**Please read the following before applying for assistance.**

The City of Laconia Welfare Department provides temporary emergency assistance to City residents for the basic necessities of life when no other resource is available. Assistance is rendered in voucher form only.

If you need any of the services listed below, contact the State Division of Health and Human Services (State Welfare). The Laconia office is located at 65 Beacon Street West. Their phone number is 603-524-4485. The Web Site is www.dhhs.state.nh.us.

- ANB – Aid to the Needy Blind
- APTD – Aid to the Permanently and Totally Disabled
- Child Care
- Child Support
- DEAS – Division of Elderly and Adult Services
- DCYF – Division of Children, Youth and Families
- EBT – Electronic Benefits Transfer
- Food Stamps
- Healthy Kids Program
- Medicaid/Medicare
- OAA – Old Age Assistance
- TANF – Temporary Assistance to Needy Families
- Relative/Guardian pay

To apply for emergency assistance, please complete the attached application. **Once completed, please call City Welfare at 603-527-1267 to schedule an appointment. (**NOTE: Incomplete applications and/or insufficient documentation may delay assistance).

The completed application must be signed by all adult household occupants and brought in person to the scheduled appointment, along with the following:

- Proof of identification for all household members. Acceptable identification includes driver's license, birth certificate or social security card.
- Proof of income and benefits from any source for all household members. Income and benefits include: TANF/Relative pay, food stamps, child support, Social Security (SSI/SSD/Retirement), Unemployment Compensation, Workers' Compensation, VA, tax refunds, inheritance monies, cash gifts and/or **current pay stubs for the past 4 weeks**. If self-employed, a Profit/Loss statement is required, along with the most recent income tax return.
- Proof of residency, such as current rent receipts, copy of rental agreement or lease, or statement from person with whom you are residing.
- Proof of expenses, such as rent, utilities, child care, medical or any other receipts you have for the household.
- Proof of cash resources for all household members, such as savings passbooks, current checking or savings account statements from your bank or credit union, cash on hand.
- A doctor's statement is required if anyone in the household is unable to work. This statement must include the nature and extent of the disability, as well as any work limitations.
- Proof of any programs you have applied for, such as APTD (State disability), TANF, food stamps, Medicaid/Medicare, Social Security (SSI/SSD/Retirement), VA benefits, Fuel Assistance, W.I.C., Unemployment Compensation or Workers' Compensation
- If you are seeking rental assistance, you must have your landlord complete the landlord form. If you are facing eviction, bring copies of all documents relating to the eviction.

If you have any questions, please call us at 603-527-1267.

(603) 527-1267

# Application For Assistance

Date of Application _____ Referred By _____

Reason for Request _____

Assistance Requested _____

***General Information:***

Name _____ Date of Birth_____

Address _____

Telephone_____ SS#_____ US Citizen Yes ☐ No ☐

Marital Status_____ Rent or Own _____ How Long at this Residence _____

Spouse/Co-Applicant Name_____ SS# _____

Spouse Address (If not same as applicant) _____

Have you applied for local assistance before? _____ When? _____

Where? _____ Under What Name? _____

List below all persons living in your household, **Provide picture ID, SS Card or Birth Certificate for "Everyone" living in the household.**

| Full Name | Relationship | Date of Birth | Social Security # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

| Street | Town/City | State | Date of Residence |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***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? _____

If Homeowner: Mortgage Amount _____ Date Last Paid _____Owed _____

Bank/Mortgage Co _____ Address _____

***Education / Training / Employment:***

| | Special Training/Skills | Military Service | What Branch | How Long |
|---|---|---|---|---|
| Applicant: | _____ | _____ | _____ | _____ |
| Co Applicant: | _____ | _____ | _____ | _____ |

***Applicant Work History:***

Are you employed now? _____ Employer _____ Position _____

When Began Work? _____ All Household Income in Past 30 Days _____
(Documentation Needed)

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**

| Name | Employer | Pay | wk/bwk | Dates of Employment | Reason for Leaving |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

**If unable to work please provide a Doctor's note which should include your current ability to work with the extent and duration of the disability.**

***Household Assets:***

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

| Name | Bank/Credit Union | Savings Acct. # | Savings Balance | Checking Acct. # | Checking Balance |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Provide current value of any assets held by you and all household members including current bank statements and printouts.**

Cash on hand (All Household Combined) _____ Certificates of Deposits (CD's) _____

Savings Bonds _____ Mutual Funds _____ Annuities _____ Stock _____

Trust Funds _____ Retirement Accounts _____ Insurance Policies _____

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 _____

Retroactive Unemployment or Worker's Compensation Check _____ Inheritance _____

Other Lump Sum Payments (explain) _____

**Do you or any member have a lawsuit pending? _____** Who? **_____**

Please give details _____

Lawyers Name/Address _____

**Motor vehicles owned by you and all household members:**

| Owner | Auto Make | Model | Year | Value | Payments | Insurance |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

