

Town of Hampton, NH

Welfare Office

Hours: 9AM to 1PM, Wednesday 9AM to 5 PM
100 Winnacunnet Road
Hampton, NH 03842
603 – 926-5948

Appointment Date: _____

Time: _____

The following documentation/verifications are required for you to bring to any appointment scheduled for you with the Welfare Officer. Failure to provide this verification/documentation may cause any assistance to be delayed or denied. Please, call the phone number listed above if you have any questions.

- Complete Application Form & Read, sign & Date "Responsibilities of the Applicant/Client" in this package.
- Identification for each household member (Driver's License, Birth Certificate, Social Security Cards, etc.)
- Last four weeks pay-stubs or other proof of net wages on ALL employed household members. If you do not have 4 weeks of pay stubs, provide a statement from the employer(s) that includes the date of hire, start date, hourly rate, hours per week, pay schedule, contact name & phone number.
- Verification of any unearned income, this includes, but is not limited to: Aid to Need Blind, Aid to the Permanently & Totally Disabled, Old Age Assistance, Childcare, Temporary Aid to Needy Families, Emergency Assistance, Social Security benefits for all household members, and Child Support, any loans or assistance from family or friends.
- Apply for Emergency Food Stamps immediately through the Department of Health & Human Services at 30 Maplewood Avenue in Portsmouth, M – F, 8 a.m. to 3:30 p.m. Ask for EMERGENCY Food Stamps. This is NOT required, but may be very helpful, especially with purchasing food.
- Documentation of divorce, custody/child support and/or restraining orders.
- If you are unemployed, verification that you have applied for or are receiving Unemployment Compensation.
- If you applying for rental or utility assistance, Rental/Residency Verification Form (the last page of this packet) MUST BE FILLED OUT BY LANDLORD. This office will arrange for your Landlord to complete an IRS W9 if needed.
 - Apartments and houses - Notice to Quit / Demand for Rent
 - For motels & hotels – provide invoice of last paid amount + signed contract from motel/hotel
- Last 4 weeks of receipts and proof of bills paid. Written statement, or a combination of receipts & statement accepted.
- Bills currently due, any disconnect notices, eviction papers .
- Vehicle registration if you own a vehicle (car, motorcycle, etc.)
- If you share a house/apartment with a roommate(s), statement outlining division of expenses.
- Verification of injury or illness – Doctor's note, if appropriate to your situation.
- Current 30-day activity report/s for all checking & savings accounts in the household as well as bank verification of account balances within 48 hours of the appointment
- Rent Receipts or Rent Record from Landlord – LAST 6 MONTHS
- Lease Agreement
- Other _____

Responsibilities of the Applicant/Client

At the time of the initial application, and as long as a client is receiving assistance or the case is open, the client shall comply with each of the following responsibilities. Applicants shall:

1. Submit an Application for Assistance, sign all releases of information, include any supporting documentation, provide complete, accurate and truthful information in all respects and to comply with all requirements set forth in each Notice of Decision, for example, client must provide proof of all household income and dated receipts for all household expenses;
2. Provide accurate and complete information without misrepresentation or omission concerning needs and resources; cooperate fully and completely in answering all questions asked by the welfare official, including providing information regarding all legally liable relatives (RSA 165:19). Refusing to answer all questions asked by the welfare official may result in a denial of the requested assistance.
3. Report to the welfare official, within three (3) working days, any and all changes in circumstances, particularly the receipt of any financial resources from any source;
4. Apply for and accept any benefit or resource (public or private) that reduces or eliminates the need for local General Assistance upon application and within seven (7) days after the date of the interview;
5. Cooperate fully and completely with the welfare official in verifying all information that has been provided and is necessary to determine eligibility and to notify the welfare official, within three (3) working days, of any changes which differ from the information provided on the Application For Assistance or on the Update Application;
6. Cooperate fully and completely with the welfare official when the welfare official(s) make(s) a home visit;
7. Keep all appointments as scheduled unless a verifiable emergency prevents keeping the scheduled appointment. In such an event, promptly providing verifiable documentation of the emergency;
8. Provide records and other required information and access to such records and information, when requested;
9. Provide the Request for Medical Information form completed by a medical doctor or physician's assistant as to the level of work that can be performed by the client if claiming an inability to work due to medical problems. Chiropractors, social workers, and psychologists are not considered licensed medical providers for purposes of these Guidelines;
10. Immediately report the theft and/or loss of any money, voucher or other valuable property to the appropriate entity and/or law enforcement authority and provide the welfare official with proof of the report to law enforcement;
11. Diligently search for employment;
12. If you are employed; not quit your job without good cause.
13. Provide verifiable documentation of work search (the number of work search contacts to be 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 once assistance has been granted. RSA 165:1-b, I(c);
14. Participate fully in the Welfare Work Program, if physically and mentally able if assigned by the welfare official. RSA 165:1-b I (b);
15. Cooperate fully and completely with the welfare official to obtain reimbursement to the Town of Hampton for assistance provided by any means authorized by law, and to notify the welfare official of any pending civil judgment(s), law suit(s), inheritance(s), financial settlement(s), insurance claim(s) and any other financial award(s);
16. Make reimbursement of any assistance granted when and if returned to income status and if such reimbursement can be made without financial hardship. RSA 165:20-b; 16. To read and sign a copy of the "Responsibilities of Applicant/Client" document which has been provided.
17. You have the right to request a Fair Hearing based on the receipt of an Adverse Action on a Notice of Decision. A request for a Fair Hearing must be received, in writing, within five (5) days starting with the date of the Notice of Decision at issue. You have the right to request that assistance be continued until the Fair Hearing is heard.

