

Town of Charlestown, New Hampshire  
Health and Human Services

**GENERAL ASSISTANCE PROGRAM**

The Town of Charlestown provides financial and resource assistance for eligible applicants who are struggling to meet their basic needs and who are facing a threat to their health or safety as a result.

These are *some* examples of situations in which you *may* be eligible for assistance:

- You are at risk of losing or have lost your residence
- You are at risk of losing or have lost necessary utilities
- You don't have enough food
- You don't have enough fuel to heat your home or cook food
- You don't have income due to being unemployed or disabled

*You have the right to apply for General Assistance at any time for any reason. Your eligibility for General Assistance is determined according to whether or not your allowed expenses exceed your income. You must provide specific information and documentation in order to have your application evaluated for eligibility. If you fail to comply with specified conditions, you may be found ineligible for assistance. Therefore, please read this application carefully. Complete it as best you can and ask questions if you have difficulty understanding any part of this application.*

If you have questions, please contact the Welfare Administrator. The Charlestown Health and Human Services office is open each Tuesday and Thursday 8:30-1:00, and you can call 826-5266 during these hours. To reach the Welfare Administrator outside of these hours, please call 1-800-894-8400.

I have read the application for General Assistance with the Town of Charlestown, NH, and I acknowledge that I understand its contents. I acknowledge that I have received and understand the Notice of Rights and Responsibilities.

\_\_\_\_\_  
Signature of Applicant(s)

\_\_\_\_\_  
Date

## Town Assistance Instruction Sheet

- Read.** Read these instructions and the application carefully. Answer all questions.
- Application.** Fill out application completely. If information does not apply to your situation, indicate this by writing "N/A" in the appropriate spaces on the application form.
- Document emergency.** Town Assistance is an emergency assistance program and you must document the emergency you are facing. For example, you must provide a shut-off notice (for electricity), a foreclosure notice, notice to quit, or demand for rent (for rental or mortgage assistance) to qualify for assistance under this program. Some emergency situations are difficult to document (such as the need for food, a family or individual facing homelessness, or fuel for heat) and are handled on a case-by-case basis.
- Relatives must assist, if possible.** *New Hampshire State Law provides that in certain cases, close relatives may be liable to provide you support. See: Title XII, Chapter 165:19 of Revised New Hampshire Statutes Annotated (Liability for Support). Be certain to provide information about your relatives on the application.*
- Document rent/mortgage expense.** Have your landlord complete the Rental Verification Form completely. This form is part of the application. **Homeowners:** provide a current mortgage statement. *New Hampshire State Law provides that towns may place a lien on real property for assistance granted to property owners. See: Title XII, Chapter 165:28 of Revised New Hampshire Statutes Annotated (Liens on Real Property).*
- Sign and date application.** Sign and date the application where indicated. If you are married, your spouse must also sign.
- Schedule an appointment.** Call the following number to schedule an appointment;
  - Charlestown: (603) 863-9529 or (800) 894-8400
- Document income.** Gather documentation on income during the past 30-day period for all members of your household (pay stubs, statement from employer indicating wages, statement of benefits from state/federal sources, etc.). *Bring this documentation to your appointment.*
- Document assets.** Gather documentation on assets for all members of your household (checking/savings account statements, cash on hand, child support payments, vehicle registrations, retirement accounts, etc.). Also, gather documentation on any state, local, or federal benefits or programs that you are receiving (fuel assistance, food stamps, WIC, Section 8 housing, or other benefits). *Bring this documentation to your appointment.*
- Document basic living expenses.** Gather documentation on basic living expenses for all members of your household during the past 30-day period (electric bills, Rental Verification Form, heating expenses, or other proof of basic living expenses). *Bring this documentation to your appointment.*
- Identification.** Gather identification materials for all members of your household (photo identification is preferable for adults, birth certificates or social security cards for children are acceptable). *Bring this documentation to your appointment.*
- Medication assistance.** If you are requesting medication assistance, have your medical provider fill out the Medication Expense Verification Form. *Bring this documentation to your appointment.*
- Cancellations and other concerns.** Call the number listed above if you cannot keep your appointment so that other applicants can have the opportunity to meet with the Town Welfare Administrator.
  - **Failure to read these instructions and supply the necessary documentation may cause a delay in processing your application.**
  - **Do not turn in the application (or any documentation) before your scheduled appointment.**

