FORM A

APPLICATION FOR ASSISTANCE – Atkinson Welfare Dept.

Date of Application _____ Referred by _____

1. General Information:

Name _____ Date of Birth _____

Address _____

Telephone _____ Social Security number _____ US Citizen? _____

Marital Status _____ Rent or Own? _____ How long at this address? _____

Spouse/Co-Applicant Name _____ SS# _____

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:

Full Name	Relationship	Date of Birth	Social Security #

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

Street	Town/City	State	Dates of Residence

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: Name _____ Telephone _____

Address _____

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

Bank/Mortgage Co _____ Address _____

3. Education / Training / Employment

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

Applicant Work History:

Are you employed now? _____ Employer _____ Position _____

When began work _____ 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:

Name	Employer	Pay	Weekly/ Biweekly	Employment Dates	Reason for Leaving

4. 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:

Cash on hand (all household combined) _____ 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_____

Retroactive Unemployment or Worker's Compensation check_____ Inheritance_____

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 member have a lawsuit pending? _____ Who?_____

Please give details _____

Lawyer Name/Address_____

Motor vehicles owned by you and all household members:

Owner	Auto Make	Model	Year	Value	Payments	Insurance

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				
Unemployment				
Vacation Pay				
Veteran's Pension				
Vocational Rehabilitation				
WIC(Women/Infants/Children)				
Worker's Compensation				
Other: [ ]				

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

Name	Agency Name	Contact Person

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 Reparis _____	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 _____

8. Liability for Support 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 _____

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

FORM B

AUTHORIZATION FOR THE RELEASE OF INFORMATION – DHHS

I, _____, the undersigned, understand that from time to time,
Print Your Name
the local welfare administrator for Atkinson, NH may require certain information about assistance I am applying 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 application(s), type(s) of assistance applied for, date of eligibility determination, expected date of benefit issuance, 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 above 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

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM C

NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE ATKINSON WELFARE DEPARTMENT

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 fair hearing.

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

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM D

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION
Atkinson Welfare Dept.

I/We, _____, authorize any relative, physician, lawyer, banker, employer, insurance company, mental health professional, school official or other person or organization having information concerning my/our circumstances to furnish such information to the Atkinson Welfare Department. I/We also authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth and Families, Division of Adult and Elderly, New Hampshire Legal Assistance, any City/Town Welfare Department, shelter, Department of Employment Security, Veteran's Administration and Fuel Assistance, or any non-profit agency to release information from their files to the Atkinson Welfare Department.

_____ _____
Applicant Signature Date

_____ _____
Spouse or Co-applicant Signature Date

_____
Signature of person completing form (if not applicant); Relationship to applicant

_____
Date

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM F

REQUIRED VERIFICATIONS – Atkinson Welfare Dept.

Applicant Name: _____ Date: _____

Social Security Number: _____ D.O.B.: _____

Address: _____ Phone: _____

YOUR APPOINTMENT IS SCHEDULED FOR: _____

You must provide the following verification/documentation at this appointment or assistance may be delayed or denied:

_____ Completed Application Form
_____ Rental Verification Form
_____ Last four weeks pay-stubs or other proof of net wages
_____ Last four week's receipts or other proof of bills paid or currently due
_____ Employment verification form from your employer
_____ Employment termination form from your last employer
_____ You have applied for / are receiving Social Security benefits
_____ You have applied at the HHS District Office for:

- ❑ Emergency Food Stamps ❑ Food Stamps ❑ TANF
- ❑ Title XX Daycare ❑ APTD/MA ❑ OAA
- ❑ TANF Emergency Assistance

_____ You have applied for / are receiving Fuel Assistance benefits
_____ Verification of injury or illness
_____ You have applied for / are receiving Unemployment Compensation
_____ If available, picture ID (Adults); Birth certificate/SS card (minors)
_____ Vehicle registration
_____ Savings and checking account, liquid asset statements, bankbooks
_____ Statement child support payments received / Child support court order
_____ Statement from room-mate(s) regarding division of expenses
Other: _____

I understand that failure to provide the indicated information may result in delay and/or denial of my request for assistance, and I understand that if approved for assistance I may be required to do a job search and participate in workfare.

_____ _____
Welfare Staff signature Applicant signature

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM G

INTAKE FORM – Atkinson Welfare Dept.