Applicant/Client

Date

Welfare Office

(Please answer each question)

Phone: (603) 926-5948 Fax: (603) 926-6853

Have you ever applied for Hampton welfare before? Yes___ No___ If yes, When?_____ What Name_____

Name _____

Maiden Name _____

Address _____

Referred By _____

City _____ State _____ ZIP _____

Spouse/Cohab/Roommates _____

Maiden Name _____

Telephone _____ Cell Phone _____

Taken By _____

Contact Phone Number _____

Relationship _____

LIST EVERYONE WHO LIVES IN THE HOUSEHOLD, BEGIN WITH YOURSELF ON THE FIRST LINE

Full Name	Relationship	Marital Status	Birthdate	Age	Social Security Number	Name of Child's School	Grade
	self						
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

LIST ANY OF YOUR CHILDREN WHO DO NOT LIVE WITH YOU. INCLUDE CHILDREN OVER 18 YEARS OF AGE

Full Name	Birthdate	Address	Employer	Name of Guardian if child is under 18
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LIST MARITAL HISTORY OF ALL ADULT HOUSEHOLD MEMBERS

Your Name	Spouses Name	Date of Marriage	Place of Marriage City/Town/State	Legal Status (Divorce/Sep)	Date of Div/Sep	Custody of Children
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

LIST YOUR ADDRESSES FOR THE LAST TWO YEARS, BEGIN WITH YOUR PRESENT ADDRESS

Street Address Room or Apt. #	Town / City / State	From (Month / Date / Year)	To (Month / Date / Year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever applied or received assistance from any other city, town, or state welfare office? Yes___ No___ If yes, provide details: Where? _____ When? _____ What type of assistance? _____

Under what name? _____ Duration of assistance? _____

LIST YOUR PARENTS & THE PARENTS OF YOUR SPOUSE, ROOMMATE OR COHAB

Your Name _____
Place of Birth _____
Father _____ Address _____
City/State _____
Phone Number(s) _____
Employer _____ Income _____
Mother _____ Address _____
City/State _____
Phone Number(s) _____
Employer _____ Income _____

Spouse, Roommate or Cohab Name _____
Place of Birth _____
Father _____ Address _____
City/State _____
Phone Number(s) _____
Employer _____ Income _____
Mother _____ Address _____
City/State _____
Phone Number(s) _____
Employer _____ Income _____

SERVICE RECORD

Name & Rank at Discharge	Branch of Service	Dates of Service	Type of Discharge	Reason for Leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you or anyone in the household serving in the National Guard or Reserves? Yes___ No___ Name _____
List the date of last National Guard or Reserves pay _____ Amount _____

PLEASE LIST CURRENT & LAST THREE EMPLOYERS FOR YOURSELF & ALL HOUSEHOLD MEMBERS

Employee's Name	Employer	Weekly Wage	Last Date Paid	Dates of Employment	Reason for Leaving
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICAL, ACCIDENT OR INJURY INFORMATION

Is anyone in your household unable to work? Yes___ No___ Name(s) _____
Check Reason: Non Work-Related Accident___ Non Work-Related Illness___ Work-Related Accident___ Work-Related Illness ___
Date of Injury, Accident or Illness _____ Date Workers Comp Claim Filed _____
Name & Address of Employer _____ Phone number _____