Charlestown Department of Health & Human Services  
P.O. Box 385 • Charlestown, NH 03603  
Phone (603) 863-9529 or (800) 894-8400 • Fax (603) 863-9554

**CHARLESTOWN, NEW HAMPSHIRE  
DEPARTMENT OF HEALTH & HUMAN SERVICES**

**APPLICATION FOR ASSISTANCE**

Date of Application \_\_\_\_\_ Referred by \_\_\_\_\_

**1. General Information:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone(H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

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	G.E.D. or		Military
	<u>Attended</u>	<u>Diploma</u>	<u>Special Training or Skills</u>	<u>Service</u>

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:**

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

**4. Household Assets:**

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

<u>Name</u>	<u>Bank/Credit Union</u>	<u>Savings Acct. #</u>	<u>Savings Balance</u>	<u>Checking Acct. #</u>	<u>Checking Balance</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**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:**

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

**5. Household Income**

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

	Name	Date Applied	Date Last Received	Monthly Amount
ANB (Aid to the Needy Blind)	_____	_____	_____	_____
APTD	_____	_____	_____	_____
Child Support	_____	_____	_____	_____
Disability (Employer)	_____	_____	_____	_____
Food Stamps	_____	_____	_____	_____
Fuel Assistance	_____	_____	_____	_____
Gifts/Loans	_____	_____	_____	_____
Maternity Benefits	_____	_____	_____	_____
Medicaid	_____	_____	_____	_____
OAA (Old Age Assistance)	_____	_____	_____	_____
Retirement	_____	_____	_____	_____
Severance Pay	_____	_____	_____	_____
Social Security	_____	_____	_____	_____
SSDI (SS Disability)	_____	_____	_____	_____
SSI (Supplemental Security)	_____	_____	_____	_____
TANF	_____	_____	_____	_____
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?

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

**6. Household Expenses**

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

Bank Fees _____	Diapers _____	Mortgage _____
Bus/Cab _____	Electric _____	Prescriptions _____
Cable/Internet _____	Food _____	Rent _____
Child Support Paid _____	Fuel Oil _____	Rent-To-Own _____
Car Gasoline _____	Gas, Bottled _____	School Loan _____
Car Insurance _____	Gas, Natural _____	Storage _____
Car Payment _____	Health Insurance _____	Telephone _____
Condo Fee _____	Laundry _____	Other _____
Child Care _____	Loan _____	Other _____
Credit Card _____	Lot Rent _____	Other _____

List unplanned, emergency or irregular periodic expenses during the past 30 days:

Car Inspection _____	Drivers License _____	Medical _____
Car registration _____	Fines/Court Payments _____	Sewer/Water _____
Car repair _____	Home Repairs _____	Tax (Income/Property) _____
Dental _____	Home/Rent Insurance _____	Other _____

**7. Criminal Information**

Have you or any member of your household ever been convicted of a felony which has not been annulled? (yes/no) \_\_\_\_\_ If yes, who? \_\_\_\_\_ When? \_\_\_\_\_

Town/City & State of conviction \_\_\_\_\_ Details of conviction: \_\_\_\_\_

Are you or any member of your household presently on parole or probation? (yes/no) \_\_\_\_\_

If yes, who? \_\_\_\_\_ Court or jurisdiction? \_\_\_\_\_

Name & phone number of parole/probation officer \_\_\_\_\_

**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 Un-sworn Falsification (RSA 641:3)

I understand that if I obtain a job after the municipality assists me, 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*

# AUTHORIZATION FOR THE RELEASE OF INFORMATION – DHHS

I, \_\_\_\_\_, the undersigned, understand that from time to time,  
Print Your Name  
 the local welfare administrator for \_\_\_\_\_ may require certain information about  
Town/City

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

Charlestown Department of Health & Human Services  
 P. O. Box 385, Charlestown, NH 03603  
 Tele: (603) 826-5266 or (800) 894-8400 Fax: (603) 826-5181

# NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF CHARLESTOWN, NH

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.

