



City of Dover Welfare Department

61 Locust Street, Suite 334, Dover, NH 03820

Phone (603) 516-6500 Fax (603) 516-6508

Email: dover-publicwelfare@dover.nh.gov

CITY OF **DOVER**

GENERAL ASSISTANCE **APPLICATION**



City of Dover Welfare Department
61 Locust Street, Suite 334, Dover, NH 03820
Phone (603) 516-6500 Fax (603) 516-6508

THIS APPLICATION IS A LEGAL DOCUMENT

Please read carefully before completing this application for assistance. Once submitted to the department for consideration, the application and related material become the property of the CITY OF DOVER and shall be considered confidential.

YOU, THE APPLICANT, ARE RESPONSIBLE AT EACH APPOINTMENT FOR PROVIDING FULL AND ACCURATE INFORMATION REGARDING YOUR HOUSEHOLD INCOME AND EXPENSES, HOUSEHOLD MEMBERS, CURRENT ADDRESS, DETAILS OF YOUR CURRENT SITUATION AND ANY CHANGES IN REGARDS TO THIS INFORMATION.

All questions must be answered fully. Failure to complete any part of this application may delay processing the request for assistance. Blank spaces will be considered an omission of information. Applicants must comply with any requests for information by the Welfare Department necessary for determination and investigation of applicant's eligibility for assistance. Failure to comply with requests may result in withdrawal of the application for assistance, denial of assistance requested or suspension pursuant to RSA 165:1-b.

If you have any questions or anything on this form is unclear to you, you may contact our office during normal business hours Monday – Friday 8:00am till 4:00pm for further clarification.

I (we) have read and understand the above.

Signature: _____

Date: _____

Signature: _____

Date: _____

*NOTICE OF RIGHTS AND RESPONSIBILITIES OF ANYONE RECEIVING ASSISTANCE
FROM THE CITY OF DOVER*

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 fairhearing.
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 if you must care for a child under the age of five (5), or to conduct a job search if you must care for a child under the age of one year (1), if you are disabled or ill, or if you must take care of a member of your family who is disabled or ill.

You have the following responsibilities:

1. To provide accurate, complete and current information concerning needs and resources and the whereabouts and circumstances of relatives who may be responsible under RSA 165:19;
2. To notify the Welfare Official promptly when there is a change in needs, resources, address, or household size;
3. To apply for immediately, but no later than seven (7) days from completed application, and accept any benefits or resources, public or private, that will reduce or eliminate the need for imminent or potential future general assistance. RSA 165:1-b, Kd);

4. To keep all appointments as scheduled;
5. To provide records and other pertinent information and access to said records and information when requested;
6. To provide a verifiable doctor's statement if claiming an inability to work due to medical problems;
7. Following a determination of eligibility for assistance, to diligently search for employment, and provide a verifiable job search as determined by the Welfare Official, to accept employment when offered (except for documented reasons of good cause (RSA 165: 1-d)), and to maintain such employment. RSA 165:1-b (c);
8. Following a determination of eligibility for assistance, to participate in the workfare program (if required) and if physically and mentally able. RSA 165: 1-b, 1(b); and
9. To reimburse assistance granted if returned to an income status and if such reimbursement can be made without financial hardship. RSA 165:20-b.
10. To not voluntarily terminate employment without good case as determined by the Welfare Officer. If you voluntarily terminate employment, you shall be ineligible to receive assistance for ninety (90) days from the date of employment termination.

Once the Welfare Officer makes a decision, a written notice of decision shall be provided on the same day or next business/working day. The notice of decision shall state that assistance of a specific kind and amount has been given and the time period of aid, or that the application has been denied, in whole or in part, with reasons for denial. The notice of decision shall contain a first notice of conditions for assistance and shall notify the applicant of his/her right to a fair hearing if dissatisfied with the Welfare Official's decision.

I/We have read and reviewed the Welfare Rights and Responsibilities with the Welfare Administrator.

Applicant Signature

Date

Co-Applicant Signature

Date

**CITY OF DOVER WELFARE DEPARTMENT
APPLICATION FOR GENERAL ASSISTANCE
(PLEASE ANSWER ALL QUESTIONS)**

Date of Application _____ Social Security # _____

1. General Information:

Name _____ Date of Birth _____

Address _____

How long at this address? _____ Telephone _____

Email _____ US Citizen? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Gender: ☐ female ☐ Male

Spouse/Co-Applicant Name _____ SS# _____

Date of Birth _____ Telephone _____

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:

<u>Full Name</u>	<u>Relationship</u>	<u>Date of Birth</u>	<u>Social Security #</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If at your current address less than 12 months, please list past 12 month's addresses:

<u>Street</u>	<u>Town/City</u>	<u>State</u>	<u>Dates of Residence</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. 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 INFO: Name _____ Telephone _____

Address _____

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

Bank/Mortgage Co _____ Address _____

3. Education / Training / Employment

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

Applicant Work History:

Are you employed now? _____ Employer _____ Position _____

When work began _____ 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:

<u>Name</u>	<u>Employer</u>	<u>Pay</u>	<u>Weekly/ Biweekly</u>	<u>Employment Dates</u>	<u>Reason for Leaving</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

4. Household Assets:

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

<u>Name</u>	<u>Bank/Credit Union</u>	<u>Savings</u>	<u>Savings</u>	<u>Checking</u>	<u>Checking</u>
	<u>Chime, Venmo, cash app</u>	<u>Acct. #</u>	<u>Balance</u>	<u>Acct. #</u>	<u>Balance</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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

Cash on hand (all household members)_____ 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_____ Inheritance_____

