



TOWN OF BELMONT, NEW HAMPSHIRE GENERAL ASSISTANCE

14 Mill Street, P.O. BOX 310, BELMONT, NEW HAMPSHIRE 03220-0310
Telephone: (603) 267-8313 or 603-387-2199
crisismgmt@belmontnh.gov

Welfare & General Assistant
Donna J Cilley, Director

GENERAL ASSISTANCE APPLICATION

*****PLEASE NOTE*****

PLEASE DO NOT EMAIL THIS APPLICATION OR DROP IT OFF WITHOUT FIRST MAKING CONTACT WITH THE GENERAL ASSISTANCE DIRECTOR AS IT MAY CAUSE DELAYS OR DENIAL

Before Meeting with The General Assistance Director

↓ The Following is Required ↓

- A Completed Application. **The Following Are Required**, Unemployment / Work Search Paperwork, Copy of Child Support Check or Paperwork, Medicaid Cards or Paperwork, Food Stamps Determination Letter, Disability Paper work (*if you have applied and are pending we need a copy of the pending letter*), Employment Pay Stub(s), Copy of Your Driver's License & Social Security Cards For All Individuals Residing In Your Household (*1st page of your tax return will also act as a replacement for s/s cards*).
- If you are Requesting Rental Assistance the landlord form must be filled out and signed by your landlord prior to meeting with the welfare office. Your landlord may, *Mail, Hand Deliver, Email* or give to you the required *landlord form*. If you are having difficulty getting your landlord to fill this document out, please call the welfare office. If you are requesting Utility Assistance your disconnection notice is a required document. It is also recommended that you call the Utility Company and make payment arrangements prior to your appointment to let them know you have a scheduled appointment with the welfare office to *Avoid Disconnection*.
- If You Are Out of Work Due to a Temporary Medical problem you are required to provide a hospital or doctor's statement stating, you are out Full Time or out on Light Duty, and for how long. If you are put out on light duty how many hours can you work a day or week.
- If You Are Living with Your Parents Or At One Of Your Parents Residences The Following Documentation Is Required, A Notarized Statement That Your Parents Income Is Not Sufficient To Help You, Along With Your Parents Prior Years Tax Return.
- All Qualified Food Stamp (SNAP) and FANF Applicants Must Apply to The Department of Health & Human Services for Emergency Funds Prior To Requesting Town Assistance.

If you have questions or need help filling this application out, please call the Welfare Office at 603-267-8313. If you have an emergency and you are unable to reach the welfare office, please call the office offline at 603-387-2199.

REQUIRED CHECK LIST

You must provide the FOLLOWING verifications and or documentation that apply to you at your time of appointment or assistance may be delayed or denied:

- _____ Completed Application Form
 - _____ Rental Verification Form
 - _____ 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; Pay stubs will supplement verification if working full time.
 - _____ Employment termination form from your last employer if within 30-days
 - _____ You have applied for/are receiving Social Security benefits (S/S award letter proof)
 - _____ You have applied at the Dept Health & Human District Office for:
 - Emergency Food Stamps Food Stamps (SNAP) FANF (TANF)
 - Title XX Daycare APTD/MA OAA
 - FANF (TANF) Emergency Assistance
 - _____ You have applied for/are receiving Fuel Assistance benefits
 - _____ Verification of injury or illness (proof necessary)
 - _____ You have applied for/are receiving Unemployment Compensation (proof necessary)
 - _____ If available, picture ID for all (Adults)
 - _____ Social Security cards for all household members or the front page of your income tax return.
 - _____ Vehicle registration (all vehicles)
 - _____ Bank Statements/Savings and/or checking account, liquid asset statements, bankbooks
 - _____ Statement child support payments received/Child support court order
 - _____ Statement from mom-mate(s) regarding division of expenses
 - _____ Income Tax Return if Applicable
- Other: _____

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.

PLEASE NOTE- If you need assistance making copies of requested documents, please bring your originals to the General Assistance Office at the time of interview.

If you have questions regarding required documents, please call the Welfare Office at, 603-267-8313.

