



TOWN OF BOSCAWEN
116 N. MAIN ST.
BOSCAWEN, NH 03303
(603)753-9188 X303 fax: 603-738-9184
sgerlack@townofboscawen.org

WELFARE ASSISTANCE

APPLICATION FOR ASSISTANCE

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 TOWN OF BOSCAWEN and shall be considered confidential.

It shall be the right of any individual regardless of race, age, gender, sexual orientation, religious or political affiliation to apply for local welfare assistance.

Each application will be reviewed with the applicant in order to make a determination regarding the applicant's eligibility for assistance. If the applicant does not agree with the decision of the Welfare Administrator regarding the determination of eligibility based on the current Welfare Guidelines of the TOWN OF BOSCAWEN, the applicant may request a Fair Hearing within five (5) days of the date of such written decision.

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 Administrator 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 a question on this form is unclear to you, discuss it with the welfare official.



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WELFARE ASSISTANCE

Contact Information

Request Date: _____ Date of Birth _____ Soc.Sec.# _____ Cell Phone _____ Employed? Full/Part/Self/No _____
 Applicant: _____
 Co-Applicant: _____
 Current Address: _____ Home Phone: _____
 Household Makeup: _____
 Homeless: Yes No
 Prior Address if less than 30 days at current address: _____

ASSISTANCE NEEDED: _____

REASON FOR SEEKING ASSISTANCE: _____

Number of Household Members
 # of Adults _____ # of Children _____ Available Cash the Household has now: \$ _____

Complete the following if you are renting:	Complete the following if you own a home:
Rent Payment \$ _____ Monthly <input type="checkbox"/> Weekly <input type="checkbox"/>	Mortgage Payment \$ _____ Monthly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/>
Do you have a Notice to Quit/Demand for Rent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a foreclosure notice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a Writ of Possession from the Court? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Type of Home: <input type="checkbox"/> House <input type="checkbox"/> Condo <input type="checkbox"/> Mobile Home
Landord/Property Manager Name and Telephone: _____	Lending Institution/Mortgage Holder & Account Number: _____

	Head of Household	Other Household Members
Has anyone in household applied to this office before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If working, indicate TAKE HOME (NET) Pay	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly \$ _____
If NOT working, is it due to illness and/or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no longer working, list date of last employment:	Date _____	Date _____
List benefits received by any household member:	APTD Cash \$ _____	APTD Cash \$ _____
	TANF \$ _____	TANF \$ _____
	SSA \$ _____	SSA \$ _____
	SSDI \$ _____	SSDI \$ _____
	SSI \$ _____	SSI \$ _____
	Workers Comp \$ _____	Workers Comp \$ _____
	Child support \$ _____	Child support \$ _____
	Unemployment \$ _____	Unemployment \$ _____
	Food Stamps \$ _____	Food Stamps \$ _____
	Other \$ _____	Other \$ _____

List Health Insurance Benefits for all household member:

Medicaid Ins# _____
 Medicare Ins# _____
 Other Ins Names and Numbers: _____

 EBT Card # _____

RELEASE OF INFORMATION: I do hereby authorize and request any relative, physician, lawyer, banker, insurance company, or any other person or organization having information concerning my circumstances, to furnish such information to the TOWN OF BOSCAWEN WELFARE ASSISTANCE. I also waive my right to privacy and confidentiality contained in my file and/or any information received by the TOWN OF BOSCAWEN WELFARE ASSISTANCE and authorize the TOWN OF BOSCAWEN WELFARE ASSISTANCE to release such information to other agencies to the extent that such release is made to further my request for, or receipt of, assistance from that agency. This authorization shall expire 180 days from the date it is signed.

Applicant Signature: _____ **Date:** _____
Co-Applicant Signature: _____ **Date:** _____

If you are completing this request in the absence of the applicant, assisting or representing the applicant, please provide the information below.