Doctor's Name, Address, Phone Number _____ Date able to return to work _____

Name of Insurance Co. for work-related and/or non work-related accident and/or injury _____

List prescribed medications _____

Are you or any other member of the household under doctor's care? Yes___ No___ If yes, provide the following details:

Name _____ Doctor's Name, Address & Phone Number _____

Diagnosis _____ Medications _____

Name _____ Doctor's Name, Address & Phone Number _____

Diagnosis _____ Medications _____

PROPERTY

List all property & vehicles bought, sold or transferred within the last 3 years

Descripton/Address _____ Date _____ Price _____ Bought _____ Sold _____

Descripton/Address _____ Date _____ Price _____ Bought _____ Sold _____

Descripton/Address _____ Date _____ Price _____ Bought _____ Sold _____

Do you or any other household member own any real estate? Yes ___ No ___ Name of owner(s) _____

Address of property _____ Multi or single family? _____

Mortgage holder name/address/phone & fax #'s. _____

Rental income property? _____ Purchase date _____ Purchase price _____

Payment _____ Date of last payment _____ Foreclosure pending? _____

LIST ALL VEHICLES OF ALL HOUSEHOLD MEMBERS INCLUDING BOATS, MOTORCYCLES, ATV's, ETC.

Year	Model	Plate #	Registered To	Ownership		Date of Purchase	Purchase Price	Date of Last Payment	Amount of Payment
				Own _____	Rent _____				
_____	_____	_____	_____	Lease _____	Borrow _____	_____	_____	_____	_____
_____	_____	_____	_____	Own _____	Rent _____	_____	_____	_____	_____
_____	_____	_____	_____	Lease _____	Borrow _____	_____	_____	_____	_____

RENTAL INFORMATION: Landlord's name _____ Address _____ Tel # _____

Rental amount \$ _____ Due weekly _____ Due every two weeks _____ Due monthly _____

Do you have a lease Yes ___ No ___ Are you receiving subsidized housing? Yes ___ No ___ If yes, what type? _____

How many bedrooms in your apartment? _____ Which utilities are included in your rent? _____

Date rent last paid _____ Covering time period from _____ to _____

Name & phone no. of any person(s) or agency(ies) who paid your rent: Name _____ Phone _____

Have you received an eviction notice? Yes ___ No ___ Have you been to court? Yes ___ No ___ If yes, when? _____

LIST INCOME TAX INFORMATION FOR ALL HOUSEHOLD MEMBERS

Name	Date Filed	Where/How Filed?	Date Tax Refund Rec'd	Amount of Refund
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LIST ALL ASSETS FOR YOURSELF & ALL OTHER HOUSEHOLD MEMBERS

Do you or any other household members, including children have any bank accounts? Yes ___ No ___ If yes, provide information on all personal and/or business accounts owned singly or jointly.

Name	Name of Bank / Credit Union	Savings Acct.	Balance	Checking Acct.	Balance
_____	_____	_____	_____	_____	_____

Have you or any other household member closed a bank or credit union account within the last 6 months? Yes ___ No ___
If so, who? _____ When? _____ What type of account? _____
Which bank? _____ Bank location _____

Do you or any other household member have or cashed in any of the following within 3 years? Yes ___ No ___ If yes, list each amount
Trust funds _____ Certificates of Deposit (cds) _____ Mutual funds _____ Retirement account _____ Savings Bonds _____
Stocks _____ 401 K _____ Profit Sharing _____ Annuities _____ Other (give details) _____

Have you or any household member made a loan against or received disbursements involving the above accounts within 3 years?
Yes ___ No ___ If yes, Date _____ Provide loan and/or disbursement details _____

Do you or any other household member have any insurance policies? Yes___ No___ If yes, provide the following details:

Name	Name of Insurance Co.	Type of Policy	Cash Value
_____	_____	_____	_____
_____	_____	_____	_____

LIST IF YOU OR ANY OTHER HOUSEHOLD MEMBER HAVE APPLIED FOR, OR ARE CURRENTLY RECEIVING INCOME OR BENEFITS FROM THE FOLLOWING SOURCES:

Name	Date Applied	Date Last Received	Amount
ANB (Aid to Needy Blind)	_____	_____	_____
Boarders in your household	_____	_____	_____
Cash available or set aside	_____	_____	_____
Disability – State/APTD	_____	_____	_____
Disability – Short Term _____ Long Term _____	_____	_____	_____
Fuel Assistance: Rent ___ Heat ___ Elect ___	_____	_____	_____
Help from friends, relatives, employers, coworkers	_____	_____	_____
Maternity Benefits	_____	_____	_____
Medicaid	_____	_____	_____
OAA (Old Age Assistance)	_____	_____	_____
Retirement Pension	_____	_____	_____
Severance Pay	_____	_____	_____
SS _____ SSD _____ SSI _____	_____	_____	_____
TANF _____ Relative Payee _____	_____	_____	_____
Unemployment	_____	_____	_____
Vacation Pay___ Earned Time___ Sick Time___	_____	_____	_____
Veteran's Pension	_____	_____	_____
WIC (Women, Infants & Children)	_____	_____	_____
Worker's Compensation	_____	_____	_____
Other	_____	_____	_____

PAYEE INFORMATION

Do you have a payee for any of your benefits? Yes___ No___ Which benefits? _____

Payee Name, Address & Daytime Phone Number _____

Are you a payee for anyone else? Yes___ No___ Benefits for which you are payee _____

His/her Name, Address & Phone Number _____

Are you compensated for your payee services? Yes_____ No_____ Amount_____ Date last received_____

Have you or any member of the household consulted with an attorney or are working with an attorney for any reason, including a possible lawsuit? Yes___ No___ If yes, provide details: _____

If yes, provide the Attorney's Name, Address, Phone Number _____

Are you or any member of the household expecting an inheritance, retroactive disability payment, insurance claim or any lump sum payment or settlement of any type? Yes___ No___ If yes, explain _____

Have you or any member of your household received any of the above or any type of lump sum payment in the last 3 years? Yes___ No___

Name_____ When?_____ What type?_____ Amount _____

Provide details _____

ARE YOU OR ANY OTHER HOUSEHOLD MEMBERS WORKING WITH ANY OTHER AGENCIES? Yes___ No___

Client Name	Agency Name/Location	Contact Person/Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILD SUPPORT INCOME (Request additional sheet of paper if necessary)

1. Child's Name & Address _____ DOB _____
Absent Parent's Name & Address _____ Phone No _____
Amount last received _____ Cash___ Check___ Money Order___ Date last received _____ Next Due _____
Are support payments made directly to you? Yes___ No___ If not, through which state or agency? _____
Court ordered? Yes___ No___ Name & Address of Court _____
2. Child's Name & Address _____ DOB _____
Absent Parent's Name & Address _____ Phone No _____
Amount last received _____ Cash___ Check___ Money Order___ Date last received _____ Next Due _____
Are support payments made directly to you? Yes___ No___ If not, through which state or agency? _____
Court ordered? Yes___ No___ Name & Address of Court _____
3. Child's Name & Address _____ DOB _____
Absent Parent's Name & Address _____ Phone No _____
Amount last received _____ Cash___ Check___ Money Order___ Date last received _____ Next Due _____
Are support payments made directly to you? Yes___ No___ If not, through which state or agency? _____
Court ordered? Yes___ No___ Name & Address of Court _____

CHILD SUPPORT PAYMENTS YOU OR SOMEONE IN HOUSEHOLD MUST MAKE (Request additional sheet of paper if necessary)

1. Support Provider's Name _____ Child's Name & Address _____ DOB _____
Name & Phone No. of Parent/Guardian with whom child resides _____
Relation to Child _____
Name, Address, Phone No. of person receiving support payments _____
Amount Last Paid _____ Date Last Paid _____ Cash___ Check___ Money Order___
Court ordered? Yes___ No___ Name & Address of Court _____
2. Support Provider's Name _____ Child's Name & Address _____ DOB _____
Name & Phone No. of Parent/Guardian with whom child resides _____
Relation to Child _____
Name, Address, Phone No. of person receiving support payments _____
Amount Last Paid _____ Date Last Paid _____ Cash___ Check___ Money Order___
Court ordered? Yes___ No___ Name & Address of Court _____
3. Support Provider's Name _____ Child's Name & Address _____ DOB _____
Name & Phone No. of Parent/Guardian with whom child resides _____
Relation to Child _____
Name, Address, Phone No. of person receiving support payments _____
Amount Last Paid _____ Date Last Paid _____ Cash___ Check___ Money Order___
Court ordered? Yes___ No___ Name & Address of Court _____

