APPLICATION FOR (WELFARE) ASSISTANCE

For ALL welfare assistance, questions, and information, you must contact the welfare official at: 603-608-6627. If there is no answer, please leave a message and your call will be returned as soon as possible.

Please read all of the application instructions, information and requirements carefully.

CLIENTS ARE SEEN BY APPOINTMENT ONLY

Clients must complete an application prior to scheduling a welfare intake appointment.

Clients will not be interviewed without a completed application.

Determination of eligibility can not occur without a completed application which includes all the required supporting documentation and applicable forms included in this packet.
INSTRUCTIONS/INFORMATION

To apply for any assistance from the Tilton Welfare Department you must **THOROUGHLY COMPLETE** the following application. All documentation requested is required to complete the application process. A decision cannot and will not be made until all documentation requested has been supplied.

As you complete your request for General Assistance, we ask you to remember that Local Town Welfare is not a hand out, but designed to be a safety net that is not automatic, ongoing, or indefinite and is solely funded through local taxpayer's property tax dollars. It by law requires that you cooperate with the Welfare Official and take responsibility for your own personal behavior and actions.

If you are currently not working or not working full time, you will be required to complete an extensive job search, defined of at least 5 job contacts a day and provide signed confirmation from the perspective employer of your application. You may also be required to participate in the Town's Workfare Program. If you are physically or mentally unable to work you will need to have medical documentation completed by your physician.

If you recently left employment, you will need to have your previous employer complete the employment form. You will also have to apply for unemployment whether or not you may think you are eligible and have the employment office form completed. If you are currently working you will need to provide **copies of the last 4 paycheck stubs** or **have your employer complete the income form found in this application.**

You will be expected to do everything in your power to live within your income by adjusting your financial situation to eliminate the need for General Assistance. You will be required to provide this office with ongoing verification of information requested. The purpose of this office is to assist you in becoming self-supporting and self-sufficient. Town Welfare is to assist with supplying basic needs only. Basic needs are expenses defined as those that support life and health.
RESPONSIBILITIES OF EACH APPLICANT AND RECIPIENT

AT THE TIME OF THE INITIAL APPLICATION, AND AT ALL TIMES THEREAFTER, THE APPLICANT/RECIPIENT HAS THE FOLLOWING RESPONSIBILITIES:

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

2. To notify the Welfare Official or his/her designee within 72 hours when a change in needs or resources may affect eligibility for continuing assistance.

3. Within 7 days of application, to apply for and utilize any benefits or household resources, public, or private, that will reduce or eliminate the need for Town General Assistance.

4. To keep all appointments as scheduled and to return all information that is needed within the specified time frames so that once assistance is granted, no lapse in benefits such as TANF checks or Food Stamps will occur.

5. To notify the Welfare Official within 72 hours of a change of address and any change in the members of the household.

6. To diligently search for employment and provide verification of applications for employment when requested, following a determination of eligibility for assistance. You must ACCEPT ANY employment offer following a determination of eligibility. Refusal to accept employment is grounds for denial or sanction.

7. To provide a doctor's statement if any work eligible adult in the household claims an inability to work due to medical problems.

8. To participate in the welfare workfare program if physically and mentally able, following a determination of eligibility for assistance.

9. To keep appointments as scheduled for Town Welfare knowing that if you are more than 15 minutes late, you will be considered a no show and may not be eligible for rescheduling for 7 calendar days for your missed appointment date.

A RECIPIENT'S ASSISTANCE MAY BE TERMINATED OR SUSPENDED FOR FAILURE TO FULFILL ANY OF THESE RESPONSIBILITIES WITHOUT A REASONABLE JUSTIFICATION.

Signature ___________________________ Date: __________________
VERIFICATIONS REQUIRED FROM APPLICANTS

You will need to bring the following documentation with you for all your appointments. Photocopies are acceptable. A decision cannot and will not be made until all documentation requested has been supplied.

