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 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 Municipal Welfare Department.

____________________________________________   ___ ________________________
Applicant Signature Date

____________________________________________   ___ ________________________
Spouse or Co-applicant Signature Date

____________________________________________________    ________________________
Signature of person completing form (Relationship to applicant) Date
Date: _______________

Name: _________________________________________________________________________________

First                             Middle                             Last                                Birth Date

Address: _______________________________________________________________________________

Street / # / Apartment    Town

How Long at This Address?___________________________Telephone: ___________________________

WHAT TYPE OF EMERGENCY ASSISTANCE ARE YOU REQUESTING AT THIS TIME? _________

______________________________________________________________________________________

Names and Ages of All Household Members:

______________________________________________________________________________________

DOB:________________________

______________________________________________________________________________________

DOB:________________________

______________________________________________________________________________________

DOB:________________________

______________________________________________________________________________________

DOB:________________________

DOB:________________________

DOB:________________________

Name of Employer ________________________________________________________________

Landlord Contact Information_________________________________Telephone__________________

LIST ALL SOURCES AND AMOUNTS OF HOUSEHOLD’S INCOME:

______________________________________________________________________________________

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

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

I understand that according to NH RSA 641:3 Unsworn Falsification, 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