## City of Manchester, NH Welfare Department

## **APPLICATION FOR ASSISTANCE**

DATE	

Welfare Department 1528 Elm St.

**Complete Each Section** 

Phone: (603) 624-6484 Fax: (603) 628-6179

CASEWORKER	

Has any household	member ever appli	ed with this o	office before? Y	'es No I	f yes, When?	'What	t nam	e?	
Name				Maider	n Name				
Address				Cell# (	()	7	ГеI# (	)	
City	Sta	ite ZIP							
Name of Spouse	'Cohab/Roomma	te		Maider	n Name				
								)	
LIST EVERYONE	WHO LIVES IN TH			VITH YOURSE					
Full Name	RelationshSelf_	-		ate Age		I Security umber	_	Most Recent School Attended	Grade
							_		
							_ _		
							_		
Full Name	Birthd		Address			pployer		ne of Guardian if ch	
LIST MARITAL H	Spouse's Name	Dat	<b>SEHOLD MEME</b> te of rriage	BERS Place of Marri City/Town/St		Legal Status (Divorce/Sep/W	idow)	Date of Div/Sep/Wid	Custody of Children
LIST ADDRESSES Street Address,			D MEMBERS I	FOR THE LAST		RS, BEGIN WI		THE PRESENT A To (Month / Dat	
							to		
							to		
							to		
					<del></del>		to		
Has any household	member applied fo	r or received	assistance fron	n any other city	, town, or sta	ate welfare offi	ice? \	/es No	
If yes, where?		Who?	Wł	nen?	What	t type of assist	ance?		

## LIST YOUR PARENTS AND THE PARENTS OF YOUR SPOUSE, ROOMMATE OR COHAB

Your Name Place of Birth							
Full Address		Income	Full Address		Income		
		Date of Death if Deceased	Employer	Date of Deathif Deceased			
Mother		Tel#	Mother		Tel#		
Full Address		Income	Full Address		Income		
Employer		Date of Death if Deceased	Fmplover		Date of Death if Deceased		
		OR ALL HOUSEHOLD M					
Name	Branch	Dates of Service	Type of Discharge	Type of Benefits	Date / Amount of Last Pay		
		PLOYERS FOR ALL HOUS, ETC. INCLUDE EMP			YMENT,		
Name	Employer	Date Last Paid	Amount Last Paid	Dates of Employment	Reason for Leaving		
LIST ALL MEDICA	L, ILLNESS, ACCID	ENT AND/OR INJURY	INFORMATION				
Is any member of the	e household under do	octor's care? YesNo_	If yes, who?				
Name	Doo	ctor's name, address and	tel#				
Diagnosis		Medications					
Name	Do	octor's name, address and	d tel#				
Diagnosis		Medications					
Is any member of the	e household <b>unable</b>	to work? Yes No	_ If yes, who?				
Check Reason: Non	Work-Related Accide	nt Non Work-Rela	ted Illness Work-Re	lated Accident W	ork-Related Illness		
Date of Illness, Accid	lent or Injury	_ If work related, list dat	e Workers Comp. claim f	iled Date able t	o return to work		
If work related, list n	name and address of o	employer			Tel#		
Doctor's name and a	ddress				Tel#		
Insurance Co. name	and address				Tel#		