***Household Income:***

**Provide Documentation of 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 Stamps | | | | |
| Healthlink/Community Care | | | | |
| Insurance | | | | |
| Maternity Benefits | | | | |
| Medicaid | | | | |
| Medication Connection | | | | |
| NH Healthy Kids | | | | |
| OAA (Old Age Assistance) | | | | |
| Prenatal Care | | | | |
| Retirement | | | | |
| School Loans/Grants | | | | |
| Social Security | | | | |
| SSDI (SS Disability) | | | | |
| TANF | | | | |
| Unemployment | | | | |
| Veteran's Pension | | | | |
| WIC (Woman/Infant/Children) | | | | |
| Worker's Compensation | | | | |
| Other | | | | |

Provide Documentation if you or any other household member working, volunteering, and/or receiving assistance from any other agencies.

| Name | Agency Name | Contact Person |
|---|---|---|
| | | |
| | | |
| | | |

***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.) Bring receipts.

| | | |
|---|---|---|
| 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 _____ | _____ |
| Credit Card _____ | Lot Rent _____ | _____ |

**List unplanned, emergency or irregular expenses during the last 30 days:**

| | | |
|---|---|---|
| Car Inspection _____ | Driver's License _____ | Medical _____ |
| Car Registration _____ | Fines/Court Payments _____ | Sewer/Water _____ |
| Car Repair _____ | Home Repairs _____ | Tax (Income/Property) _____ |
| Dental _____ | Home/Rent Insurance _____ | Other _____ |

## 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 on 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 _____

## Liability For Support Information

Please provide following details:

Your Father _____ Address _____

Your Mother _____ Address _____

Co-Applicant Father _____ Address _____

Co-Applicant Mother _____ Address _____

You or your co-applicant's adult children _____

_____

***Certification 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 165:128-a.

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 (except any worker's compensation settlement) which I receive within six years of receiving municipal assistance. RSA 165:25-a.

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 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 165:3.

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.

I understand that an investigation will be conducted in order to verify facts and statements presented by the applicant and that this investigation may take place prior, during, and subsequent to the applicant's receipt of welfare assistance.

_____ _____

Applicant or Person Completing Form Signature Date

_____ _____

Spouse or Co-Applicant Signature Date

_____ _____

Welfare Official Date

# AUTHORIZATION FOR THE RELEASE OF INFORMATION – DHHS

I, _____, the undersigned, understand that from time to time, the local welfare
Print Your Name

administrator for _____ may require certain information about assistance I am applying
Town/City

for or receiving from the New Hampshire Department of Health and Human Services, Division of Family Assistance (DFA). When information cannot be provided by me personally, I hereby authorize DFA to release the following information to the local welfare administrator for the specific purposes outlined below.

| Type of Information | Purpose for Requesting this Information |
|---|---|
| Date of DFA applications(s), type(s) of assistance applied for, date of eligibility determination, expected date of benefit insurance, amount of cash grant (if applicable) and/or the reason my case closed or my application was denied | Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance |
| Date my Medicaid case opened and my Medicaid Identification Number(s) | Processing of Medicaid reimbursements if/when, during the time my Medicaid application was pending, the local welfare administrator makes an expenditure on my behalf for an item covered by Medicaid |
| Date of any sanction of my cash assistance grant | Determining countable household income also called “deeming” |
| Reason for any sanction of my cash assistance grant | Helping me to remove the sanction |

**I understand that** I have the option to provide any or all of the requested information myself.

**I understand that** any use of the above information inconsistent with these purposes is forbidden.

**I understand that** the local welfare administrator may not release information provided under this authorization to any other person without my written permission.

**This authorization shall expire 180 days from the date it is signed.**

_____ _____
Signature Date

If the signature is not that of the person to whom the requested information pertains, the relationship of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

_____ _____ _____
Relationship to You Witness Date

# Authorization for Release of Information

I, _____ of the CITY OF LACONIA in the COUNTY OF BELKNAP, being an applicant for assistance, do hereby authorize and request any relative, physician, lawyer, banker, employer, insurance company, fraternal order, or any other person or organization having information concerning my circumstances to furnish such information to the Welfare Director. I also, authorized the Laconia Welfare Department to release information to other welfare and social service agencies involved in servicing my case.

| _____ | _____ | _____ |
|---|---|---|
| Applicant Signature | Date | Signature of Person Completing App If Not Applicant |
| _____ | _____ | _____ |
| Co-Applicant Signature | Date | Relationship |

Laconia
CITY ON THE LAKES

Date_____

TOTAL INCOME RECEIVED IN THE LAST 30 DAYS (**if no income, see next page)**:

$_____

In the past 30 days I, _____, have approximately spent

my income on the following items listed below:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Expense Total** $0.00

X _____
(Client Signature)

Laconia
CITY ON THE LAKES

Date_____

To Whom It May Concern,

I,_____, have had no income for the past 30 days. Income is defined as any and all monetary benefits received, to include gifts, refunds, loans, other state, local or federal benefits received, or any money received by me at all.