I/we have read and understand the rights set forth in this notice. I/we have been given a copy of this notice.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-applicant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Welfare Officials signature

\_\_\_\_\_  
Date

Charlestown Department of Health & Human Services  
P.O. Box 385 • Charlestown, NH 03603  
Phone (603) 863-9529 or (800) 894-8400 • Fax (603) 863-9554

# APPLICANT ONLY

## AUTHORIZATION TO RELEASE INFORMATION

(Charlestown, New Hampshire—APPLICANT ONLY)

I, \_\_\_\_\_ of the town of Charlestown, New Hampshire, County of Sullivan, being an applicant for Town Assistance under the laws of the State of New Hampshire, RSA 165 *et seq.*, hereby authorize and request any relative, health care provider, banker, financial firm or organization, fiscal officer, police officer, parole officer, employer, utility company, fraternal order, Social Security Office, Church, minister, priest, State or local welfare department or human services department, local or regional community action program (CAP), shelter program, or any other person, firm, association, or organization having any information concerning my circumstances as they may relate to eligibility for Town Assistance to furnish such information to the *Welfare Official* of Charlestown, New Hampshire. I also authorize the *Welfare Official* of Charlestown, New Hampshire to release information to other Welfare and Social Service agencies, or any other person, firm, association, or organization involved in the servicing of my case. A photocopy or facsimile of this release may be used in place of the original.

By signing below, I, \_\_\_\_\_, indicate that I have: (1) read this authorization; and (2) approved this authorization.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Social Security Number*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Charlestown Welfare Official's Printed Name*

\_\_\_\_\_  
*Signature of Charlestown Welfare Official*

TOWN OF CHARLESTOWN, NH • DEPARTMENT OF HEALTH AND HUMAN SERVICES  
P. O. Box 385, Charlestown, NH 03603  
Telephone: (603) 826-9529 or (800) 894-8400 • Fax: (603) 863-9554

# CO-APPLICANT ONLY

## AUTHORIZATION TO RELEASE INFORMATION

(Charlestown, New Hampshire—CO-APPLICANT ONLY)

I, \_\_\_\_\_ of the town of Charlestown, New Hampshire, County of Sullivan, being an applicant for Town Assistance under the laws of the State of New Hampshire, RSA 165 *et seq.*, hereby authorize and request any relative, health care provider, banker, financial firm or organization, fiscal officer, police officer, parole officer, employer, utility company, fraternal order, Social Security Office, Church, minister, priest, State or local welfare department or human services department, local or regional community action program (CAP), shelter program, or any other person, firm, association, or organization having any information concerning my circumstances as they may relate to eligibility for Town Assistance to furnish such information to the *Welfare Official* of Charlestown, New Hampshire. I also authorize the *Welfare Official* of Charlestown, New Hampshire to release information to other Welfare and Social Service agencies, or any other person, firm, association, or organization involved in the servicing of my case. A photocopy or facsimile of this release may be used in place of the original.

By signing below, I, \_\_\_\_\_, indicate that I have: (1) read this authorization; and (2) approved this authorization.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Social Security Number*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Charlestown Welfare Official's Printed Name*

\_\_\_\_\_  
*Signature of Charlestown Welfare Official*

TOWN OF CHARLESTOWN, NH • DEPARTMENT OF HEALTH AND HUMAN SERVICES  
P. O. Box 385, Charlestown, NH 03603  
Telephone: (603) 826-9529 or (800) 894-8400 • Fax: (603) 863-9554