Retroactive Unemployment or Worker's Compensation check_____

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 members have a lawsuit pending? _____ **Who?** _____

Please give details_____

Lawyer Name/Address_____

Do you or any household members have A COURT DATE IN THE NEXT 90 DAYS? _____

Motor vehicles owned by you and all household members:

<u>Owner</u>	<u>Auto Make</u>	<u>Model</u>	<u>Year</u>	<u>Value</u>	<u>Payments</u>	<u>Insurance</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

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/FAP	_____	_____	_____	_____
Unemployment	_____	_____	_____	_____
Vacation Pay	_____	_____	_____	_____
Veteran's Pension	_____	_____	_____	_____
Worker's Compensation	_____	_____	_____	_____
Income Tax Refund	_____	_____	_____	_____
IRS Stimulus Payment	_____	_____	_____	_____
Other: [_____]	_____	_____	_____	_____

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

<u>Name</u>	<u>Agency Name</u>	<u>Contact Person</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____

Can everyone in the family leave Strafford county? ☐ Yes ☐ No

8. Parent 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 who are not in the home _____

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



61 Locust Street, Suite 334
Dover, New Hampshire 03820-3704
(603) 516-6500

Fax: (603) 516-6508

s.gaston@dover.nh.gov or j.carnes@dover.nh.gov

**DOVER HUMAN SERVICES DEPARTMENT
APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION**

I understand that as part of the administration of the general assistance program, a municipal welfare official may verify information I have provided on my application for assistance and any other information that would affect my eligibility. My signature below authorizes the City of Dover Welfare Officials, to obtain information from _____ regarding factors relevant to my application for general assistance benefits.

This authorization shall expire one year from the date it is signed.

A photocopy of this signed authorization may be used in place of an original.

Applicant

Date

Welfare Official



City of Dover Welfare Department
61 Locust Street, Suite 334, Dover, NH 03820
Phone (603) 516-6500 Fax (603) 516-6508

RELEASE

I (WE) AUTHORIZE AND REQUEST ANY RELATIVE, PHYSICIAN, PHARMACIST, LAWYER, BANKER, EMPLOYER, INSURANCE CO., LANDLORD (WHICH SHALL INCLUDE OWNER/MANAGER OF HOTEL/MOTEL OR OTHER TEMPORARY HOUSING), SHELTER, SOBER LIVING FACILITY, LOCAL WELFARE OFFICE, HOSPITAL, MEDICAL PROVIDER, MENTAL HEALTH PROFESSIONAL, CHURCH GROUP, SOCIAL WORKER, OR ANY OTHER ORGANIZATION OR PERSON HAVING INFORMATION CONCERNING MY/OUR ELIGIBILITY FOR ASSISTANCE TO FURNISH SUCH INFORMATION TO THE DOVER WELFARE DEPARTMENT. I/WE ALSO AUTHORIZE THE SOCIAL SECURITY OFFICE, NEW HAMPSHIRE LEGAL SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (IN ALL OF ITS DIVISIONS), LOCAL OR STATE POLICE, DEPARTMENT OF EMPLOYMENT SECURITY, VETERANS ADMINISTRATION, SCHOOL PERSONNEL, COMMUNITY ACTION PROGRAM, OR ANY PERSON, NON-PROFIT ORGANIZATION, OR OTHER ORGANIZATION TO SUPPLY ANY INFORMATION NEEDED IN ORDER TO CONDUCT WELFARE INQUIRIES AND FOR DOVER WELFARE TO SHARE SUCH INFORMATION AS NECESSARY SO AS TO DETERMINE MY/OUR ELIGIBILITY FOR GENERAL ASSISTANCE.

THIS INFORMATION MAY BE TRANSMITTED BY PHONE, FAX, EMAIL, US MAIL OR IN PERSON.

THIS AUTHORIZATION SHALL REMAIN EFFECTIVE FOR ONE YEAR FROM THE DATE GIVEN BELOW.

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

Authorization to Release Information

Printed Name of Person to Whom the Release of Information Pertains

Case #, RID #, or MID #, if known

I hereby authorize and request:

Name and Address of
Individual or Agency
Providing the Information:

NH DHHS – All Programs & Divisions

To provide the following information: Case Detailed Information

To:

Name and Address of
Individual or Agency
Receiving the Information:

Dover City Welfare
61 Locust St Ste. 334
Dover, NH 03820

I grant my permission for the reproduction of the above information to be given to the individual or agency named. Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual/agency I have named. **This authorization expires 12-months from the date this form is signed.**

Information released cannot be re-released by the receiving individual/agency without additional authorization.

(Signature)

(Date)

(Printed Name)

If the signature above is not that of the person to whom the information pertains, the relationship of the signer to that person must be indicated. In addition, the signature must be witnessed.

(Relationship)

(Witness)

(Date)

Case # _____

Community Action Partnership of Strafford County

Release Form

I, (please print full name clearly) _____ grant Community Action Partnership of Strafford County permission to release information to the following organization and/or any third party as stated below related to the case deemed by the client.

1. CITY OF DOVER _____
2. _____
3. _____
4. _____

I grant permission for the following specific information from my record at Community Action Partnership of Strafford County to be released to the above named individuals:

- ☐ Attend appointment on my behalf
- ☐ Energy Program Assistance benefit status and amount
- ☐ Status of application, including discussing missing information
- ☐ Household financials for each individual
- ☐ All aspects of the Weatherization Program
- ☐ All aspects of housing and personal welfare
- ☐ Other: _____

This Release Form is good for 1 year from date of signature below

Client Signature

Date

Client Printed Name

Client Signature

Date

Client Printed name