Application for General Assistance

Belmont, New Hampshire

Office Phone #267-8313 or 603-387-2199

Date: _____

Phone: _____

Name of **Applicant**: _____

Name of **Other**/(Spouse, Boy/Girlfriend /Friend/Partner): _____

Current Address, _____ How Long? _____

Mailing Address if Different (PO Box): _____

Housing/Rental Status, Do You **Own** or **Rent** (please circle one) How Long? _____

Are You Homeless? ___ Y ___ N How Long? _____

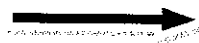
Previous Address: _____ How Long? _____

Applicants Date Of Birth: _____ Applicant Social Security Number: _____

Marital Status (Please Circle One) SINGLE MARRIED DIVORCED SEPARATED

For Employment Purposes Only.

Do You Have A High School Diploma or GED? _____



WHAT IS YOUR REQUEST AT THIS TIME:

Please attach requested bills or documentation to this application.

Request: _____ Due Date? _____

Request: _____ Due Date? _____

Request: _____ Due Date? _____

LIST "ALL" INDIVIDUALS LIVING IN YOUR HOME:

(Spouse, Partner, Boyfriend, Roommate, Parents, Children, Friends & How Long)

_____ How Long? _____
Please print

_____ How Long? _____
Please print

_____ How Long? _____
Please print

_____ How Long? _____
Please print

_____ How Long? _____
Please print

IF ADDITIONAL SPACE IS NEEDED PLEASE USE THE BACK SIDE OF THIS PAPER

Children's Health Insurance Information:

Do you have health insurance coverage for your children? Yes _____ (or) No _____

Do adults have health insurance, Medicaid Yes ___ or No ___ ? Private Ins. YES ___ NO ___ ?

Last Two Years Of Work History

(Most Recent Employer First)

APPLICANT:

Employer Name and Address: _____

Type Of Work: _____ Dates of Employment _____ TO _____

Number of Hours Per Week _____ Hourly Wage _____ Take Home Pay _____

Employed: ___ Y ___ N Reason Leaving: _____

Employer Name and Address: _____

Type Of Work: _____ Dates of Employment _____ TO _____

Number of Hours Per Week _____ Hourly Wage _____ Take Home Pay _____

Employed: ___ Y ___ N Reason For Leaving: _____

If You Have Additional Employment Please Use The Back Of This Paper

IF YOU ARE UNEMPLOYED, **HOW LONG?** _____

ARE YOU COLLECTING UNEMPLOYMENT? _____ **HAVE YOU APPLIED?** _____

IS THERE ANY *REASON* WHY **YOU ARE NOT WORKING**, PLEASE EXPLAIN: _____

DO YOU HAVE A DOCTORS NOTE
THAT DIRECTS YOU TO BE OUT OF WORK AND FOR **HOW LONG?** _____

OTHER/SPOUSE/ROOMMATE:

Employer Name and Address: _____

Type Of Work: _____ Dates of Employment _____ TO _____

Number of Hours Per Week _____ Hourly Wage _____ Take Home Pay _____

Reason For Leaving: _____

Employer Name and Address: _____

Type Of Work: _____ Dates of Employment _____ TO _____

Number of Hours Per Week _____ Hourly Wage _____ Take Home Pay _____

Reason For Leaving: _____

If You Have Additional Employment Please Use The Back Of This Paper

IF YOU ARE UNEMPLOYED, **HOW LONG?** _____

ARE YOU COLLECTING UNEMPLOYMENT? _____ **HAVE YOU APPLIED?** _____

IS THERE ANY *REASON* WHY **YOU ARE NOT WORKING**, PLEASE EXPLAIN: _____

DO YOU HAVE A DOCTORS NOTE
THAT DIRECTS YOU TO BE OUT OF WORK AND FOR **HOW LONG?** _____

**TOWN OF BELMONT
MUNICIPAL GENERAL ASSISTANCE 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

*Thank you for taking the time to complete this form.
Please contact the General Assistance Director if you have any questions, 603-267-8313.*

Applicant Income Verification Check List

APPLICANT

(Check One or Both)

	Yes	No
Savings or Checking Account	_____	_____
Savings Account# & Amount _____		
Checking Account# & Amount _____		

INCOME

	Yes	No	Amount Receiving
Weekly Take Home Pay	_____	_____	_____
Unemployment- How Often	_____	_____	_____
Sub-Contracted Monies	_____	_____	_____
Workmen's Comp - How Often	_____	_____	_____
Military or Pension Monies	_____	_____	_____
Severance Pay or Settlement Money	_____	_____	_____
Rental Property Income	_____	_____	_____
Child Support Received	_____	_____	_____
Money From Relatives or Boarders	_____	_____	_____
Disability Money, SSI, APT or Other	_____	_____	_____
Social Security Money	_____	_____	_____
TANF	_____	_____	_____
Fuel Assistance CAP	_____	_____	_____
Medicaid	_____	_____	_____
Food Stamps	_____	_____	_____
NH Housing or Housing Assistance	_____	_____	_____
Other:	_____	_____	_____

I hereby affirm that all the information stated in this Income Verification Check List is *true*.