# RENTAL VERIFICATION FORM

*THIS FORM MUST BE COMPLETED BY THE LANDLORD*

Tenant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Number of adults in apartment: \_\_\_\_\_ Number of children in apartment: \_\_\_\_\_

List of people in apartment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Occupancy date: \_\_\_\_\_ Security Deposit: Amount: \$ \_\_\_\_\_ Date paid: \_\_\_\_\_

Rent amount: \_\_\_\_\_; Paid:  monthly  weekly  other \_\_\_\_\_;

Payment type:  Cash  Personal Check  3<sup>rd</sup> Party Check  Money Order  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: \$ \_\_\_\_\_

Payment type:  Cash  Personal Check  3<sup>rd</sup> Party Check  Money Order  Other \_\_\_\_\_

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 # must be provided:

Tax ID #: \_\_\_\_\_ OR Social Security #: \_\_\_\_\_

Failure to provide the correct Tax ID or Social Security # may subject payments to backup withholding.

**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

*\*Whenever the owner of property rented to a person receiving general assistance from the Town of Charlestown is in arrears in sewer, water, electricity, or tax payments to the Town of Charlestown, the Town of Charlestown may apply the assistance which the property owner would have received in payment of rent on behalf of such assisted person to the property owner's delinquent balances, regardless of whether such delinquent balances are in respect of property occupied by the assisted person. RSA 165:4-a.*

TOWN OF CHARLESTOWN, NH • DEPARTMENT OF HEALTH AND HUMAN SERVICES

P. O. Box 385, Charlestown, NH 03603

Telephone: (603) 826-9529 or (800) 894-8400 • Fax: (603) 863-9554

CHARLESTOWN, NEW HAMPSHIRE  
**EMPLOYMENT VERIFICATION FORM**

*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: \_\_\_\_\_

I, \_\_\_\_\_, authorize the release of information regarding my employment to the Town of Charlestown Health and Human Service Office.

Signature: \_\_\_\_\_

STARTING DATE OF EMPLOYMENT: \_\_\_\_\_ HOURLY PAY RATE: \_\_\_\_\_

\_\_\_\_ FULL-TIME POSITION      \_\_\_\_ PART-TIME POSITION      # HRS/WK \_\_\_\_\_

\_\_\_\_ TEMPORARY POSITION (Please indicate time frame expected to work: \_\_\_\_\_)

FREQUENCY OF PAY (please check one): \_\_\_\_ WEEKLY \_\_\_\_ BI-WEEKLY \_\_\_\_ OTHER: \_\_\_\_\_

PLEASE LIST THE LAST FOUR (4) PAY PERIODS AND AMOUNTS OF NET PAY:

DATE: \_\_\_\_\_ AMOUNT: \$ \_\_\_\_\_

DIRECT DEPOSIT (please check one): \_\_\_\_ YES \_\_\_\_ NO

EMPLOYMENT STATUS:

\_\_\_\_ STILL EMPLOYED

\_\_\_\_ TERMINATION / SEPARATION

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

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

\_\_\_\_ LAY OFF      \_\_\_\_ TEMPORARY LEAVE (Medical or other personal leave)

\_\_\_\_ VOLUNTARY RESIGNATION      \_\_\_\_ RETIRED

\_\_\_\_ DISMISSED WITH CAUSE      \_\_\_\_ OTHER: \_\_\_\_\_

DOES THIS EMPLOYEE RECEIVE ANY OF THE FOLLOWING THROUGH EMPLOYER:

\_\_\_\_ CREDIT UNION ACCT      \_\_\_\_ SICK PAY      \_\_\_\_ MEDICAL INSURANCE

\_\_\_\_ LIFE INSURANCE      \_\_\_\_ RETIREMENT PLAN (i.e.: 401K, IRA, etc.)