LIST ALL HOUSEHOLD EXPENSES, DATE LAST PAID & THE AMOUNT DUE (Provide complete information)

<u>Basic Expenses</u>	<u>Amount</u>	<u>Frequency</u>	<u>Date Last Paid</u>	<u>Name on Bill</u>	<u>Amount Due</u>
Rent/Mortgage	_____	Wk___ Mo___	_____	_____	_____
Food	_____	Wk___ Mo___	_____	_____	_____
Diapers	_____	Wk___ Mo___	_____	_____	_____
Gasoline for vehicles(s)	_____	Wk___ Mo___	_____	_____	_____
Household Supplies	_____	Wk___ Mo___	_____	_____	_____
Gas	_____	Wk___ Mo___	_____	_____	_____
Electric	_____	Wk___ Mo___	_____	_____	_____
Oil	_____	Wk___ Mo___	_____	_____	_____
Prescriptions	_____	Wk___ Mo___	_____	_____	_____
OTHER EXPENSES					
Cable	_____	Wk___ Mo___	_____	_____	_____
Car Payments	_____	Wk___ Mo___	_____	_____	_____
Court Fees, Fines, etc.	_____	Wk___ Mo___	_____	_____	_____
Credit Cards	_____	Wk___ Mo___	_____	_____	_____
Personal Loans	_____	Wk___ Mo___	_____	_____	_____
Rent to Own Items	_____	Wk___ Mo___	_____	_____	_____
Telephone	_____	Wk___ Mo___	_____	_____	_____
Cell Phone	_____	Wk___ Mo___	_____	_____	_____
Internet Connection	_____	Wk___ Mo___	_____	_____	_____
Other	_____	Wk___ Mo___	_____	_____	_____

ASSISTANCE REQUESTED (Be specific) _____

REASON FOR REQUEST _____

Have you or any other members of your household ever been convicted of a felony? Yes___ No___ If yes, who? _____

When? _____ Which city/town & state? _____

Provide details _____

Are you or any other members of your household presently on parole or probation? Yes___ No___ If yes, who? _____

Which city/town & state? _____ Name of Parole/Probation Officer? _____

Phone No. _____ Provide details _____

READ CAREFULLY BEFORE SIGNING

I/We understand that:

I/We, the undersigned, agree to repay the Town of Hampton for any assistance granted pursuant to RSA 165; any misrepresentation of information pursuant to RSA 641:3 used in determining eligibility would terminate all aid from the Town of Hampton for up to one year; all information supplied by me / us is subject to investigation and verification. Any change in my status must be reported to the Welfare Office within 3 working days and failure to do so may result in suspension of my/our assistance. I/We may request a fair hearing if I am/We are not satisfied with any decision regarding my / our assistance.

I/We must do so in writing to the welfare official within 5 working days. My / Our signature(s) below constitute(s) the granting of my / our authority for the Town of Hampton to obtain verification and/or proof from all sources concerning my / our household's circumstances.

Applicant's Signature	Date	Co-applicant's Signature	Date
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Spouse's Signature	Date	Co-applicant's Signature	Date
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APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

I/We authorize any relative, physician, lawyer, banker, check cashing service, employer, former employer, insurance company, health care provider, mental health professional, pharmacy, hospital, emergency care facility, ambulance service, police, Sheriff, State Police, firefighter, EMT, Red Cross, Salvation Army or any persons or organizations concerning my/our circumstances to furnish such information to Hampton Welfare Office. I/We further authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth & Families, Bureau of Elderly & Adult Services, NH Legal Assistance, any City/ Town Welfare Department, shelter, Department of Employment Security, Veteran's Administration, Community Action, or any non profit agency to release information from their files to the Town of Hampton Welfare Office.

Applicant's Signature	Date	Co-applicant's Signature	Date
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Spouse's Signature	Date	Co-applicant's Signature	Date
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APPLICANT'S RELEASE OF INFORMATION

I/We authorize the Town of Hampton Welfare Office to release information to any persons or organizations concerning my/our circumstances or to any State or County Division of Health and Human Services, Division of Children, Youth & Families, Social Security Administration, Internal Revenue Service, school administration, physician, Community Action, Red Cross, mental health professional, Bureau of Elderly & Adult Services, NH Legal Assistance, any City/Town Welfare Department, shelter, Department of Employment Security, Salvation Army, food pantries or any Town of Hampton departments connected with the administration of Welfare.