X _____
(Client Signature)

# CITY OF LACONIA-WELFARE DEPARTMENT
## Notice of Work Program Requirements

Name:_____ Date:_____

1. Under state law and the Welfare Guidelines of this City, any recipient of assistance may be required to work for this City at any available job that is within his/her capacity and to search for work. This work requirement will be imposed only after there has been a determination of eligibility for assistance and such assistance has been authorized. A recipient will not be required to work more hours than necessary, at no less than the minimum hourly wage, to reimburse the City for assistance received.

2. Participation in the City work program will not be required as a condition of continuing eligibility for assistance if the recipient can prove they are unable to participate due to any of the following circumstances:

Is a parent who must care for children under 5 and adequate day care facilities are not available;

Has a mental or physical disability certified by a physician and are incapable of participating in city work relief, as determined by the City Welfare Specialist;

Has a documented medical appointment or illness that cannot be scheduled at non-workfare hours;

Must remain at home because of illness or disability (certified in writing by a physician) to another member of the family;

Has a documented conflicting job interview that cannot be scheduled at non-workfare hours;

Has a documented conflicting interview at a service or welfare agency that cannot be scheduled at non-workfare hours;

Does not possess the materials or tools to perform the task and the City fails to provide them;
Lacks transportation where it is reasonably necessary for participation in the work program.

6. General assistance may be suspended for failure to comply with City Welfare Guidelines relating to appropriate participation in a work program. While employed by the work program, you will be expected to perform all legitimate tasks assigned to you in a reasonable and proficient manner, and conduct yourself in a manner consistent with any employment. Foul language, insubordination, fighting, theft, use of alcohol or drugs, or disrespect towards your supervisor, other town officials or employees, or citizens will not be tolerated. Failure to keep the agreed working hours (except for the reasons listed above), or failure to fulfill your obligations relative to this work program, will likely result in suspension of public assistance eligibility.

I have read and understand these requirements:

SIGNATURE: _____ DATE: _____

# NOTICE OF WORK PROGRAM REQUIREMENTS
# (GENERAL)

As a recipient of public assistance you are required to work for this City. In doing so, you will be subject to the following:

1. You will be allowed no more than one break a day, no longer than 10 minutes;

2. You will report "on time" to the job and leave on time. You are not to leave early without prior authorization from the Department Supervisor;

3. You will be courteous to customers as well as employees;

4. You will do the job. You are here to participate in the work program;

5. Any information that is confidential, you will keep confidential. You must act within the scope of your duties.

6. You are not an employee of the City of Laconia and the work you perform does not create an employee/employer relationship.

I have reviewed and understand these General Requirements of the City of Laconia Workfare Program.

_____ _____

APPLICANT WELFARE OFFICIAL

_____

DATE

## WORK PROGRAM

JOBS REQUIRE THE FOLLOWING:

Raking, mowing, sweeping, shoveling, moderate lifting, pushing/pulling, clerical work, sitting, typing, filing, etc.

Are you able to perform any of these functions: _____
If not, why? _____
_____

Do you have any physical or medical limitations that would restrict your capability to perform any of the above or similar tasks?

_____

_____

_____

_____ _____
APPLICANT SIGNATURE DATE

_____ _____
CO-APPLICANT SIGNATURE DATE

**(SEE OTHER SIDE)**

## ONE MUST NOT VOLUNTARILY LEAVE A JOB WITHOUT GOOD CAUSE

Public assistance applicants who voluntarily leave a job without good cause, within sixty days of applying for local welfare and having received local assistance within the past 365 days, may be disqualified from receiving assistance for 90 days from the date of voluntary quit. Such sanction shall not affect applicants who are responsible for supporting minor children within their household or those mentally or physically unable to work.

Any sanctioned applicant must have received prior notice that a voluntary job quit without good cause may result in a temporary eligibility cut-off. Likewise, they must receive a written application and a notice of decision. RSA 165:1-d.

I understand that quitting a job voluntarily, or not reporting to work without good cause, leading to employment termination, may result in a potential 90-day period of local public assistance ineligibility.