LIST /	ALL VEHICLE		DUSEHOLD MEM	BERS INCLU	JDING, MOTO		ATV'S, BOATS		Amount of
Year	Model	State and Plate #	Registered To			Date of Purchase	Price	Date of Last Payment	Amount of Payment
					Loan Borrow				
				Own	Loan Borrow				
							•		
			ERTY OWNED BY						
	_	_	property(ies)? Yes_						
						•			
			al income property?_						
Foreclo	sure pending?	Does an	y household member	own any other	real estate inclu	ding timeshares? Y	es No	_ Address	
RENT	AL INFORMA	ATION Land	dlord's name		Addr	ess	Tel <del>a</del>	# ()	
Rental	amount \$	Due	weekly Du	ie every two v	weeks D	ue monthly	_ Do you have	a lease? Yes	No
List all	names on the	e lease		Is	there a co-sign	er? Yes No_	Name of c	o-signer	
Date r	ent last paid	Amour	nt of last payment	Ren	tal period from	to	Is the rer	nt subsidized? Yes	No
If yes,	what type? _		Which utilities	are included	in your rent?			_ How many bedro	ooms?
Do you	u have an Evic	tion Notice?	/esNo	_ Expiration o	date Hav	ve you been to co	ourt? YesN	o Court dat	e
Has ar	ny person or a	gency helped	you with rent? If y	yes, who?			Amount pai	d	Date
PROP	ERTY HISTO	RY Has any	household member	er had any rea	al estate proper	ty or vehicles wh	ich have been s	old, foreclosed, re	possessed,
traded	l, totaled or jui	nked within th	ne last year? Yes _	_ No If ye	es, who?	List prope	erty/vehicle(s) _		· 
Date s	old	Sale price	Da	te foreclosed .	Date	repossessed, tra	ded, totaled or	junked	
FEDEI Name	RAL INCOME		te Filed Where,	WHO FILED / How Filed?	A 2016 Date Refun			# Of Dependent	s Claimed
			ember, INCLUDING						
Name	<b>:</b>		of Bank or al Institution	Savings Acct.	Balance	Checking Acct.	Balance	Name of Debit or Prepaid Car	
Lac an	w household r	mombor had	a bank, credit unio			account closed w	within the last 4	months? Vos	
	•		n? What ty	•					
•			e any of the follow	•					
	•		f Deposit (cds)	•		-			
Stocks	5 Γ	Deferred Com	pensation	Profit Sh	naring	Annuities	Oth	ner	<del></del>
			owed from, cashed						No
Is any	y household	member a p	articipant in, or	has been the	e recipient of	any charitable	fundraising o	r monetary gifts	s within the

last 6 months? Yes\_\_\_\_ No\_\_\_\_ If yes, amount last received \_\_\_\_\_ Date last received \_\_\_\_\_ Source\_

INSURANCE Does any household n policies? Yes No If yes, li	nember have any insurance st the following details for		utomobile, ho	meowner's,	renter's, life o	r any other	insurance
Name	Name of Insurance Co.		Type of Poli	cy 	Cash		
LIST IF ANY HOUSEHOLD MEMBE FOLLOWING SOURCES. CHECK T							
		Name		Date Applied	Date Last Received	Amount	None
ANB (Aid to the Needy Blind) OA	A (Old Age Assistance)	-					
APTD (Aid to Permanently and To	tally Disabled)						
Boarders in your household							
Cash or any money available or set as	side						
Disability – Short Term Lo	ong Term						
Food Stamps							
Fuel Assistance: Rent Heat _	Electric						
Help from friends, relatives, employer	r, co-workers, etc.						
Maternity Benefits							
Medicaid							
Retirement Pension							
Severance Pay							
SS SSD SSI							
TANF Relative Payee							
Unemployment Compensation							
Utility Allowance Benefit (from subsid	ized housing)						
Vacation Pay Earned Time_	Sick Time	-					
Veteran's Pension Veteran's	Disability						
WIC (Women, Infants & Children)							
Worker's Compensation							
Date and amount of last income/finar household member	ncial resource for each						
Other							
PAST / FUTURE RESOURCES							
Is any household member expecting Insurance claim Workers Co		•			•		
Yes No If yes, who?		_	_			-	
Has any household member consulted							
YesNo If yes, who?	• ,	•	•	•			
GUARDIANSHIP / REPRESENTAT	IVE PAYEE						
Does any household member have a	Legal Guardian? Yes I	No and/or Rep	o. Payee? Yes	sNo	If yes, who? _		
Name of Legal Guardian or Rep. Payer	ee	·			Tel#		
Is any household member a Legal Gu	ardian or Rep. Payee for a	inyone else? Yes	No If	yes, who? _			
What benefits?Name	and Tel# of person(s) you	are a Legal Guardia	n or Rep. Pay	ee for			