1. You must provide Proof of Identification for each member of the household. This can be a birth certificate, a social security card, or a picture I.D. ______

2. Proof of Residence. This is either a completed Welfare rental form or a delivered piece of U.S. Mail to your stated address. ______

3. Proof of Income. Examples include: current months paycheck stubs, statement from employer with net and gross amounts for past month, Workers Compensation Papers, Unemployment Compensation, check stub from Social Security or TANF. All sources of income including gifts, and if you have just started a new job, a statement from the employer as to hourly rate, hours per week and date and amount of anticipated first net paycheck. ______

4. Proof of all allowable bills that you are paying (basic needs including rent, electric food, heat, babysitters for work, Prescriptions/medications. ________

5. Proof that you have applied for the following: TANF, FOOD STAMPS, WORKERS COMPENSATION, UNEMPLOYMENT COMPENSATION, SOCIAL SECURITY, WIC, APTD, MEDICARE AND OR MEDICAID AND FUEL ASSISTANCE. ________


7. Proof of any Cash Resources, Current statements of any bank accounts for all members of the household including children. ________

8. Doctor's statement of disability or reason for leave from work. This should include diagnosis and list of medications prescribed, clearly identify what condition each medication is used to treat, as well as anticipated length of disability and return to work date. ________

9. Proof that parent or spouse cannot help you financially including federal tax returns see NH RSA 165:19. ________
10. Complete list of any other sources of income or financial help you have received during the past four weeks from any and all sources such as a church, charitable group, loan from a family member or friends, loan from institutions, winnings from Bingo or lotteries, fuel assistance, trust funds money borrowed or withdrawn from a retirement account, or CAP. ____________

11. Other case specific documentation:

________________________________________________________________________

________________________________________________________________________
It is very important that applicants are aware of the laws regarding welfare fraud and therefore understand and expect that the TOWN OF TILTON will pursue all criminal remedies including prosecution to the full extent of the law as well as:

ANY PERSON MAY BE DENIED OR TERMINATED FROM GENERAL ASSISTANCE AND OR BE PROSECUTED FOR A CRIMINAL OFFENSE, WHO BY MEANS OF INTENTIONALLY MAKING FALSE STATEMENTS OR INTENTIONAL MISREPRESENTATION OR BY IMPERSONATION OR THE WILLFULLY FRAUDULENT ACT OR DEVICE OBTAINS OR ATTEMPTS TO OBTAIN ANY ASSISTANCE TO WHICH HE OR SHE IS NOT LEGALLY ENTITLED.

The above responsibilities and list of verifications have been read and I believe that I understand my responsibilities fully when completing this application for Town Welfare/General Assistance.

Applicant Signature: __________________________ Date: _____

Applicant Signature: __________________________ Date: _____

Applicant Signature: __________________________ Date: _____
WELFARE APPLICATION

1. APPLICANT NAME: ___________________ DATE OF BIRTH ____________
   SOCIAL SECURITY NUMBER: ________________________________
   CURRENT ADDRESS: _________________________________ (how long at this address? ___)
   PREVIOUS ADDRESS: past 2 years, include all towns in NH __________________________
   BEST CONTACT PHONE NUMBER: _______________________

2. APPLICANT NAME: ___________________ DATE OF BIRTH ____________
   SOCIAL SECURITY NUMBER: ________________________________
   CURRENT ADDRESS: _________________________________ (how long at this address? ___)
   PREVIOUS ADDRESS: past 2 years, include all towns in NH __________________________
   BEST CONTACT PHONE NUMBER: _______________________

3. APPLICANT NAME: ___________________ DATE OF BIRTH ____________
   SOCIAL SECURITY NUMBER: ________________________________
   CURRENT ADDRESS: _________________________________ (how long at this address? ___)
   PREVIOUS ADDRESS: past 2 years, include all towns in NH __________________________
   BEST CONTACT PHONE NUMBER: _______________________