(to be completed at the time of each request for assistance)

DATE:_____

NAME:_____
Last First Middle Maiden

ADDRESS: _____
Street / # / Apartment Town

HOW LONG AT THIS ADDRESS?_____TELEPHONE: _____

WHAT TYPE OF ASSISTANCE ARE YOU REQUESTING AT THIS TIME? _____

_____

NAMES AND AGES OF ALL HOUSEHOLD MEMBERS:_____

_____

_____

LIST ALL SOURCES AND AMOUNTS OF HOUSEHOLD'S EARNED AND UNEARNED INCOME. THIS INCLUDES CASH, SAVINGS AND CHECKING ACCOUNTS:

_____

_____

INDICATE ANY CHANGES IN YOUR PERSONAL SITUATION SINCE YOUR LAST VISIT.

_____

_____

_____

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 a crime.

_____
SIGNATURE

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM H

ATKINSON WELFARE DEPT.
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#:_____ **dob:** _____

I hereby request the release by a doctor, hospital or clinic to the Municipal Welfare Department, or it's authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization. A photocopy of this signed release may be used in place of an original, in effect for six months from date of my signature below:

_____ _____
APPLICANT SIGNATURE **DATE**

TO THE PHYSICIAN OR CLINIC:

The person named above has indicated that he/she is currently unable to work and is in treatment with you. New Hampshire General Assistance laws require able-bodied welfare applicants to seek and retain work as a condition of continued assistance, with the goal of minimizing the period of assistance necessary. The Municipality also may require welfare recipients to work in any capacity that the recipient is able in exchange for assistance. For these reasons, will you please briefly respond to these questions:

What is the condition(s) for which you are treating this person? _____

What is the nature and extent of this individual's limitations? _____

Is this person disabled? No ❑ Yes ❑ (If yes, please clarify below)
❑ Temporarily ❑ Permanently ❑ Partially ❑ Totally

Date incapacity began: _____ Expected to end: _____

When will this individual be capable of returning to work? What type of work would be suitable for this individual? Please describe any limitations: _____

_____

_____

Medications Prescribed: _____

_____ _____
Physician Name / Signature **Date**

Thank you for taking the time to complete this form.
Please contact the Atkinson Welfare Department (603-362-5266) if you have any questions.

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
Fax 603-362-5305

FORM I

EMPLOYMENT VERIFICATION FORM – Atkinson Welfare Dept.

To Employer _____ Date _____

Address_____

Phone _____

For the purpose of administration of municipal assistance, the following information is required for:

_____
[name of employee]

Date of Hire _____ _____ Date starting/started work _____Hourly Pay Rate _____

Full/part time _____ Hours per week_____ Paid ❑ weekly ❑ biweekly ❑other ____

Date of first/most recent paycheck_____ Net amount_____

==========

If_____ is no longer employed by your company:

Date of termination/separation_____ Date/net amount of last paycheck _____

Reason for termination/separation _____

_____ _____
Signature and Title of immediate supervisor or person completing form Date

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM J

RENTAL VERIFICATION FORM – Atkinson Welfare Dept.

THIS FORM MUST BE COMPLETED BY THE LANDLORD

Tenant's Name: _____ Date: _____

Address: _____

(Number/Street) (Apt. #) (City) (State)

Number of Household Members:_____ List of Household Members: _____

_____

_____

_____

Occupancy date: _____ Security Deposit: Amount: $_____ Date paid: _____

Rent amount: $_____; paid ❑ monthly ❑weekly ❑other _____

If subsidized rent, please list tenant portion: $_____

Rent Includes: ❑ All utilities ❑ No Utilities ❑ Hot Water ❑ Heat ❑ Electric

Type of Heat: ❑ Electric ❑ Oil ❑ Gas ❑ Other _____

Date last rent was paid: _____ Amount Paid: $ _____ Back rent owed: $ _____

(if back rent is owed, please attach accounting of months and amounts)

For IRS reporting, landlord's Tax ID or Social Security # <u>must</u> be provided:

Tax ID #: _____ **OR** Social Security #: _____

CHECK IS TO BE MADE PAYABLE TO: (PLEASE PRINT)

_____ _____

Landlord's Name Telephone / Fax Numbers

_____

Landlord Address

_____

Name of Manager or other Representative

_____ _____

Landlord Signature Date

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

Town of Atkinson
603.362.5266

FORM K

BUDGET WORKSHEET

Name _____ Date _____

A. Available assets and income:

_____ _____ mo/wk
_____ _____ mo/wk
_____ _____ mo/wk

A. Total available income: _____

B. Allowable Expenses:

	Actual Expenses	Allowed Expenses	Ineligible Expenses
Rent/Board/Mortgage	_____ mo/wk	_____ mo/wk	_____
Electric	_____ mo/wk	_____ mo/wk	_____
Gas	_____ mo/wk	_____ mo/wk	_____
Fuel Oil	_____ mo/wk	_____ mo/wk	_____
Water/sewer	_____ mo/wk	_____ mo/wk	_____
Cooking fuel	_____ mo/wk	_____ mo/wk	_____
Telephone	_____ mo/wk	_____ mo/wk	_____
Food	_____ mo/wk	_____ mo/wk	_____
Personal & Household	_____ mo/wk	_____ mo/wk	_____
Medical/Prescription	_____ mo/wk	_____ mo/wk	_____
Transportation	_____ mo/wk	_____ mo/wk	_____
Childcare/Daycare	_____ mo/wk	_____ mo/wk	_____
Car payment	_____ mo/wk	_____ mo/wk	_____
Gasoline	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____
Other	_____ mo/wk	_____ mo/wk	_____