Your Name: _____ Contact #: _____
 Agency or Relationship: _____
 Case Technician: SGerlack Your Next Appointment is: _____ at _____



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WELFARE ASSISTANCE

BASIC NEEDS POLICY

Per the TOWN OF BOSCAWEN WELFARE ASSISTANCE guidelines, it is the applicant/recipient's responsibility to utilize any available benefits or resources to reduce the need for general assistance. This department will direct the applicant/recipient to apply for all other resources and also will require the applicant/recipient to use current resources to meet basic needs in order to reduce the need for general assistance.

While working with this department, you will be required to use your earned or unearned resources for basic needs only. These are:

- | | |
|---------------------------|---------------|
| Rent/Mortgage | Diapers |
| Food | Utilities |
| Non-food hygiene products | Prescriptions |

The cost of public transportation will be allowed if needed for work or medical appointments or other appointments made in order to meet conditions of assistance.

Following are examples of what may be UNALLOWABLE expenses in determining eligibility:

- | | |
|------------------------|-----------------------------|
| Telephone | Insurance Payments |
| Credit Card Payments | Bail Payments |
| Loan Payments | Repayment of personal loans |
| Cable & Internet | Restaurant/Fast Food |
| Miscellaneous Payments | Tobacco/Alcohol Products |

As a condition of assistance, you will be required to first use all available resources, as directed, to meet your basic needs. Unaltered, dated receipts for these expenses are required. Should you choose to use your resources for other than basic needs as outlined above and/or in your written decision from this department, those amounts will be considered available to you, and assistance will be reduced accordingly; a sanction or denial may be issued.

I/We have read and reviewed the Basic Needs Policy with my/our Welfare Administrator.

Applicant: _____	Co-Applicant: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

APPLICATION FOR ASSISTANCE

Date of Application _____ Referred By _____

Assistance Requested _____

Reasons for Request _____

1. General Information

Applicant

Name: _____ Date of Birth: _____

Current Address _____

Mailing Address, if different _____

Home Phone _____ Rent or Own? ____ How Long at this address? _____

Type of Housing: _ House _ Apt _ Mobile Home Other: _____

Household Composition: # 18 & Over ____ # under 18 ____ # of Bedrooms ____

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

Street	Town/City	State	Dates of Residence
_____	_____	_____	_____
_____	_____	_____	_____

Cell Phone: _____ Work Phone: _____ Social Security# _____

E-Mail Address: _____ Marital Status: _____

Education: _ High School Diploma _ Less than HS Diploma _ GED _ Some College
_ 2 Year Associates _ 4 Year Bachelor _ Graduate Studies

Citizenship: _ United States _ Other: _____

Ethnicity: _ White/Caucasian _ Other: _____

Special Training/Skills: _____

Currently employed? _ Full Time _ Part Time _ Self Employed _ Unemployed

Have you applied for local assistance before? _ Yes _ No when? _____

where? _____ Under what Name? _____

Actively serving in the U.S. Military? _ Yes _ No If YES, Branch _____

U.S. Veteran? _ Yes _ No Discharge Date: Month ____ Year ____
Discharge Status: _ Honorable _ Dishonorable _ Other

Do you have Medicare or Medicaid? (circle one) ID Number: _____

Other Insurance: _____ EBT Card # _____

Spouse/Co- Applicant

Name: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Social Security# _____

E-Mail Address: _____ Marital Status: _____

Education: High School Diploma Less than HS Diploma GED Some College
 2 Year Associates 4 Year Bachelor Graduate Studies

Citizenship: United States Other: _____

Ethnicity: White/Caucasian Other: _____

Special Training/Skills: _____

Currently employed? Full Time Part Time Self Employed Unemployed

Have you applied for local assistance before? Yes No When? _____

where? _____ Under what Name? _____

Actively serving in the U.S. Military? Yes No If YES, Branch _____

U.S. Veteran? Yes No Discharge Date: Month _____ Year _____
Discharge Status: Honorable Dishonorable Other

Do you have Medicare or Medicaid? (circle one) ID Number: _____

Other Insurance: _____ EBT Card # _____

Other Household Members: List all persons living in your household

Full Name	Relation	Birth Date	Social Security #	Health Insurance
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If children listed have a biological parent not residing with you, list information on each child's biological parent. (Do not list yourself under Parent's Name)