ARE YOU OR ANY OTHE	ER HOUSEHOLD MEMB	ERS WORKING W	ITH ANY OTHE	R AGENCIES?	Yes No		
Client Name	Agency <sub>-</sub>		Contact F	Person		Tel#	
Client Name	Agency <sub>-</sub>		Contact F	Person	7	ГеI#	
LIST ALL HOUSEHOLD	MEMBERS ENROLLED I	IN HIGHER EDUC	ATION CLASSES	s			
Client Name	School		Full Time	Part Time	Financial Aid Amou	ınt	
Client Name	School		_ Full Time	Part Time	Financial Aid Amou	ınt	
ABSENT PARENT /CO-F	ARENT INFORMATION	FOR ALL CHILD	REN WHO LIVE	IN YOUR HO	<b>JSEHOLD</b>		
1. Child's /Children's name	(s) that have the same biolog	gical parent					
Name of absent parent / co-p	parent		_ Address		Te	el #	
Does the absent parent / co-	parent have visitation or shar	ed custody? Yes	No If yes,	what are the arra	ingements?		
Do you receive support from	this parent? Yes No_	Are the payments	court ordered? Yes	s No	Arrearages ow	ed? Yes	No
Are the child support paymer	its wage garnished? Yes	No Date last	received	Amount last rece	ived D	ate next due_	
How is the support paid to yo	ou? Cash Check	Money Order	Direct Deposit	Child Su	pport Card	_ Other	
Recent or upcoming court he	arings? Yes No	Date of court hearing	Reaso	on for hearing			
2. Child's /Children's name							
Name of absent parent / co-p							
Does the absent parent / co-		-	_		_		
Do you receive support from							
Are the child support paymer							
How is the support paid to yo		-					
Recent or upcoming court he	arings? Yes No	Date of court hearing	Reaso	on for hearing			
3. Child's /Children's name	(s) that have the same biolog	gical parent					
Name of absent parent / co-p	parent		_ Address		Te	el #	
Does the absent parent / co-	parent have visitation or shar	ed custody? Yes	No If yes,	what are the arra	ingements?		
Do you receive support from	this parent? Yes No_	Are the payments	court ordered? Yes	s No	Arrearages ow	ed? Yes	No
Are the child support paymer	its wage garnished? Yes	No Date last	received	Amount last rece	ived D	ate next due_	
How is the support paid to yo	ou? Cash Check	Money Order	Direct Deposit	Child Su	pport Card	_ Other	
Recent or upcoming court he	arings? Yes No	Date of court hearing	Reaso	on for hearing			
LIST INFORMATION O	N ALL MINOR CHILDRE	N THAT DO NOT	LIVE IN YOUR	HOUSEHOLD	(Request additiona	al paper if ne	cessary.)
Person paying support	Chile	d's/Children's name(s)	that have the sam	e biological parer	nt	_	
Name, address and Tel # of	parent/guardian with whom o	child resides			Relation to	o child	
Name, address and Tel #of p	erson receiving support payr	nents (if different fror	n the above)				
Date last paid Amt. I	ast paid Cash	Check Mone	ey OrderW	/age garnishment	Court order	red? Yes	_ No
2. Person paying support	Chile	d's/Children's name(s)	that have the sam	e biological parer	nt		
Name, address and Tel # of	parent/guardian with whom o	child resides			Relation to	o child	
Name, address and Tel #of p	erson receiving support payr	nents (if different fror	n the above)				
Date last paid Amt. I	ast paid Cash	Check Mone	ev Order W	/age garnishment	Court order	red? Yes	No

BASIC EXPENSES	Amount	Frequency Weekly or Monthly	Date Last Paid	Balance Due	Name on Bill
Rent / Mortgage		Wk Mo			
Food		Wk Mo			
Diapers		Wk Mo			
Gasoline for vehicle(s)		Wk Mo			
Household Supplies		Wk Mo			
Gas Utility		Wk Mo			
Electric		Wk Mo			
Oil		Wk Mo			
Prescriptions		Wk Mo			
OTHER EXPENSES					
Cable/Satellite		Wk Mo			
Car Payments	- <del></del>	Wk Mo			
Cell Phone(s)		Wk Mo			
		Wk Mo			
Child Care		Wk Mo			
Court Fees, Fines, etc		Wk Mo			
Credit Cards		Wk Mo			
Internet Connection		Wk Mo			
Laundry		Wk Mo			
Personal Loans		Wk Mo			<u> </u>
Pet Expenses		Wk Mo			
Streaming Services		Wk Mo			
Rent to Own Items		Wk Mo			
Storage Unit		Wk Mo			
Telephone (landline)		Wk Mo			
Tobacco Products		Wk Mo			
Other		Wk Mo			
		Wk Mo			
WHAT ASSISTANCE AR	F YOU REQUEST	ING?			
7	_ 100 K				
WHAT IS THE REASON	FOR YOUR REOL	JEST?			
Has any household member	er ever been convi	cted of a felony? YesN	lo If yes, who?		When?
Is any household member	presently on parol	le or probation? Yes No	If yes, who?		
Which city / town and stat	e?	Name of	parole / probation offi	cer	
-					
161#PIO	viue uetalis				