TOTAL NUMBER OF HOUSEHOLD OCCUPANTS - LIST BELOW ALL PEOPLE LIVING AT THIS RESIDENCE/AND OR HOUSEHOLD

<table>
<thead>
<tr>
<th>NAME</th>
<th>BIRTHDATE/AGE</th>
<th>RELATIONSHIP</th>
<th>SOCIAL SECURITY #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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</tbody>
</table>
PER RSA 165.19 - LIST THE NAMES AND ADDRESSES OF YOUR PARENTS:

______________________________  1.
______________________________  2.
______________________________  3.
______________________________  4.

LAST FULL GRADE COMPLETED:

______________________________

MARITAL STATUS:

______________________________

Are you a legal citizen or resident of the United States? Yes  No

WHAT TYPE OF ASSISTANCE ARE YOU RECEIVING?

______________________________

WHY ARE YOU REQUESTING GENERAL ASSISTANCE FROM TOWN WELFARE?
**EMPLOYMENT:**

Are you Currently Employed? ____________________

EMPLOYER NAME: ___________________________________________________________

EMPLOYER ADDRESS: ___________________________ PHONE#: ___________________

DATES OF EMPLOYMENT: ___________________________ JOB TITLE: ________________

Co-Applicant:

EMPLOYER NAME: ___________________________________________________________

EMPLOYER ADDRESS: ___________________________ PHONE#: ___________________

DATES OF EMPLOYMENT: ___________________________ JOB TITLE: ________________

Co-Applicant:

EMPLOYER NAME: ___________________________________________________________

EMPLOYER ADDRESS: ___________________________ PHONE#: ___________________

DATES OF EMPLOYMENT: ___________________________ JOB TITLE: ________________

**PLEASE IDENTIFY THE SOURCE OF REFERRAL TO THIS OFFICE:**

1. SELF  
2. SOCIAL SECURITY  
3. MEDICAL SERVICES  
4. NH HOSPITAL  
5. FAMILY/FRIEND  
6. MENTAL HEALTH  
7. VETERAN'S ADMINISTRATION  
8. SCHOOL  
9. JUSTICE SYSTEM  
10. DES  
11. SHELTER  
12. OTHER  

HAVE YOU EVER REQUESTED TOWN WELFARE ASSISTANCE BEFORE? ____________________

WHERE: ______________________________________________________________________

DATES OF ASSISTANCE: _______________________________________________________

TYPE OF ASSISTANCE: _________________________________________________________

**CURRENT BENEFIT / INCOME AMOUNTS**

<table>
<thead>
<tr>
<th>Source of Assistance</th>
<th>DATES OF APPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE WELFARE</td>
<td></td>
</tr>
<tr>
<td>TANF</td>
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<tr>
<td>SOCIAL SECURITY</td>
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<td>APTD</td>
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<tr>
<td>SSDI/SSI</td>
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<tr>
<td>OAA</td>
<td></td>
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<tr>
<td>VETERANS BENEFITS</td>
<td></td>
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<tr>
<td>UNEMPLOYMENT COMPENSATION</td>
<td></td>
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<tr>
<td>WORKERS COMPENSATION</td>
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<tr>
<td>CURRENT BENEFIT / INCOME AMOUNTS</td>
<td>DATES OF APPLICATION</td>
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<tr>
<td>MEDICAL</td>
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<tr>
<td>CHILD SUPPORT</td>
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<tr>
<td>SETTLEMENTS</td>
<td></td>
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<tr>
<td>ALIMONY</td>
<td></td>
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<tr>
<td>PRIVATE DISABILITY INSURANCE</td>
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<tr>
<td>PENSION</td>
<td></td>
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<tr>
<td>NATIONAL GUARD</td>
<td></td>
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<tr>
<td>TRUSTFUND</td>
<td></td>
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<tr>
<td>WEEKLY PAYCHECK</td>
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<tr>
<td>TAXREFUNDS</td>
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<tr>
<td>OTHER PAYCHECK</td>
<td></td>
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<tr>
<td>OTHER INCOME</td>
<td></td>
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<tr>
<td>FOOD STAMPS</td>
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</tbody>
</table>
RESOURCES FOR THE HOUSEHOLD:

<table>
<thead>
<tr>
<th>AMOUNT</th>
<th>LOCATION</th>
<th>OWNER OF RESOURCE</th>
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</thead>
<tbody>
<tr>
<td>CASH</td>
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<tr>
<td>SAVINGS</td>
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<tr>
<td>CHECKING</td>
<td></td>
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<tr>
<td>CHILD SUPPORT</td>
<td></td>
<td></td>
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<tr>
<td>STOCK BONDS</td>
<td></td>
<td></td>
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<tr>
<td>PENSION/RETIREMENT SAVINGS</td>
<td></td>
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<tr>
<td>LIFE INSURANCE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LIST ALL VEHICLES:

OTHER ASSETS (I.E. TRAILERS, MOBILE HOMES, JET SKI'S, A.T.V'S, BOATS, SNOW MOBILES, MOTORCYCLES, LAND etc.)

DOCUMENTATION FOR ALL RESOURCES WILL BE REQUIRED TO COMPLETE APPLICATION. Examples of acceptable documentation include: complete current bank statements within 30 days, court order for child support, pension statements, life insurance policies, vehicle registrations and/or titles, mortgage statements, property assessment statements. Failure to provide this documentation will result in application being determined as non-complete and a delay in processing and determination of assistance.

PLEASE KEEP IN MIND THAT IT IS UNLAWFUL FOR ANY APPLICANT OR RECIPIENT TO KNOWINGLY MAKE FALSE REPRESENTATION VERBALLY OR IN WRITING, OR BY OMISSION AS TO HIS OR HER CIRCUMSTANCES. (NH RSA 641:3) ANYONE WHO DOES SO MAY BE SUBJECT TO CRIMINAL PROSECUTION FOR SUCH ACTIONS, AND MAY FORFEIT CONFIDENTIALITY PROTECTION FOR PROSECUTION PURPOSES.
MONTHLY EXPENSES

RENT $___________ PER: WEEK MONTH BI-MONTHLY

DATE LAST PAID________________________ AMOUNT PAID____________________

UTILITIES INCLUDED IN RENT (circle one): NONE HEAT ELECTRICITY WATER

NAME OF LANDOWNERS (MUST BE THE LEGAL PROPERTY OWNERS OF RECORD)

_________________________________________________________

Address of landlord:______________________________________________

Contact phone number(s) for landlord:______________________________

CLIENTS MONTHLY EXPENSES:

RENT/ MORTGAGE $______________

FOOD $______________

ELECTRICITY $______________

HEAT $______________

WATER $______________

COOKING GAS $______________

PRESCRIPTIONS $______________

CELL PHONE $______________

MISC (Pet food, gas, tobacco) $______________

TOTAL MONTHLY EXPENSES $______________
APPLICANTS WORK RECORD FOR PAST YEAR:

Employer:__________________________________________________________

Dates of Employment:______________________________________________

Type of Work:_________________________________ Wages:______________

Reason left:_______________________________________________________

CO-APPLICANT WORK RECORD FOR PAST YEAR:

Employer:__________________________________________________________

Dates of Employment:______________________________________________

Type of Work:_________________________________ Wages:______________

Reason left:_______________________________________________________

OTHER HOUSEHOLD (ADULT) MEMBER WORK RECORD FOR PAST YEAR:

Employer:__________________________________________________________

Dates of Employment:______________________________________________

Type of Work:_________________________________ Wages:______________

Reason left:_______________________________________________________

PER NH STATE LAW:
ANY PERSON WHO QUILTS A PLACE OF EMPLOYMENT WITHOUT ANOTHER VERIFIABLE JOB TO GO TO, AND/OR WITHOUT VERIFIABLE CAUSE WITHIN 60 DAYS OF SUBMITTING AN APPLICATION FOR ASSISTANCE, SHALL BE INELIGIBLE FOR ASSISTANCE FOR 90 DAYS FROM THE DATE OF LEAVING EMPLOYMENT.

OTHER INFORMATION REQUIRED:

Has anyone in your household been convicted of a crime?________________________

Does anyone in your household have a lawsuit pending?________________________

If yes, name of law firm, attorney, address and phone number:____________________

________________________________________________________________________

Does any member of the household expect to receive an income tax refund or earned income credit in the next 45 days?________________________
AVAILABLE SOURCES OF INCOME:

APPLICANT'S AVAILABLE INCOME:

Hourly Wage:$__________ Wages per week: __________ Hours worked per week: ____

CO-APPLICANT AVAILABLE INCOME:

Hourly Wage:$__________ Wages per week: __________ Hours worked per week: ____

OTHER ADULT HOUSEHOLD MEMBER INCOME:

Hourly Wage:$__________ Wages per week: __________ Hours worked per week: ____

VEHICLES:

Do you own a vehicle(s)? ________________ Number of household vehicles ____________

(1) Make __________ Model __________ Year __________
Is there a payment on the vehicle? ____________ Amount of payment ____________
Where is the vehicle registered (town)? ____________

(2) Make __________ Model __________ Year __________
Is there a payment on the vehicle? ____________ Amount of payment ____________
Where is the vehicle registered (town)? ____________

FAMILY HISTORY:

APPLICANTS SPOUSE, EX-SPOUSE(S) OR ESTRANGED SPOUSE: ____________

Address of above: ____________________________________________________________________ Social Security Number ____________
Age: __________
Date and place of marriage ____________________________________________________________________
Date and place of separation or divorce ____________________________________________________________________

CO-APPLICANT SPOUSE, EX SPOUSE(S) OR ESTRANGED SPOUSE: ____________

Address of above: ____________________________________________________________________ Social Security Number ____________
Age: __________
Date and place of marriage ____________________________________________________________________
Date and place of separation or divorce ____________________________________________________________________
RECOVERY OF ASSISTANCE
(ALL ADULT HOUSEHOLD MEMBERS MUST SIGN)

I understand that the Town of Tilton may recover the amount of assistance provided once I have returned to an income status which would allow me to reimburse the Town without hardship. I understand that a lien will be placed on my home, land or trailer for any assistance provided. I hereby affirm that all the information stated herein is true to the best of my knowledge and belief and that I may be subject to criminal penalties for material misrepresented.

SIGNATURE_________________________ DATE____________________

SIGNATURE_________________________ DATE____________________

SIGNATURE_________________________ DATE____________________

RELEASE OF INFORMATION
(ALL ADULT HOUSEHOLD MEMBERS MUST SIGN)

I authorize and request any Relative, Physician, Counselor, Mental Health worker, NH Division of Human Services, Lawyer, Banker, Insurance Company, Local Welfare Office or any other organization or person having information concerning my eligibility for assistance to furnish such information to the Tilton Welfare Director. I have the right to review such information if I am not satisfied with the decision. I authorize the Town of Tilton Welfare Director or their agent to release information as required to the Social Security Office, NH Division of Human Services, School Personnel, Community Action Program or any person or organization in order to conduct Welfare business and determine eligibility for general assistance.

SIGNATURE_________________________ DATE____________________

SIGNATURE_________________________ DATE____________________

SIGNATURE_________________________ DATE____________________
WELFARE WORK PROGRAM

When you are receiving Town Welfare/General Assistance, you may be required to participate in the Workfare program through the Welfare Department. If you have a medical problem that limits the type of duties that you can perform, you will need a medical statement to verify them. If you are physically or mentally unable to participate on the Workfare program, you will need a medical statement to verify this. The medical statement should state the length of time you will need to be excused from the program and for what reason.

While you are on the Workfare Program, you will be expected to perform your duties in a courteous and respectful manner. You are to show respect for the supervisor, and you are expected to do your duties as instructed. If you are dismissed from the Workfare program for any reason (examples of cause for dismissal—please see below), you will be suspended from receiving benefits for 7 days and you will be expected to make up the missed work time before you can apply for future benefits. If you are dismissed for a second time in the period of 6 months, the suspension period will be for 14 days and until lost time has been made up.

Examples of dismissal reasons:

1. Use of foul language
2. Showing disrespect to the Supervisor
3. Refusal to perform the work as instructed
4. Not reporting to work on time
5. Reporting to your work assignment under the influence of alcohol or a substance.
6. Causing a disruption of me work flow

The Workfare program as stated above has been discussed with me and I agree to participate on the Workfare program if requested and assigned to do so. I am aware that willful non-compliance of the Workfare Program will result in disqualification for General Assistance. The Workfare program allows you to work off your debt to the Town and you will not receive cash payments or a paycheck for your efforts—you will be paying off your obligations to the town.

Signature _______________________________ Date: ____________

Signature _______________________________ Date: ____________

Signature _______________________________ Date: ____________

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WORKFARE MEDICAL SCREENING FORM

Medical Screening for Welfare Workfare Participation Program

1. Do you have any problems with your knees, back, shoulders or hands?__________
   If Yes, Please explain_________________________________________________________

2. Do you have any serious disease(s) now? ______________________________________
   If Yes, please explain________________________________________________________

3. Have you been hospitalized for accident/illness?______________________________
   If Yes, When and What type__________________________________________________

4. Have you ever received worker's compensation for injuries on the job?__________
   If Yes, please briefly explain date and type of injury___________________________

5. Have you had a physical exam recently?______________________________________
   If yes, please provide Doctor's Name_________________________________________

6. Do you have a valid driver's license? _________________________________________

7. Do you have a police record? ______________________________________________

8. In case of emergency, who should we notify? _________________________________

9. Do you take any medications? _____________________________________________
   If yes, please list___________________________________________________________

10. Do you feel that you are physically able to join/participate in the Workfare program?____

I hereby affirm that all the information stated above is true to the best of my knowledge and belief and that I may be subject to penalties for material misrepresentations, and falsification of any un-sworn document. False representation will affect eligibility or may terminate the amount of assistance I receive and will result in court action.

Signature___________________________________________Date:_______________________

INDEMNIFICATION

I__________________________, of Tilton, New Hampshire, Social Security Number__________________________
do hereby swear that I will hold harmless now and forevermore, the TOWN OF TILTON, its Town Selectman, any employee of the TOWN OF TILTON and member of any Town Board for any medical expenses, loss of time or any difficulty involving a problem with my__________________________which occurred prior to participation in Workfare with the TOWN OF TILTON.

Signature of Workfare Participant__________________________
Witness____________________________________________________

If you object to signing the above, please explain:___________________________________________
## Income Status

### MONTHLY INCOME:

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>TANF</td>
<td>$</td>
</tr>
<tr>
<td>SSI/SSDI/APTD</td>
<td>$</td>
</tr>
<tr>
<td>Child Support</td>
<td>$</td>
</tr>
<tr>
<td>Food Stamps</td>
<td>$</td>
</tr>
<tr>
<td>Pay Checks (monthly)</td>
<td>$</td>
</tr>
<tr>
<td>Worker's Compensation</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment</td>
<td>$</td>
</tr>
<tr>
<td>Tax Return</td>
<td>$</td>
</tr>
<tr>
<td>Other Miscellaneous Income</td>
<td>$</td>
</tr>
</tbody>
</table>

**Total Monthly Income:** $      

### MONTHLY EXPENSES:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Rent</td>
<td>$</td>
</tr>
<tr>
<td>Heat</td>
<td>$</td>
</tr>
<tr>
<td>Electricity</td>
<td>$</td>
</tr>
<tr>
<td>Phone</td>
<td>$</td>
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<tr>
<td>Child Care</td>
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<td>Doctors</td>
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<td>Food</td>
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<td>Vehicle</td>
<td>$</td>
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<tr>
<td>Prescriptions</td>
<td>$</td>
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<td>Other</td>
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**Total Monthly Expenses:** $      

### For Office Use Only:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Total Income</td>
<td>$</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$</td>
</tr>
<tr>
<td>Funds Remaining</td>
<td>$</td>
</tr>
</tbody>
</table>
LANDLORD/RENTAL VERIFICATION FORM  
(TO BE COMPLETED BY LANDLORD)  

ATTENTION CLIENT:  
TAKE THIS FORM TO YOUR LANDLORD AND HAVE THEM FILL OUT ALL THE INFORMATION COMPLETELY. Do not complete this form yourself.  

ATTENTION LANDLORD:  
This document details who is living in the household and all the detailed rental information. Please complete the form in its entirety and return to the client or mail to the address above.  
THE CLIENT SHOULD NOT COMPLETE THIS FORM.  
Intentional misrepresentation of the household information to assist in Welfare Fraud will be considered falsification of an un-sworn document and will be prosecuted under penalty of the law.  

Tenant's Name: ____________________________________________________________  
Tenant's Address: __________________________________________________________  
Names of ALL people residing at this address: __________________________________  

________________________________________________________________________  
Number of Bedrooms: ______________________________________________________  
Date of Occupancy: ________________________________________________________  
Rent Amount: __________________________ Per: week, month.  
Rent Includes: Heat______ Electricity______ Gas______ Water______ Other______  
Deposit Paid: __________________________ By Whom: ___________________________  
Date last rent paid: __________________________ Amount Paid: ___________________  
Is there any government subsidy paid on tenant's behalf? If Yes, give amount, frequency and type:  
________________________________________________________________________  
Is any back rent due?_________________________ Amount:_________________________  
ARE YOU IN ANYWAY RELATED TO THE TENANTS? _______________________________  
A W-9 Form is required from each Landlord. If you are not incorporated, your Social Security Number is needed for an annual 1099 IRS Form.  

________________________________________________________________________  
Landlord Signature  Address  Telephone Number  SSN  

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PHYSICIAN'S STATEMENT / MEDICAL REPORT
(Required only if Applicant or Co-Applicant is claiming disability)

TO THE PHYSICIAN:

________________________________________ has applied to the Town of Tilton Human Services/Welfare Department for financial aide to meet his/her basic living needs or rent, food, and utilities. It is customary for the participants who are not working to participate in the Town's Workfare Program to work off some of their account balance while they are unemployed. This work can be yard work, street sweeping, dusting in the library, stuffing envelopes and filing etc. This client has stated he/she cannot do any work at all for any length of time. Your completion of this form will verify that the participant is totally disabled at this time.

Thank you for completing the following:

1. Is the above named disabled? Yes____ No _____
2. Please state the diagnosis in order of importance________________________________________
3. Is this person able to perform any type of work (i.e., clerical, yard work, sweeping, light housekeeping?)________________________________________
4. Is there a restriction on the amount of time this person can work each day? If yes, how many hours:________________________________________
5. Date incapacity began:________________________________________
6. Expected end date of disability:________________________________________

________________________________________
Physician's Signature

Date

I hereby request the above information be released, accepted, and honored by my physical or medical health provider including my doctor, hospital, counselor, and or psychiatrist. Please provide the Town of Tilton, Welfare Official with the information regarding my diagnosis, abilities, physical limitations and medical history. I recognize that this includes the release of confidential medical information to the Welfare Official who will use this information to make a determination of eligibility for general assistance and applicable programs.

Signature of Patient________________________________________Date:________________________________________
PREVIOUS EMPLOYER FORM

(It is the Applicant's responsibility to submit this form to the previous employer and ensure it is returned to the General Assistance Office either by employer or employee)

To: Name of Previous Employer:_______________________________________________

Address of Previous Employment:_____________________________________________

Name of Employee:__________________________________________________________

Signature of Employee to Release Information:_________________________________

Employee Home Address:______________________________________________________

Employee Social Security Number:_____________________________________________

To Whom It May Concern:

The above named has applied for General Welfare Assistance with the Town of Tilton. In order to determine eligibility, please complete the information below and return to the above address as soon as conveniently possible. Thank you for your cooperation.

1. Date of termination:_________________ is this permanent _______ or temporary ______

2. Reason for termination:_________________ Voluntary (resignation etc); Laid Off _______
   Retired_________ Other______________________________

3. Date of last paycheck ________________________ Net Amount __________________

4. Did this employee receive money, or will they be receiving money from any other source at the time of termination, such as severance pay, vacation pay, sick pay, workers compensation, retirement plan or other? ________________________________________________

Employer Signature and Title _____________________________ Phone Number __________
CURRENT EMPLOYER FORM
(For use when Employee is on leave of absence)
(It is the Applicant's responsibility to submit this form to the previous employer and ensure it is returned to the General Assistance Office either by employer or employee)

To: __________________________

______________________________

RE: __________________________

The above named person has applied to the Town of Tilton for assistance. This person has indicated that he/she is employed by you or your company and that he/she will be out of work due to __________________________ for (length of time) __________________________

The following information is needed to determine eligibility for general assistance. Please complete and return to the address above:

1. Is this person covered for financial benefits from insurance coverage during this absence?

______________________________

2. Does this person have any sick or vacation time that can be used during his absence?

______________________________

3. Please indicate the last date this person will be receiving a paycheck during this absence_________ Pay check net amount________________________

4. Other information: __________________________

______________________________ Date: ____________

Signature of Employer

______________________________ Date: ____________

Signature of Employee for Release of Information
INCOME VERIFICATION FORM
(For use when no paycheck stub is available)

(It is the Applicant's responsibility to submit this form to the previous employer and ensure it is returned to the General Assistance Office either by employer or employee)

To Whom It May Concern:

_________________________ has applied for assistance from the Town of Tilton to meet his/her basic living needs. He/she has stated they are employed by you or your company. The following information is needed to determine their eligibility for assistance.

Please indicate both Gross and Net Earnings for the last four (4) weeks of employment:

<table>
<thead>
<tr>
<th>Pay Check date</th>
<th>Gross Earnings</th>
<th>Net Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>wk 1</td>
<td>_____________</td>
<td>____________</td>
</tr>
<tr>
<td>wk 2</td>
<td>_____________</td>
<td>____________</td>
</tr>
<tr>
<td>wk 3</td>
<td>_____________</td>
<td>____________</td>
</tr>
<tr>
<td>wk 4</td>
<td>_____________</td>
<td>____________</td>
</tr>
</tbody>
</table>

________________________________________
Employer Signature

________________________________________
Employer Name

________________________________________
Address

________________________________________
Telephone Number
Form W-9

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.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

- Individual/sole proprietor
- C Corporation
- S Corporation
- Partnership
- Trust/estate

Exemptions (see instructions):

- Exempt payee code (if any)
- Exemption from FATCA reporting code (if any)

Print or type, if possible. See Specific Instructions on page 2.

Limit liability company. Enter the tax classification (C=Corporation, S=S Corporation, P=partnership)

Other (see instructions)

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requester's name and address (optional)

List account number(s) here (optional)

**Part I  Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

**Social security number**

**Employer identification number**

**Part II  Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined below), and

4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign Here**

Signatures of U.S. person

Date

**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding,
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively-connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign partner, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.