Parent's Full Name	Relationship	Birth Date	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Employment History

Applicant

Employer _____ Position _____

Date you started work: _____ Date & Amount of last paycheck: _____

Pay Period Frequency: Daily Weekly Bi-Weekly Monthly Quarterly

If you are currently unemployed, state reason: _____

Former Employer _____ Position _____

Date last worked: _____ Date & Amount of last paycheck: _____

Are you able to work now? Yes No If NO, why not? _____

List two most recent jobs before current:

Employer	Pay	Employment Dates	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____

Spouse/Co- Applicant

Employer _____ Position _____

Date you started work: _____ Date & Amount of last paycheck: _____

Pay Period Frequency: Daily Weekly Bi-Weekly Monthly Quarterly

If you are currently unemployed, state reason: _____

Former Employer _____ Position _____

Date last worked: _____ Date & Amount of last paycheck: _____

Are you able to work now? Yes No If NO, why not? _____

List two most recent jobs before current:

Employer	Pay	Employment Dates	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____

Work History for Other Household Members over 18: List two most recent jobs

Name	Employer	Pay	Employment Dates	Reason for Leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Housing Information

Rent \$ _____ per (month/week) Date last paid _____ Date Due _____

Currently have: Demand for Rent/Notice to Quit Landlord/Tenant Writ

Total Rent Owed _____

Do you have a housing subsidy? Yes No If YES, how much? _____

Utilities Included: Heat Electric Gas Water/Sewer Other _____

LANDLORD: Name _____ Telephone _____

Address _____

IF HOME-OWNER:

Mortgage Payment: _____ Date last paid _____ Date Due _____

Bank/Mortgage Co _____ Telephone _____

Address _____

4. Household Assets

Do you have a foreclosure notice? Yes No

Provide account information & current balances held by all household members:

Household Member	Bank/Credit Union	Savings Acct. #	Savings Balance	Checking Acct. #	Checking Balance
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Provide current value of the following assets held by all household members:

Asset	Value	Household Member
Cash on Hand (household combined)	_____	_____
Certificates of Deposit (CDs)	_____	_____
Retirement	_____	_____
401K	_____	_____
Life Insurance (Cash Value)	_____	_____
Investments	_____	_____
Time Share	_____	_____
Real Estate	_____	_____

List Properties and Locations (other than primary residence): _____

Motor vehicles owned by you and all household members:

Owner	Auto Make/Model	Year	Value	Payments	Insurance
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

5. Claims/Settlements/Income due to you or any household member

IRS Refund:_____ Date Rec:_____ Insurance Claim:_____ Date Rec:_____

Retroactive disability check:_____ Date Rec:_____

Retroactive Unemployment or Worker's Compensation check:_____ Date Rec:_____

Inheritance:_____ Date Rec:_____

Other Lump Sum Payment (explain):_____

Do you currently have an attorney pursuing any civil suit, workers compensation claim, a social security denial, etc? Yes No If YES, complete the following, and briefly explain the details of the situation:

Attorney Name _____ Phone number _____

Address _____

6. Household Income/Benefits

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

Income:	Household Member	Amount	Date Last Received
ANB (Aid to the Needy Blind)	_____	_____	_____
APTD (Aid to Perm/Totally Disabled)	_____	_____	_____
child support	_____	_____	_____
Charities/Churches	_____	_____	_____
Disability (STDA/LTDA - work)	_____	_____	_____
Gifts/Loans	_____	_____	_____
Income Tax Refund	_____	_____	_____
Maternity Pay/Benefits	_____	_____	_____
OAA (Old Age Assistance)	_____	_____	_____
Retirement Benefit	_____	_____	_____

Income (continued):	Household Member	Amount	Date Last Received
Severance Pay	_____	_____	_____
Social Security (Retirement)	_____	_____	_____
SSDI (SS Disability)	_____	_____	_____
SSI (Supplemental Security)	_____	_____	_____
TANF	_____	_____	_____
Unemployment (DES)	_____	_____	_____
Veteran's Pension	_____	_____	_____
Worker's Compensation	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Benefits:			
Child Care Assistance	_____	_____	_____
Food Stamps	_____	_____	_____
Fuel Assistance	_____	_____	_____
Medicaid	_____	_____	_____
WIC (Women/Infants/Children)	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

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

Name	Agency Name and Phone#	Contact Person
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Household Expenses

List actual or estimated regular expenses. (Not all expenses are allowable to be included in your eligibility determination, but all should be listed to show your financial situation.)