Applicant Name	(PRINT)	Co-applicant Name (Pl	RINT)
Spouse Name	(PRINT)	Co-applicant Name (Pl	RINT)
	READ BEF	ORE SIGNING	
	from all sources concerning my/c	my/our authority for the City of Manchester, N our household's circumstances. All information	
I/We have the right to re	equest a Fair Hearing based on th	e receipt of an adverse action issued by the W	Velfare Official.
I/We, the undersigned, a	agree to repay the City of Manche	ster, NH Welfare Department for any assistan	ce granted pursuant to RSA 165.
Applicant Signature	e Date	Co-applicant Signature	Date
Spouse Signature	 Date	Co-applicant Signature	Date
-	ADDI ICANIT/S ALITHODIA	ATION TO FURNISH INFORMATION	
department, shelter, dor Administration, Southerr	mestic violence or crisis organizati	of Adult and Elderly, NH Legal Assistance, any on, religious/charitable organization, Departmo other person, company, organization or agen are Department.	ent of Employment Security, Veteran's
Applicant Signature	e Date	Co-applicant Signature	Date
Spouse Signature	Date	Co-applicant Signature	Date
	APPLICANT'S AUTHORIZ	ATION TO RELEASE INFORMATION	
physician, landlord/renta employer, rental/leasing pharmacy, hospital, eme fire department, emerge Department of Homelan Children Youth and Fam domestic violence or cris	al agent, lawyer, banking/lending/ company, utility, insurance comp ergency care facility, ambulance se ency medical technician, Red Cross d Security, Social Security Administilies, Division of Adult and Elderly,	tment to release information concerning my/o financial institution, school department, check any, health care provider, day care provider, revice, funeral home/crematorium, rent-to-owis, Salvation Army, food pantry, Internal Revenstration, any state or county division of Health NH Legal Assistance, any town, city, county, the organization, Department of Employment Secondary, organization or agency.	cashing service, employer, former mental health professional/facility, in business, police, sheriff, State Police tue Service, tax preparer, accountant, and Human Services, Division of state or federal department, shelter,
Applicant Signature	e Date	Co-applicant Signature	Date
 Spouse Signature	 Date	Co-applicant Signature	Date

If you need a disability-related accommodation, notify front desk. TTY access through Relay NH at 711

## EACH ADULT HOUSEHOLD MUST INITIAL EACH STATEMENT BELOW SHOWING THAT YOU HAVE READ AND UNDERSTAND THE STATEMENT. PLEASE DO NOT HESITATE TO ASK QUESTIONS.

I understand that if our household receives assistance, then provided, if we are returned to an income status which enable (RSA 165:20-b) (initials)	our household members will be required to repay any assistance bles us to reimburse the City without financial hardship.
I understand that if our household receives assistance from required to participate in the work program to repay assista (RSA 165:31) (initials)	the City, adult household members over 18 years of age may be nce.
I understand that if our household receives assistance, the household member owns. (RSA 165:28)	City may place a lien against any real estate property in which any (initials)
I understand that if assisted, the City may place a lien again property passing under the terms of a will, or by intestate st (RSA 165:28-a) (initials)	ist any property settlement, civil judgment for personal injuries, or uccession.
I understand that the City reserves the right to contact and (RSA 165:19) (initials)	pursue assistance and reimbursement from legally liable relatives.
I understand that any changes in my circumstances must be (initials)	e reported to the Welfare Official within 3 working days.
I understand that misrepresentation or omission of informationand documentation I provide is subject to verifice (initials)	ion may result in suspension of assistance. I understand that the cation.
return to this office while my case is still open that I must dobut is not limited to; providing proof of all income and financial	om the date of last contact with this office. I understand that should emonstrate compliance with all prior Notices of Decision. This include cial resources received and receipts to verify that all monies have rither understand that my failure to comply with the requirements of ibility of assistance.
VOLUNTARY QUIT LAW	
Pursuant to the provisions of RSA 165:1-d voluntary termina from receiving general assistance in the future.	ation of employment without good cause could lead to disqualification
DO NOT SIGN THE STATEMENT BELOW UNTIL AFTER	THE END OF THE INTERVIEW.
true. I hereby certify that all notes and/or alterations writte accurately reflect my responses to questions and any addition or misleading information or withhold or omit information re	oth in writing and verbally to Manchester City Welfare is complete an n on my application by the caseworker(s) during the intake process anal information I provided. I understand that if I knowingly give falsolated to my receipt of assistance, now or in the future, I may be d for a crime (i.e. RSA 641:3 – Unsworn Falsification and/or RSA
Applicant Signature:	Date:
Spouse Signature:	Date:
Co-Applicant Signature:	Date:
Co-Applicant Signature:	Date: