welfare and fuel assistance
_____ Savings and checking account, liquid asset statements, bankbooks
_____ Statement child support payments received / Child support court order
_____ Proof of residency

I 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

APPLICATION FOR ASSISTANCE

Date of Application _____ Referred by _____

1. **General Information:**

Name _____ Date of Birth _____

Address _____

Telephone _____ Social Security number _____ US Citizen? _____

Marital Status _____ Rent or Own? _____ How long at this address? _____

Spouse/Co-Applicant Name _____ SS# _____

Spouse address (if not same as applicant) _____

Assistance Requested _____

Reason for request _____

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

Where? _____ Under what name? _____

List below all persons living in your household:

Full 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 Residence

Housing Information:

Rent amount _____ per (month/week) _____ Date last paid _____ Date due _____

Do you have a current: ☐ Demand For Rent ☐ Notice to Quit ☐ Landlord/Tenant Writ

Total rent owed _____ Do you have a housing subsidy? _____

Utilities Included: ☐ Heat ☐ Electric ☐ Gas ☐ Water/Sewer ☐ Other

LANDLORD: Name _____ Telephone _____

Address _____

IF HOME-OWNER: Mortgage Amount _____ Date last paid _____ Owed _____

Bank/Mortgage Co _____ Address _____

3. **Education / Training / Employment**

	Highest Grade Attended	G.E.D. or Diploma	Special Training or Skills	Military Service
Applicant:				
Spouse/Co-Applicant:				

Applicant Work History:

Are you employed now? _____ Employer _____ Position _____

When began work _____ Date/Amount of most recent check _____

Are you unemployed now? _____ Reason _____

Date last worked _____ Employer _____ Date/Amount last check _____

Are you able to work now? _____ If not able, why not? _____

Current and two most recent jobs of yourself and all household members aged 18 & older:

Name	Employer	Pay	Weekly/ Biweekly	Employment Dates	Reason for Leaving

4. **Household Assets:**

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

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

Motor vehicles owned by you and all household members:

Owner	Auto Make	Model	Year	Value	Payments	Insurance

Provide current value of any assets held by you and all household members:

Cash on hand (all household combined) _____ Certificates of Deposit (CD's)_____

Savings Bonds _____ Mutual Funds_____Annuities_____Stocks _____

Trust Funds_____Retirement Accounts _____Insurance Policies (cash value)_____

401k _____ Property other than primary residence _____Location _____

Other Investments _____Motorcycles/Boats/Snowmobiles/ATV's/RV's _____

Other Assets (please list) _____

Claims/settlements/income due to you or any household member

IRS Refund_____ Insurance Claim _____ Retroactive disability check_____

Retroactive Unemployment or Worker's Compensation check_____ Inheritance_____

Other Lump Sum Payment (explain) _____

Have you or any household member consulted a lawyer regarding a possible lawsuit?:

Lawyer Name/Address_____

Reason _____

Do you or any household member have a lawsuit pending? _____ Who?_____

Please give details _____

Lawyer Name/Address_____

5. Household Income

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

	Name	Date Applied	Date Last Received	Monthly 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 (SS Disability)				
SSI (Supplemental Security)				
TANF				
Unemployment				
Vacation Pay				
Veteran's Pension				
Vocational Rehabilitation				
WIC(Women/Infants/Children)				
Worker's Compensation				
Other: [ ]				

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

Name	Agency Name	Contact Person

6. 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 _____ Mortgage _____

Bus/Cab _____ Electric _____ Prescriptions _____

Cable/Internet _____ Food _____ Rent _____

Child Support Paid _____ Fuel Oil _____ Rent-To-Own _____

Car Gasoline _____ Gas, Bottled _____ School Loan _____

Car Insurance _____ Gas, Natural _____ Storage _____

Car Payment _____ Health Insurance _____ Telephone _____

Condo Fee _____ Laundry _____ Other _____

Child Care _____ Loan _____ Other _____

Credit Card _____ Lot Rent _____ Other _____

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

Car Inspection _____ Drivers License _____ Medical _____

Car registration _____ Fines/Court Payments _____ Sewer/Water _____

Car repair _____ Home Repairs _____ Tax (Income/Property) _____

Dental _____ Home/Rent Insurance _____ Other _____

7. 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? _____

Town/City & State of conviction _____ Details of conviction: _____

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 _____

8. Liability for Support Information

Please provide following details:

Your father _____ Address _____

Your mother _____ Address _____

Co-applicant father _____ Address _____

Co-applicant mother _____ Address _____

Your or co-applicant's adult children _____

9. 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 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)

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)

_____ _____

Applicant Signature Date

_____ _____

Spouse or Co-applicant Signature Date

_____ _____

Signature of person completing form (if not applicant) Date

REIMBURSEMENT AGREEMENT

I agree to reimburse the Town of Barrington for Welfare Assistance, if possible, at some future date. Such recovery of these expenses will be through a program of repayment mutual agreeable.

_____ _____

Applicant's Signature Spouse or Co-Applicant Signature

If you have a lawsuit, worker's compensation claim or aid from any other social service agency now pending disposition, please list the name, address and phone number of your attorney, insurance company or any other agency which may be handling this claim on your behalf.

Name: _____

Address: _____

Telephone: _____

RELEASE OF INFORMATION

I, _____, understand that as part of the administration of this program, the Town may verify information that would affect my eligibility or to actively pursue appropriate assistance on my behalf. My signature below authorizes the Town to obtain from or release to any person or organization having/requiring information concerning my circumstances, including any relative, physician, lawyer, agency, banker, employer or insurance company, and authorizes release of such information to the Town and by the Town. A photocopy or facsimile of this signed release may be used in place of the original.

_____ _____

Applicant's Signature Spouse or Co-Applicant Signature

_____

Welfare Officer Signature

MISREPRESENTATION

I understand that any misrepresentation given on this application or verbally would cancel all aid from the Town of Barrington and may result in court action for recovery. I also understand if I am dissatisfied with the action taken on this application, I have the right to request a Fair Hearing.

_____ _____

Applicant's Signature Spouse or Co-Applicant Signature

WARNING: **If you make a written or verbal false statement in this application or leave out information in order to create a false impression, you may be prosecuted under NH RSA 641:3.**

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

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

BARRINGTON 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 it's 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 under your care, and is unable to work. 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**

Thank you for taking the time to complete this form.
Please contact the Municipal Welfare Department if you have any questions.

RENTAL VERIFICATION FORM

THIS FORM MUST BE COMPLETED BY THE LANDLORD

Tenant's Name: _____ Date: _____

Address: _____

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

Number of Household Members: _____ List of Household Members: _____

_____

_____

_____

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 # must be provided:

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

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