_____ _____
APPLICANT DATE

_____ _____
CO-APPLICANT DATE

_____ _____
WELFARE OFFICIAL DATE

**(SEE OTHER SIDE)**

**WELFARE DEPARTMENT**

# Required Documentation

## Must bring all information listed below at time of interview

☐ **All Household Income** in the past 30 days, from the date of your scheduled appointment.

☐ **Receipts** or other proof of bills paid in the last 30 days.

☐ **Verification** that you have applied for any of the following programs:

WIC FS TANF/EAP MA/APTD TITLE XX HUD FAP WC HEALTHLINK/COMMCARE SS/SSI MEDICATION CONNECTION FUEL ASSISTANCE ELECTRIC DISCOUNT

☐ **Doctor's note** if you are unable to work.

☐ **Verification** that you have applied to the Dept. of Employment Security for the following:

Work Registration ☐ Unemployment Compensation ☐ Potential Benefit Amt. $ _____

☐ **Eviction paperwork (If Any)**

☐ **Resource Verification:** Be sure to provide a current printout for any item checked off below:

Checking ☐ Savings ☐ Child Support ☐ Cash/Other ☐

☐ **Completed Landlord Form & W-9** (if applicable). **Must** be completed by the landlord only.

☐ **Application**

☐ **Picture ID and SS Card or Birth Certificate** for everyone living in the household.

☐ **Please complete & return the enclosed W-9 if box is checked off.**

**Dear Landlord:**

In order to determine assistance for your tenant, it is necessary to have the following verification form completed and signed by you.

NAME(S) ON LEASE: _____

ALL OTHER HOUSEHOLD MEMBERS:_____

_____

ADDRESS OF RENTAL: _____

_____

RENT: $_____ PER MONTH WEEK BI-MONTHLY (please circle)

# OF BEDROOMS _____ TOTAL # OF ROOMS _____

INCLUDES: HEAT ELEC GAS WATER NO UTILITIES INCLUDED

DATE OF OCCUPANCY: _____

SEC. DEP. PAID: BY WHOM:_____ $_____

AMOUNT OF RENT PAID IN CURRENT MONTH: $_____

DATE RENT LAST PAID: _____ AMOUNT PAID: $_____

RENT PAID IN LAST 30 DAYS $_____ RENT PAID UNTIL: _____

MONTHLY/WEEKLY RENT DUE DATE: _____

**PLEASE MAKE CHECK PAYABLE TO:**

LANDLORD'S NAME (please print) _____

MAILING ADDRESS: _____

_____

TELEPHONE # _____

LANDLORD'S SIGNATURE _____DATE:_____

MANAGER'S NAME: (if there is one) _____

# Employment Assistance
# &
# Skills Training
# Available at your local
# NH Works Career Center

**Are you having difficulty finding a job?**
**Do you feel that you need some extra help in finding the right job for you?**
**Come in and see what we have to offer!**

## Employment Assistance

Job Listings
Job Search / Placement Assistance
One-on-one Employment Counseling
Workshops for resume & cover letter writing, interviewing techniques and using the internet as a job search tool.
Employment Referrals
Economic & Labor Market Information
Career assessment – Skills & Aptitude
Resource Center w/ fax, phone & computer to help you with your job search.

## Skills Training

If you are not having success with your job search due to lack of updated skills or a change in the employment market, you may need occupational skills training. Individual Training Accounts and On-The Job Training are available to those who qualify. Please contact your Community Action Agency WIA Counselor at the numbers listed below.

**NH Works locations / contacts:**

| | | | |
|---|---|---|---|
| Berlin | 151 Pleasant Street | 603-752-5500 | Paul Lozier |
| Claremont | 404 Washington Street | 603-542-3394 | Bill Ingalls |
| Concord | 10 West Street | 603-229-4428 | Jean Donzello |
| Conway | 518 White Mountain Highway | 603-447-2214 | Nicolle Bradbury |
| Keene | 109 Key Road | 603-357-5037 | Betsy Chatman |
| Laconia | 426 Union Ave | 603-528-9315 | Melinda Wilson |
| Lebanon | 85 Mechanic Street Suite 4 | 603-448-5873 | Bill Ingalls |
| Littleton | 646 Union Street | 603-444-1065 | Nicolle Bradbury |
| Manchester | 300 Hanover Street | 603-656-6503 | Ginny Haley / Mary McGee |
| | | | Mitch Cranmer |
| Nashua | 6 Townsend West | 603-594-8547 | Dave Roberts / Maureen Griffin |
| Portsmouth | 2000 Lafayette Road | 603-559-9130 | Fran Bishop |
| Salem | 29 South Broadway | 603-894-5107 | Jane Sullivan |
| Somersworth | 243 Route 108 | 603-742-4290 | Cheri Trombley |

All offices are open for business Monday – Friday from 8 a.m. – 4:30 p.m.

Website: www.nhworks.org