STATE OF NEW HAMPSHIRE **3000**
Department of Health and Human Services **12/09**
Bureau of Elderly and Adult Services

APPLICATION FOR SOCIAL SERVICES

The NH Department of Health and Human Services, Bureau of Elderly and Adult Services (BEAS), requires that this form be completed by any adult requesting services under the Social Services Block Grant (Title XX) either from BEAS or from an agency under contract to BEAS. The information will be used to assist the BEAS/Contract Agency in understanding your needs and in determining your eligibility for Title XX services.

Please complete all items on the form, unless otherwise indicated. If there are any questions that you do not understand, you may have someone else help you or we will help you when we talk with you.

If you are completing this application on behalf of someone else, you are acting as his/her authorized representative, and your answers on this application should apply to that person, not to yourself. "Authorized representative" means any person other than a BEAS staff member or Contract Agency representative who is age 18 or older, and who, with the individual's permission, acts on the individual's behalf during all aspects of initial or continuing eligibility determination for services.

I. APPLICANT INFORMATION:

Name ____
(Last Name) (Middle Initial) (First Name)

Date of Birth________________Primary Spoken Language_____________________

If your primary spoken language is not English, do you need an interpreter? ☐ No ☐ Yes (if yes, specify)_____________________________

Do you have limitations with vision, speech or hearing? ☐ No ☐ Yes (if yes, specify)___________________
If you answered "yes", what type of accomodation do you need?______________________________

Social Security # (optional)_____/___/_______ Telephone # ______________________
Street Address (Include Apt. No.) ____
City_______________________________________State______________Zip__________________________
Mailing Address (if different from above) ____

II. LIVING ARRANGEMENT: Check the category that best describes where you live.

☐ Own home/apartment alone
☐ Own home/apartment with spouse/partner
☐ Homeless shelter
☐ Retirement community
☐ Own home/apartment with relatives or friends
☐ Relative/friend's home/apartment
☐ Motel/hotel
☐ Other (specify)_____________________

For District Office or Contract Agency Use Only: On ___/___/___, the applicant was found ☐ eligible ☐ ineligible for the Title XX services requested. Reason for ineligibility____________________________

III. MONTHLY INCOME: In lines 1-14, please enter your monthly income in the categories that apply to you. If you have no income in a particular category, leave the space blank. On line 15, enter the total amount of income you receive. "Income" is defined by BEAS as the total amount of money you receive on a regular, recurring basis each month, based on the sources listed below. When calculating the amount for each source of income, enter the face value, i.e. if the income is in the form of a check, enter the amount for which the check may be cashed.

Amount	**Income Source**
$	1. State Financial Assistance
$	2. Social Security
$	3. Supplemental Security Income (SSI)
$	4. Veterans Benefits
$	5. Disability Benefits From Insurance
$	6. Workers Compensation
$	7. Unemployment Compensation
$	8. Rental Income
$	9. Wages or Income From Self-Employment
$	10. Pension
$	11. Annuity
$	12. Interest Income From Bank Accounts, Certificates of Deposit, Stocks, Trusts, Money Market Certificates and/or Mutual Funds
$	13. Alimony
$	14. Other (specify)
$	15. **TOTAL MONTHLY INCOME**

IV. MEDICARE PREMIUMS

Do you pay separately for Medicare premiums? ☐ No ☐ Yes

If yes, what do you pay each month?________________________________

V. SERVICE NEED: Please state in your own words the kind of help you need and why, and include any major health issues or disabilities you may have:

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VI. MEDICAL ASSISTANCE:

Are you currently receiving state medical assistance (Medicaid)? ☐ No ☐ Yes
If yes, and you know your Medicaid number, please enter it here:________________________________

If not, have you applied for Medicaid? ☐ No ☐ Yes If yes, please enter the date when
you applied, or enter the words,"not sure" if you don't know when you applied: ____________________.

VII. SIGNATURES:

Please read the information below and the Assurances section on the next page before signing the application. You may also detach and keep the Assurances section for your information.

I have read and understood the information on the application, including the Assurances section on the next page, and I agree that the entries I have made on this application are true and accurate to the best of my knowledge.

I understand that as part of the administration of Bureau of Elderly and Adult Services (BEAS) programs, the BEAS or an agency under contract to the BEAS (Contract Agency) may verify information I have provided on this application and any other information that would affect my eligibility.