Expense	Monthly Expense	Any Amounts Past Due	Comments
Auto Fuel	_____	_____	_____
Auto Insurance	_____	_____	_____
Auto Loan	_____	_____	_____
Auto Registration/Inspection	_____	_____	_____
Auto Repairs	_____	_____	_____
Bank Fees	_____	_____	_____
Condo Assoc Fee	_____	_____	_____
Child Care	_____	_____	_____
Child Support Paid	_____	_____	_____
Credit Card	_____	_____	_____
Dental Care	_____	_____	_____
Diapers/Wipes	_____	_____	_____
Driver's License	_____	_____	_____
Electric	_____	_____	_____
Food	_____	_____	_____
Legal Fees/Fines	_____	_____	_____
Loan (Used for _____)	_____	_____	_____
Oil Heat	_____	_____	_____
Propane (Used for _____)	_____	_____	_____
Natural Gas (Used for _____)	_____	_____	_____
Health Insurance	_____	_____	_____
Home Repairs	_____	_____	_____
Home/Renter Insurance	_____	_____	_____
Laundry	_____	_____	_____
Medical Expenses	_____	_____	_____
Mortgage	_____	_____	_____
Prescriptions	_____	_____	_____
Rent (Including _____)	_____	_____	_____

Expense (Continued)	Monthly Expense	Any Amounts Past Due	Comments
Rent - Option to Own	_____	_____	_____
Rent - MH Lot	_____	_____	_____
Storage Unit	_____	_____	_____
Taxes (Income/Property)	_____	_____	_____
Telephone (Landline/Cell)	_____	_____	_____
Telephone (Cable/Internet)	_____	_____	_____
Transportation (Bus/Cab)	_____	_____	_____
Water/Sewer Bill	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

8. Extended Payment Arrangements

Do you or any household members currently have an EXTENDED PAYMENT ARRANGEMENT with an electric or fuel company? _ Yes _ No If YES, complete the following:

Utility Company Name	Amount				
_____	\$ _____	(Circle one)	weekly	biweekly	monthly
_____	\$ _____	(Circle one)	weekly	biweekly	monthly
_____	\$ _____	(Circle one)	weekly	biweekly	monthly
_____	\$ _____	(Circle one)	weekly	biweekly	monthly

9. Other Assistance

Has any other organization(s) or individual helped you pay any of your bills in the last four (4) weeks? _ Yes _ No If YES, complete the following:

Organization/Individual's Name	Bill Paid	Amount	Date Assisted
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

10. Criminal Information

Have you or any member of your household ever been convicted of a felony or misdemeanor which has not been annulled? _ Yes _ No

If YES, complete the following:

Name	Date	Town/City/State	Detail of Conviction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you or household member presently on parole or probation? _ Yes _ No

If YES, complete the following:

Name	Court	Parole/Probation Officer Name & Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Liability for Support Information

Parents/step-parents, spouse or grown children may be called upon to assist in time of need. Provide the following information:

APPLICANT:	Name	Address	Phone #
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse, if not living with you:	_____	_____	_____

CO-APPLICANT:	Name	Address	Phone #
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse, if not living with you:	_____	_____	_____

Adult children:

List name, address and phone # of any adult children not living with you:

12. 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 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)

I understand that my parents/step- parents, spouse or grown children may be called upon to assist me when in need of relief if they can do so without financial hardship to themselves. (RSA 165:19)

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) and/or Theft by Deception. (RSA 637)

Authorization to Release or Exchange Information *

I/ We authorize any relative, physician, attorney, banker, employer, insurance company, landlord/shelter staff or any other person(s) or organization(s) having information concerning my circumstances to furnish such information to the TOWN OF BOSCAWEN Welfare Administrator. The Social Security Administration, the Division of Health & Human Services and the Department of Employment Security may release information in their files to this office. I/ we authorize the TOWN OF BOSCAWEN WELFARE ASSISTANCE to release information as requested to the Division of Health & Human Services, Social Security Administration, Department of Employment Security, school personnel, attorney, physician, landlord, other town welfare offices, or any agencies providing supportive services regarding medical, housing/shelter, or financial assistance.

Applicant

Co- Applicant

Print Name

Print Name

Signature: _____

Signature: _____

Date: _____

Date: _____

Signature of person completing form
(if not the applicant)

Print Name

Date

** The above authorization to release or receive information is in effect for as long as the applicant is currently seeking assistance from the TOWN OF BOSCAWEN Welfare Administrator or up to six (6) months after assistance has ended.*

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 and divisions

to provide the following information:

Case Detail Information

to:

Name and Address of
Individual or Agency
Receiving the Information:

TOWN OF BOSCAWEN
116 N. MAIN ST.
BOSCAWEN, NH 03303

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 shall expire 12 months from the date this form is signed.

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

Name: _____

Signature: _____

Date: _____

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 _____



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WELFARE ASSISTANCE

EMPLOYMENT VERIFICATION FORM

I, _____, authorize the release of information regarding my employment to the TOWN OF BOSCAAWEN.

Signature: _____ Date: _____

This form is to be completed by the employer / former employer or it shall not be accepted as valid.

Name of Employee: _____ SS#: ____-____-____

Employer Name: _____

Address: _____

Phone: _____ Fax: _____

Starting Date of Employment: _____ Hourly Pay Rate: \$_____

Type of Position: Full-Time Part-Time Temporary

Please indicate time frame expected to work: _____

Frequency of Pay: Weekly Bi-weekly Other: _____

Paid By: Check Direct Deposit

Please list the last four (4) Pay Periods and Amounts of Pay:

Date: _____	Amount: \$_____
Date: _____	Amount: \$_____
Date: _____	Amount: \$_____
Date: _____	Amount: \$_____

Employment Status: Still Employed Terminated/Separated

If termination/separation, please indicate date of last employment: _____

If termination/separation, please indicate reason for termination/separation:

<input type="checkbox"/> Layoff	<input type="checkbox"/> Temporary Leave (Medical or other personal leave)
<input type="checkbox"/> Voluntary Resignation	<input type="checkbox"/> Retired
<input type="checkbox"/> Dismissed with Cause	<input type="checkbox"/> Other: _____

Does this employee receive any of the following through his/her employment:

<input type="checkbox"/> Credit Union Acct.	<input type="checkbox"/> Retirement Plan (i.e.: 401K, IRA, etc.)
<input type="checkbox"/> Medical Insurance	<input type="checkbox"/> Short-Term Disability
<input type="checkbox"/> Life Insurance	<input type="checkbox"/> Long-Term Disability
<input type="checkbox"/> Sick Pay	<input type="checkbox"/> Other: _____

Authorized Company Signature _____ Print Name _____

Phone # _____ E-mail _____ Date _____



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WELFARE ASSISTANCE

LIABILITY OF RELATIVE FORM

This form and the attached Financial Statement must be completed by each relative as outlined in RSA 165:19 below.

This NH state law only applies when an individual is seeking municipal assistance (welfare). Relatives of such applicants hold a certain liability and this form is designed for relatives to identify what assistance they can provide, or not provide based on their current financial situation. The law is as follows:

165:19 Liability for Support - The relation of any poor person in the line of father, mother, stepfather, stepmother, son, daughter, husband, or wife shall assist or maintain such person when in need of relief. Said relation shall be deemed able to assist such person if his weekly income is more than sufficient to provide a reasonable subsistence compatible with decency and health. Should a relation refuse to render such aid when requested to do so by the county commissioner, selectman, or overseer of public welfare, such person or persons shall upon complaint of one of these officials be summoned to appear in the court. If, after hearing, it is found that the alleged poor person is in need of assistance, and that the relation is able to render such assistance, the court shall enter a decree accordingly and shall fix the amount and character of the assistance which the relation shall furnish. If the relation neglects or refuses to comply with the court order without good cause, as determined by the court at a hearing, or by refusing to work or otherwise voluntarily places himself in a position where he is unable to comply, he shall be deemed to be in contempt of court and shall be imprisoned not more than 90 nor fewer than 60 days. If a poor person has no relation of sufficient ability, the town or city in which he resides shall be liable for his support.

If you can provide assistance to this family, complete the following and return it to the address above. In order to be in compliance with the above statute, I am providing or will now begin to provide (check one) the following assistance to: _____.

(Fill in the dollar amounts for each category where applicable)

Rent \$ _____	Electric \$ _____	Fuel \$ _____	Car Gas \$ _____
Phone \$ _____	Other Utility \$ _____	Food \$ _____	Insurance \$ _____
Diapers \$ _____	Personal/Household \$ _____	Car Pmt(s) \$ _____	Other \$ _____

If you are unable to provide financial assistance, please complete the statement below and the attached Relative Financial Statement and return both to the address above.

I, _____, do hereby declare that I am
 (Parent, Step-parent, son, daughter, husband, wife)

unable to provide support to the Applicant, _____,

for the reasons specifically cited below*. I attest to the validity of my statements, and recognize that I am bound to support the above named individual under state law when able to do so.

Please briefly describe any financial hardship which might preclude your ability to comply with the above (such as reduced work hours, illness, injury, etc.):

* _____

Signed: _____ Date: _____

Witness: _____

PLEASE COMPLETE THE ABOVE INFORMATION AND RETURN TO THE ADDRESS ABOVE. FAILURE TO PROVIDE THIS DOCUMENT MAY DELAY PROCESSING THE APPLICATION.



TOWN OF BOSCAAWEN
 116 N. MAIN ST.
 BOSCAAWEN, NH 03303
 (603)753-9188 X303 fax: 603-738-9184
 sgerlack@townofboscaawen.org

WELFARE ASSISTANCE

LIABILITY OF RELATIVE FORM

RELATIVE FINANCIAL STATEMENT TO BE COMPLETED WITH LIABILITY OF RELATIVE FORM

RELATIONSHIP TO APPLICANT (circle one)

Father Mother Step-Father Step-Mother Son Daughter Husband wife

Your Name: _____ Employer: _____

Spouse: _____ Employer: _____

Address: _____

DEPENDENTS:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

HOUSEHOLD INCOME AND ASSETS:

Gross Monthly Income \$ _____ Net Monthly Income \$ _____

Total Income Last Year \$ _____ Sources(s): _____

Savings Account Balance \$ _____ Checking Account Balance \$ _____

Stocks, Bonds, CDs \$ _____ Other \$ _____

Real or Personal Property \$ _____ Food Stamps \$ _____

Child support \$ _____ per _____ week _____ bi-weekly _____ monthly (check one)

MONTHLY HOUSEHOLD EXPENSES (Please list out of pocket expenses only):

Cable/Internet \$ _____ Child Support Paid \$ _____ Car Gas \$ _____

Car Insurance \$ _____ Car Payment \$ _____ Child Care \$ _____

Credit Card \$ _____ Electric \$ _____ Food \$ _____

Fuel Oil \$ _____ Natural Gas/Propane \$ _____ Health Insurance \$ _____

Life Insurance \$ _____ Loan \$ _____ Lot Rent \$ _____

Mortgage \$ _____ Prescriptions \$ _____ Rent \$ _____

Student Loans \$ _____ Telephone \$ _____ Home/Renter Ins. \$ _____

Medical \$ _____ Property Tax \$ _____ Water/Sewer \$ _____

Other \$ _____

I have read and understand the Liability of Relative Form attached including the requirements of RSA 165:19.

TOTAL MONTHLY INCOME \$ _____

TOTAL MONTHLY EXPENSES \$ _____

Signature _____ Date _____

Signature _____ Date _____