I also understand that False Representation will terminate any and all assistance and possibly result in court action.

Applicant's Signature _____ **Date** _____

Co-Applicant Income Verification Check List

CO-APPLICANT (Spouse/Friend)
 (Check One or Both)

Yes

No

Savings or Checking Account _____

Savings Account# & Amount _____

Checking Account# & Amount _____

INCOME

Yes

No

Amount Receiving

Weekly Take Home Pay	_____	_____	_____
Unemployment- How Often	_____	_____	_____
Sub-Contracted Monies	_____	_____	_____
Workmen's Comp - How Often	_____	_____	_____
Military or Pension Monies	_____	_____	_____
Severance Pay or Settlement Money	_____	_____	_____
Rental Property Income	_____	_____	_____
Child Support Received	_____	_____	_____
Money From Relatives or Boarders	_____	_____	_____
Disability Money, SSI, APT or Other	_____	_____	_____
Social Security Money	_____	_____	_____
TANF	_____	_____	_____
Fuel Assistance CAP	_____	_____	_____
Medicaid	_____	_____	_____
Food Stamps	_____	_____	_____
NH Housing or Housing Assistance	_____	_____	_____
Other:	_____	_____	_____

I hereby affirm that all the information stated in this Income Verification Check List is *true*.

I also understand that False Representation will terminate any and all assistance and possibly result in court action.

Co-Applicant's Signature _____ **Date** _____

Town of Belmont General Assistance Budget Worksheet

Applicant: _____ Date: _____

PLEASE LIST ALL MONTHLY OR WEEKLY EXPENSES

Please Circle One: Mortgage / Rent / Board \$ _____ Month / Week \$ _____

Electricity \$ _____

Food \$ _____ (The amount spent after Food Stamps)

Personal's \$ _____ (Items not covered by Food Stamps)

Prescriptions \$ _____

Phone \$ _____

Propane \$ _____

Heat / Oil \$ _____ (The amount spent after CAP)

Day Care \$ _____ (The amount after state reimbursement)

Health Ins \$ _____

Life Ins \$ _____

Child Support \$ _____ Month / Week (paid out) \$ _____

Total Expenses \$ _____

Non-Essential Expenses:

Cable TV \$ _____

Car Payment \$ _____

Car Payment \$ _____

Gasoline \$ _____

Rent to Own Furniture \$ _____

Master Card \$ _____

VISA Card \$ _____

Other Charge Cards \$ _____

Other \$ _____

Total Expenses \$ _____

All Expenses Paid Out \$ _____

All Income Received \$ _____ (Include All: Work or Unemployment,
Disability Income, TANF, Child Support)

Paid Expenses minus All Income = \$ _____ Monthly Please circle one (negative) or (positive income)

I hereby affirm that all the information stated in this Budget Work Sheet is *true*. I also understand that *False Representation* will terminate any and all assistance and possibly result in court action.

Applicant's Signature _____ Date _____

Co-Applicant Signature _____ Date _____

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

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

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Relationship to You

Witness

Date

Assets Verification

Applicant:

Location of Property owned by the Applicant: _____

Cash On Hand At This Time: _____

List All:

Cars _____ Amount Owed: _____

Trucks _____ Amount Owed: _____

Boats, Snowmobiles, Campers, Etc. _____

I hereby affirm that all the information stated in this Assets Verification Sheet is *true*. I also understand that *False Representation* will terminate any and all assistance and possibly result in court action.

Applicant's Signature _____ Date _____

Co-Applicant:

Location of Property owned by the Applicant: _____

Cash On Hand At This Time: _____

List All:

Cars _____ Amount Owed: _____

Trucks _____ Amount Owed: _____

Boats, Snowmobiles, Campers, Etc. _____

I hereby affirm that all the information stated in this Assets Verification Sheet is *true*. I also understand that *False Representation* will terminate any and all assistance and possibly result in court action.