\_\_\_\_ SHORT-TERM DISABILITY      \_\_\_\_ LONG-TERM DISABILITY

\_\_\_\_\_  
Authorized company signature

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
E-mail

\_\_\_\_\_  
Date

TOWN OF CHARLESTOWN, NH • DEPARTMENT OF HEALTH AND HUMAN SERVICES

P. O. Box 385, Charlestown, NH 03603

Telephone: (603) 826-9529 or (800) 894-8400 • Fax: (603) 863-9554

FINANCIAL STATEMENT & DISCLOSURE

*Pursuant to RSA 165:19*

NAME \_\_\_\_\_

SPOUSE \_\_\_\_\_

ADDRESS \_\_\_\_\_

DEPENDENTS: \_\_\_\_\_ AGE \_\_\_\_\_

\_\_\_\_\_ AGE \_\_\_\_\_

\_\_\_\_\_ AGE \_\_\_\_\_

\_\_\_\_\_ AGE \_\_\_\_\_

HOUSEHOLD INCOME AND ASSETS

GROSS MONTHLY INCOME: \$ \_\_\_\_\_ NET MONTHLY INCOME \$ \_\_\_\_\_

TOTAL INCOME LAST YEAR \$ \_\_\_\_\_ SOURCE(S) \_\_\_\_\_

SAVINGS ACCOUNT BAL \$ \_\_\_\_\_ CHECKING ACCOUNT BAL \$ \_\_\_\_\_

STOCKS, BONDS, CD \$ \_\_\_\_\_ OTHER \$ \_\_\_\_\_

REAL OR PERSONAL PROPERTY \_\_\_\_\_

FOOD STAMPS \$ \_\_\_\_\_ CHILD SUPPORT \$ \_\_\_\_\_ PER \_\_\_\_\_

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

CABLE/INTERNET \$ \_\_\_\_\_ CHILD SUPPORT PAID \$ \_\_\_\_\_ CAR GASOLINE \$ \_\_\_\_\_

CAR INSURANCE \$ \_\_\_\_\_ CAR PAYMENT \$ \_\_\_\_\_ CHILD CARE \$ \_\_\_\_\_

CREDIT CARD \$ \_\_\_\_\_ ELECTRIC \$ \_\_\_\_\_ FOOD \$ \_\_\_\_\_

FUEL OIL \$ \_\_\_\_\_ GAS, NATURAL \$ \_\_\_\_\_ HEALTH INS \$ \_\_\_\_\_

LIFE INS \$ \_\_\_\_\_ LOAN \$ \_\_\_\_\_ LOT RENT \$ \_\_\_\_\_

MORTGAGE \$ \_\_\_\_\_ PRESCRIPTIONS \$ \_\_\_\_\_ RENT \$ \_\_\_\_\_

STUDENT LOAN \$ \_\_\_\_\_ TELEPHONE \$ \_\_\_\_\_ HOME/RENTER INS \$ \_\_\_\_\_

MEDICAL \$ \_\_\_\_\_ PROPERTY TAX \$ \_\_\_\_\_ WATER/SEWER \$ \_\_\_\_\_

OTHER \_\_\_\_\_

TOTAL MONTHLY INCOME : \$ \_\_\_\_\_ TOTAL MONTHLY EXPENSES : \$ \_\_\_\_\_

I have read, and I understand the attached RSA 165:19.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

TITLE XII  
PUBLIC SAFETY AND WELFARE

CHAPTER 165  
AID TO ASSISTED PERSONS

**Liability for Support, and Recovery Over**

**Section 165:19**

**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 a 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 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.

**Source.** RS 66:8. CS 70:8. GS 74:8. GL 82:8. PS 84:12. 1925, 112:1. PL 106:22. 1933, 65:1. RL 124:18. RSA 165:19. 1973, 115:1. 1985, 380:11, eff. Jan. 1, 1986.

**Relatives are responsible for your assistance -- before the town.**

**Applicants can be asked to justify what support relatives are supplying, and/or justify why assistance is not being provided.**

**This may require financial information from relatives.**

Charlestown Department of Health & Human Services  
P.O. Box 385 • Charlestown, NH 03603  
Tele: (603) 826-5266 or (800) 894-8400 • Fax: (603) 826-5181