OFFICE OF
**SELECTMEN**
**CENTER HARBOR, NEW HAMPSHIRE**
PO BOX 140, CENTER HARBOR, NH 03226
P: 603-253-4561 F: 603-253-8420 E: selectmen@centerharbornh.gov

# APPLICATION FOR ASSISTANCE (V10.25)

**Date of Application:**_____ **Referred by:**_____

## General Information:

**Name:**_____ **Date of Birth:**_____
**Address:**_____
**Telephone:** _____ **Email:**_____
**Social Security Number:**_____ **US Citizen?**_____
**Marital Status:**_____ **Rent or Own?**_____ **How long at this address:**_____
**Spouse/Co-Applicant Name:**_____ **Social Security Number:** _____
**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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## 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 Company: _____ Address: _____**

## Education/Training/Employment:

| | Highest Grade Attended | G.E.D. or Diploma | Special Training/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: _____ 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 |
|---|---|---|---|---|---|
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |
| _____ | _____ | ___ | _____ | _____ | _____ |

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

| Name | Bank/Credit Union | Savings Account # | Savings Balance | Checking Account # | 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? _____ Why? _____**
**Please give details: _____**
**Lawyer Name/Address:_____**

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

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

## 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 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 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 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:** _____

## Liability for Support Information:

**Please provide the following details:**
**Your father:**_____ **Address:**_____
**Your mother:**_____ **Address:**_____
**Co-applicant father:**_____ **Address:**_____
**Co-applicant mother:**_____ **Address:**_____
**Your or co-applicant's adult children:**_____

**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 judgement for personal injuries which I receive within six (6) 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 (90) 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, the local
Print your name
Welfare Administrator for **Center Harbor, 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 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 another person without my written permission.

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

# NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF CENTER HARBOR, 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 to 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 a 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 CENTER HARBOR WELFARE DEPARTMENT
# APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

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 Municipal Welfare Department. I/We also authorize the Internal Revenue Service, Social Security Administration, any State of 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 Municipal 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 CENTER HARBOR WELFARE DEPARTMENT
# APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION
# (specific agency/individual)

I understand that as part of the administration of the general assistance program, a municipal welfare official may verify information I have provided on my application for assistance and any other information that would affect my eligibility. My signature below authorizes

_____, Town of Center Harbor Welfare Official, to obtain information from _____ regarding factors relevant to my application for general assistance benefits.

This authorization shall expire one (1) year from the date it is signed.

A photocopy of this signed authorization may be used in place of an original.

_____ _____

Applicant Date

_____

Welfare Official

## TOWN OF CENTER HARBOR WELFARE DEPARTMENT
## REQUIRED VERIFICATIONS

**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 (4) weeks pay stubs or other proof of net wages**
____ **Last four (4) weeks 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 certificates/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**

# TOWN OF CENTER HARBOR
# INTAKE FORM

**(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 may receipt of assistance, now or in the future, I may be prosecuted for a crime.**

_____
**Signature**

# TOWN OF CENTER HARBOR WELFARE DEPARTMENT
# MEDICAL RELEASE AND REPORT

**APPLICANT NAME:**_____ **D.O.B.:**_____
**APPLICANT SOCIAL SECURITY #:**_____

I hereby request the release by a doctor, hospital or clinic to the Town of Center Harbor Welfare Department, or its 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 (6) months from the 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 Town of Center Harbor Welfare Department at 603-253-4561 if you have any questions.*

## TOWN OF CENTER HARBOR WELFARE DEPARTMENT
## EMPLOYMENT VERIFICATION FORM

**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 ___ Bi-weekly ___ Other**
**Date of first/most recent paycheck: _____ New amount: _____**

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**_____ 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 CENTER HARBOR WELFARE DEPARTMENT
# BUDGET WORKSHEET

**NAME: _____ DATE: _____**

**A. Available assets and income:**

_____ _____mo/wk
_____ _____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** | _____**mo/wk** |
| **Electric** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Gas** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Fuel oil** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Water/sewer** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Cooking fuel** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Telephone** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Food** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Personal & Household** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Medical/Prescription** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Transportation** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Childcare/Day care** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Car payment** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Gasoline** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Other** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Other** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Other** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |
| **Other** | _____**mo/wk** | _____**mo/wk** | _____**mo/wk** |

**B. Total Allowed Expenses:** _____

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

**Assistance will be provided as follows:**

_____ **$**_____ _____ **$**_____
_____ **$**_____ _____ **$**_____

## TOWN OF CENTER HARBOR WELFARE DEPARTMENT
## NOTICE OF DECISION

**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 seven (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:

_____

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____ 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 CENTER HARBOR WELFARE DEPARTMENT
# WORKFARE PROGRAM
# REPORTING SLIP

In accordance with RSA 165:3,1, 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 _____
(date 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 | Hours Worked | Supervisor Initials |
|---|---|---|---|---|---|---|
| _____ | **Sunday** | _____ | _____ | _____ | _____ | _____ |
| _____ | **Monday** | _____ | _____ | _____ | _____ | _____ |
| _____ | **Tuesday** | _____ | _____ | _____ | _____ | _____ |
| _____ | **Wednesday** | _____ | _____ | _____ | _____ | _____ |
| _____ | **Thursday** | _____ | _____ | _____ | _____ | _____ |
| _____ | **Friday** | _____ | _____ | _____ | _____ | _____ |
| _____ | **Saturday** | _____ | _____ | _____ | _____ | _____ |

**TOTAL HOURS WORKED** _____

_____ Date: _____
Supervisor's Signature

**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.

_____ Date: _____
Recipient/workfare participant signature

**TOWN OF CENTER HARBOR WELFARE DEPARTMENT**
**NOTICE OF FAIR HEARING**

**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 CENTER HARBOR WELFARE DEPARTMENT
# FAIR HEARING REQUEST

I, _____, hereby request a fair hearing to review the decision dated _____ regarding my application for general assistance.

I ____ want my current assistance to continue until my appeal has been decided.
I ____ 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 CENTER HARBOR WELFARE DEPARTMENT
# FAIR HEARING DECISION

**_____** **_____**

**Client Name** **Represented by**

**VS**

**_____**

**Town of Center Harbor**

**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: _____**