Co-Applicant's Signature _____ Date _____

**Permission to Release Information to
The Town of Belmont**

I hereby give permission for the release of information to The Town of Belmont Welfare & General Assistance Department, P0 Box 310, Belmont, NH 03220 and to assist with making a financial decision based on my request for Welfare and General Assistance. I grant permission to release any information necessary to determine my eligibility for Welfare & General Assistance including wages, income, assets, debts, vehicle registrations verification through the Town Clerk Tax Collector's Office, financial obligations, benefit amounts, settlements, past / present employment, and housing information. This information may be released in writing, over the telephone, or in person to the Welfare & General Assistance Department. This permission statement is valid for a maximum of *six months* from the signing of this form.

Applicant's Name (please print)

Applicant's Signature Date

Co-Applicant's Name (please print)

Co-Applicant's Signature Date

I authorize and request any relative, physician, lawyer, banker, employer, insurance company, fraternal order, or any other person or organization having information concerning my eligibility for General Assistance to fa such information to the General Assistance Director.

Applicant's Signature Date

Co-Applicant's Signature Date

I also understand I will repay the Town of Belmont for any assistance I am given if I am able to, and that the Town will place a lien on all real estate owned by me pursuant to R5A165:28-a..

Applicant's Signature Date

Co-Applicant's Signature Date

I hereby certify that I have been given; read and filly understand all my responsibilities to each of the above mentioned signed obligations or authorizations within this application. I understand that any falsification within this application or verbal information may result in denial of further assistance from the Town of Belmont. I may also be subject to penalties for material misrepresentation, and falsification of an unsworn document, which may result in court action.

Applicant's Signature Date

Co-Applicant's Signature Date

Income Tax Refund

Please be advised that if you are requesting assistance from the Welfare and General Assistance Office all income tax refunds will be considered income and must be used for allowable expenses such as, rent (including arrears), utilities, medications, medical bills, and childcare. When determining eligibility your budget worksheet will include all income. The Welfare & General Assistance Office will determine your request based on income vs basic needs.

You are required to provide the Welfare and General Assistance Office with a copy of your full (this years) Income Tax Return paperwork filed. This rule applies between January 1st and April 30th of the filing year. You must immediately notify this office of any refund payment.

If your refund was not received during your application period this applies to a minimum of 60-days prior to your request for assistance or a maximum of 60-days after receiving Welfare & General Assistance.

I have read and understand the above. I will provide a copy of my complete income tax return at time of my interview or within 7 days after my Welfare & General Assistance appointment. I will keep receipts of what the monies have been spent and be prepared to provide them to the Welfare & General Assistance Office at the time of my appointment.

Applicant Signature

Date

Co-Applicant Signature

Date

LANDLORD RENTAL VERIFICATION FORM

Belmont Welfare & General Assistance Department
PO Box 310 Belmont, NH 03220 603-267-8313



THIS FORM MUST BE COMPLETED BY THE LANDLORD
(You may fax this form back to 603-267-8314)

Tenant's Name: _____ Date: _____

Address: _____

Number of Authorized Adult Household Members: _____ Number of Authorized Children _____

List All Household Members: _____

Type of dwelling: Duplex ___ Multi ___ Room ___ Mobile Home ___ Single Residential Home ___

Age of Rental Unit: _____ Number of Bedrooms: _____ Occupancy date: _____

Is Security Deposit Paid in Full: Yes or No Amount Paid: \$ _____ Date Paid: \$ _____

Rent amount: \$ _____ monthly weekly other _____

If subsidized rent please list tenant portion: \$ _____ Heat: Electric Oil Gas Other _____

Rent Includes: All utilities No Utilities Hot Water Heat Electric

Is The Tenant current with his or her rent, Yes or No Amount Paid: \$ _____ Back rent owed: \$ _____

Is tenant under eviction, Yes or No Date rent was last paid: _____ How Much \$ _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	<p>1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p> <p>2 Business name/disregarded entity name, if different from above</p> <p>3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____</p> <p><small>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</small></p> <p><input type="checkbox"/> Other (see instructions) ▶</p>	<p>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p><small>(Applies to accounts maintained outside the U.S.)</small></p>
	<p>5 Address (number, street, and apt. or suite no.) See instructions.</p> <p>6 City, state, and ZIP code</p>	<p>Requester's name and address (optional)</p>
	<p>7 List account number(s) here (optional)</p>	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number	OR							
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Employer identification number								
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Part II Certification

Sign Here	Signature of U.S. person ▶ _____	Date ▶ _____
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