Applicant's Signature	Date	Co-applicant's Signature	Date
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Spouse's Signature	Date	Co-applicant's Signature	Date
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TTY access is through Relay NH at 711.

If you need a disability-related accommodation,
please notify the welfare officer.

Cases will be held open for 6 month after last contact.

The Town of Hampton Welfare Office will be hold cases open for 6 months from the date of last in-person contact with this office. Returning clients must continue to comply with all the requirements of prior Notices of Decision; including but not limited to using all income for basic needs as detailed on prior Notices of Decision. Clients will be expected to provide written verification of all income and dated receipts for expenses for the weeks prior to their return date. Failure to comply may result in a delay or suspension of assistance.

Voluntary Quit Law.

Pursuant to the provisions of RSA 165:d voluntary termination of employment without good cause could lead to disqualification from receiving general assistance in the future.

RSA 641:3

The Town of Hampton Welfare Office may refer violations of RSA 641:3 to the appropriate authorities for prosecution RSA 641:3 provides.

Unsworn Falsification

A person is guilty of a misdemeanor if:

- A. S/He makes a written false statement which he does not believe to be true, on or pursuant to a form bearing a notification authorized by law to the effect that false statements made therein are punishable; or
- B. With a purpose to deceive a public servant in the performance of his official function s/he:
 - 1. Makes any written false statement which s/he does not believe to be true; or
 - 2. Knowingly creates a false impression in a written application for pecuniary or other benefit by omitting information necessary to prevent statements therein from being misleading.
 - 3. Submits or invites reliance on any writing which s/he know to be lacking in authenticity; or
 - 4. Submits or invites reliance on any sample, specimen, map, boundary mark, or their object which s/he know to be false.
- C. No person shall be guilty under this section if s/he retracts the falsification before it becomes manifest that the falsification was or would be exposed.

I/We have read the above statements and certify that I/We fully understand them.

Applicant's Signature	Date	Co-applicant's Signature	Date
Spouse's Signature	Date	Co-applicant's Signature	Date

Applicant(s)/client(s) DO NOT sign the following until the conclusion of the intake interview.

I hereby certify that all notes and/or alterations written on my application by the caseworker(s) during this intake process accurately reflect my responses to questions and any additional information I provided. I further certify that all written and verbal information I have provided has been truthful and without omission to the best of knowledge.

Applicant's Signature	Date	Co-applicant's Signature	Date
Spouse's Signature	Date	Co-applicant's Signature	Date

I hereby certify _____ signed in front of me at the conclusion of the interview.

Welfare Officer Signature	Date	Witness Signature	Date
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Town of Hampton, NH
 Welfare Department
 100 Winnacunnet Rd, Hampton, NH 03842
 603-926-5948 Voice • 603-926-6853 FAX

Rental/Residency Verification

**This form *must* be completed by the landlord/agent or owner only
 (Please complete the entire form and provide a copy of lease/rental agreement)**

Tenant's Name(s): _____ Date: _____

Address: _____
 (Number/Street) (Apt.#) (City) (State)

Number of Household Members: _____ Names of Household Members: _____

Is this tenant related to Landlord/Owner? _____ If so, how? _____

Occupancy date: _____ Lease exp. date: _____ Security Deposit: \$ _____ Date paid: _____

Is this a Winter Rental? Yes No Date Tenant is expected to vacate _____

Rent Amount: \$ _____; : Weekly Monthly other _____ Last paid: _____ Back rent owed: \$ _____
 (please attach rent record)

If subsidized rent, please list tenant portion: \$ _____ If roommate situation, please list tenant portion: \$ _____

Please check the appropriate items for the residence:
 Apt. Single family residence: Other _____; Furnished Unfurnished ; # Rooms: _____ # Bedrooms: _____

Utilities: Type of Heat: _____

Indicated which utilities are included in the rent, check to indicate inclusion:
 All utilities Water Electricity Heat Gas Cable Phone

Do you have a year round Certificate of Occupancy for this residence? Yes No CO Number: _____

Landlord/Owner's Name: _____ Agent/Manager's Name: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

**For IRS reporting, Landlord/Owner must have a W-9 for the current year on file with the Finance Office.
 If you need this form, please call the Welfare Office at the number above & one will be mailed/faxed to you.**

Comments or Special Conditions: _____

SIGNATURE: LANDLORD/OWNER/AGENT

DATE