B. Total Allowed Expenses: _____ _____

C. Eligibility: [A. Income (-) B. Expenses**]:**_____

*(If A is greater than B, applicant is ineligible. If A is less than B, applicant is eligible.)*Assistance will be provided as follows:

_____ $ _____
_____ $ _____
_____ $ _____

Note: This form should accompany a Notice of Decision. The welfare official should use discretion in accepting actual expenses relative to employment, work search, medical needs, etc.

FORM L

NOTICE OF DECISION – Atkinson Welfare Dept.

Name _____ Date _____

❑ Your application for general assistance is **GRANTED**. You will receive:

_____

_____

❑ You must COMPLY with the following conditions in order to be eligible to continue to receive assistance. You must comply within 7 days of receipt of this notice, unless another time period is indicated. Willful failure to comply with these conditions may result in a suspension of assistance.

_____

_____

_____

_____

❑ Your application for general assistance is **DENIED** for the following reason(s).

- ❑ Sufficient Income
- ❑ Other, specifically:_____

_____

❑ Your assistance is **SUSPENDED** from _____ to _____ for the following reason(s):

- ❑ Failure to complete required work search
- ❑ Failure to complete assigned workfare hours
- ❑ Failure to apply for other forms of assistance, specifically _____
- ❑ Misrepresentation of material facts, specifically _____
- ❑ Other, specifically:_____

❑ You are also suspended until you comply with the conditions imposed by taking the following actions:

_____

==========

❑ **Your next appointment is_____.**

I understand the action described above. I further understand that if my assistance has been denied or suspended I have the right to request a fair hearing within five (5) working days of receipt of this notice, and that if I am currently receiving assistance, my assistance may be continued, at my request, until the hearing.

_____ _____

Welfare Applicant Date Welfare Official Date

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM M

WORKFARE PROGRAM
REPORTING SLIP

In accordance with RSA 165:31, any recipient of general assistance may be required to work for the municipality at any available job that is within the capacity of the recipient. As a condition of continuing eligibility for assistance, you are required to participate in the workfare program as described below. Any failure to participate as required may result in suspension of assistance.

Recipient Name_____ Total hours owed _____

Work site assigned _____ Supervisor _____

First date to report _____ Daily shift, from _____ to _____

(dates and shift may change with permission of welfare official)

TO BE COMPLETED BY WORK SITE SUPERVISOR

Form to be returned on a weekly basis.

Date	Weekday	# Hours Assigned	# Hours Time In	Time Out	Worked	Supervisor Initials
_____	Sunday	_____	_____	_____	_____	_____
_____	Monday	_____	_____	_____	_____	_____
_____	Tuesday	_____	_____	_____	_____	_____
_____	Wednesday	_____	_____	_____	_____	_____
_____	Thursday	_____	_____	_____	_____	_____
_____	Friday	_____	_____	_____	_____	_____
_____	Saturday	_____	_____	_____	_____	_____

TOTAL HOURS WORKED _____

Supervisor signature_____ **Date** _____

Recipient/workfare participant certification:

I understand that failure to fully comply with the workfare program, without just cause, may result in denial of further assistance. I further understand that workfare is for the purpose of working off hours in exchange for assistance granted and that no actual wages will be paid to me.

_____ _____

Recipient/workfare participant signature Date

FORM N

EMPLOYMENT SEARCH RECORD – Atkinson Welfare Dept.

NAME:_____

[In order to remain eligible for assistance, you are required to do a job search of 3-5 contacts daily. Use this form to list each employer you contact.]

	DATE	EMPLOYER	PHONE NUMBER	JOB OR TYPE OF WORK	TYPE OF CONTACT Visit/Phone/ Mail/Resume	PERSON CONTACTED	TIME OF DAY	RESULTS
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

FORM O

FAIR HEARING REQUEST – Atkinson Welfare Dept.

I, _____hereby request a fair hearing to review the decision dated _regarding my application for general assistance. I ❑ want / ❑ do not want my current assistance to continue until my appeal has been decided. I understand that if I lose my appeal, I will be obligated to repay the assistance provided to me during the time the appeal is being decided.

_____ _____

(applicant signature) (date)

In order to be eligible for a fair hearing, this form must be completed and returned to the Welfare Office within five (5) working days of your receiving your notice of decision. Within seven (7) working days of receipt of this notice by the Welfare Official a hearing will be scheduled. You will be notified in writing of the place, date and time of the hearing.

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM P

NOTICE OF FAIR HEARING – Atkinson Welfare Dept.

DATE: _____

TO: _____

ADDRESS: _____

_____

_____

☐ Your Fair Hearing has been scheduled for:

Date: _____

Time: _____

Place: _____

If you are unable to appear at this time, please contact the Welfare Official immediately. Failure to appear may result in the denial of your Fair Hearing request.

☐ Your request for a Fair Hearing has been denied for the following reason (s): _____

_____

_____

Sincerely,

_____

Welfare Official

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM Q

FAIR HEARING DECISION – Atkinson Welfare Dept.

_____ _____

Client Name Represented by

VS

Town of Atkinson

Date of Hearing _____ Hearing Officer(s) _____

_____

ADJUDICATION

(Include Guidelines; facts relied upon, reasons for decision and any relief ordered. Use extra paper if necessary, or attach written decision to this signed form)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date_____ **Hearing Officer/Board Chair** _____

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811

FORM R

MARKET BASKET VOUCHER POLICY

HOW TO USE THIS VOUCHER:

- Voucher is only accepted at the Market Basket in Plaistow, NH
- Voucher must be used within two days of being issued.
- Voucher can only be used once; be sure to spend the entire amount even if you need to put in one or two dollars yourself.
- To get the most out of your voucher consider using coupons and buying store brand products.

You CANNOT use voucher for:

- NO Bottled Water
- NO Soda
- NO Candy
- NO Expensive meats/steak
- NO Cigarettes
- NO Toys
- NO Magazines/books
- NO Pet Food
- NO Alcohol
- NO Seafood

You CAN use voucher for:

- Store brand items
- Meat
- Milk
- Juice
- Bread
- Vegetables
- Fruits
- Toilet paper
- Shampoo
- Basic hygiene items

By signing below, you acknowledge receipt of this food voucher policy and understand the requirements of this policy. You acknowledge that misuse of the food voucher can be grounds for denying any future requests you may have for food assistance.

_____

Applicant Signature Date

_____

Co-applicant Signature Date

FORM S

NOTICE OF PROPERTY LIEN DISCHARGE – Atkinson Welfare Dept.

TO: Register of Deeds for the County of Rockingham

RE: Lien on Real Property pursuant to RSA 165:28 and any and all acts in Amendment thereof for aid given by the municipality of Atkinson

DESCRIPTION OF PROPERTY: Land and Building(s) located at No. _____Street, Town of Atkinson being Assessor's Map(s) And Lot(s) No. and/or Volume and Page No. _____

RECIPIENT: _____of the Town of Atkinson in the County of Rockingham, State of New Hampshire

BE IT KNOWN: that the above-referenced property lien is hereby satisfied and discharged.

BY: _____ **DATE:** _____
Director of Welfare/Human Services

NOTE: County Register of Deeds requires 1-3" top margin with 1" all other margins (margins displayed are not in conformity) – no less that 10 pitch in Times New Roman or Arial (Sample is Arial 12 pitch which is acceptable).

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266

FORM T

RENT VOUCHER – LANDLORD DELINQUENCY – Atkinson Welfare Dept.

The municipality of _____hereby authorizes payment to

_____on behalf of __ _____of
[landlord] *[tenant]*

_____in the amount of $_____.
[tenant address]

for rent due and owing for the period _____ to _____

NOTICE OF APPLICATION OF RENT PAYMENTS TO DELINQUENCIES

TO:_____
[landlord]

You are hereby notified that, pursuant to RSA 165:4-a, $ _____ of the above-authorized payment will be applied to your delinquent ❑ TAX ❑ SEWER ❑ WATER ❑ ELECTRIC bill owed to the municipality for your property located at _____ (address of property with delinquency). You are also notified that, pursuant to RSA 540:9-a, any application by a municipality of amounts owed to it by a landlord pursuant to RSA 165:4-a, shall constitute payment by the tenant of the amount applied by the municipality to delinquent balances of the landlord.

_____
Welfare Official

❑ Landlord copy

❑ Town/City copy (tax, sewer, water, electric)
Note: send lower portion only

❑ Welfare copy

Town of Atkinson
19 Academy Avenue
Atkinson, NH 03811
603.362.5266