My signature below authorizes the BEAS/Contract Agency to obtain verification and authorizes release of such information to the BEAS/Contract Agency. My authorization to release information remains in effect until the time of my next redetermination of eligibility.

I understand that I must report any change in my address or income to the District Office/Contract Agency where I applied for services, since such changes may affect my eligibility for services.

____ _________________________
Signature of Applicant Date

For Authorized Representatives Only: My signature below indicates that I have completed this form on behalf of the applicant, using information provided by the applicant, and that this information is true and complete to the best of my knowledge. I have the applicant's permission to act on his or her behalf during all aspects of initial or continuing eligibility for services, including compliance with the provisions described above, and have agreed to accept the responsibilities designated to me. I have read and understood the provisions described above and the Assurances section on the next page. The applicant acknowledges that he/she may be responsible for any errors, omissions or inaccurate information reported to BEAS by me acting as the authorized representative.
Signature of Authorized Representative ____________________________Date_______________
Relationship of Authorized Representative to Applicant____
Authorized Representative's Address ______________________________________Telephone#____________

VIII. ASSURANCES (This information accompanies Form 3000, "Application For Social Services".):

The State of New Hampshire, Department of Health and Human Services, does not discriminate against people because of their age, sex, race, creed, color, marital status, familial status, physical or mental disability, religion, national origin, sexual orientation or political affiliation or belief. There will be no discrimination in accepting or providing services, or the admission or access to, or treatment or employment in, any of the Department's programs or activities.

The Ombudsman is responsible for coordinating the civil rights compliance efforts of the Department, component offices and divisions to follow state and federal rules against discrimination. For more information, or to learn how to make a discrimination complaint, contact the Office of the Ombudsman at 129 Pleasant Street, Concord, New Hampshire 03301 or you may telephone **1-800-852-3345, ext. 6941, (603) 271-6941 (voice) or TDD Access: Relay NH 1-800-735-2964.**

The New Hampshire Department of Health and Human Services is subject to Title VI of the Civil Rights Act of 1964 (42 U.S.C., Section 2000d et. seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C., Section 794); Title IX of the Education Amendments of 1972 (20 U.S.C., Section 1681); the Age Discrimination Act of 1975 (42 U.S.C., Section 6101 et. seq.); NH RSA 354-A; and certain federal block grant statutes, including, but not limited to 42 U.S.C., Sections 300w-7, 300x-57, and 708, or any other provision through which the Department receives federal financial participation in its programs. These laws prohibit discrimination on the basis of age, sex, race, creed, color, marital status, familial status, physical or mental disability, religion, national origin, sexual orientation or political affiliation or belief in federally assisted and state funded activities. The U.S. Department of Health and Human Services' regulations under Title VI, Section 504, Title IX and the Age Discrimination Act are found at 45 C.F.R., Parts 80, 84, 86, and 91, respectively. The New Hampshire Department of Health and Human Services is further subject to the Americans with Disabilities Act of 1990 (42 U.S.C., Section 12101,et. seq.) and its implementing regulations at 28 C.F.R., Part 35.

All information on applicants for, and recipients of, services and programs provided by the Bureau of Elderly and Adult Services (BEAS) or an agency under contract with the BEAS (Contract Agency), is kept confidential, and only persons involved in administering these services and programs will review it, unless the applicant/recipient signs an authorization to release the information to another individual/organization, or unless BEAS is verifying information provided by the applicant, as described in the next paragraph .

An applicant's eligibility for social services is determined by the BEAS or by BEAS Contract Agencies. When determining eligibility, the BEAS/Contract Agency considers the applicant's income, and also whether or not any of the services provided by the BEAS/Contract Agency are appropriate for the applicant's needs. Information provided by applicants may be subject to verification if deemed necessary by the BEAS/Contract Agency.

Following an eligibility determination, a notice of decision is mailed to the applicant. The notice is mailed no later than 45 days from the date upon which the application was originally received by the BEAS /Contract Agency. If an applicant/recipient is dissatisfied with the eligibility determination made by the Bureau of Elderly and Adult Services or by a BEAS Contract Agency, he or she may request an administrative appeal in accordance with He-C 200. The applicant/recipient may request an administrative appeal by contacting the Administrative Appeals Unit at 105 Pleasant St., Concord, NH 03301, Telephone: **1-800-852-3345, Ext. 4292** or **TDD 1-800-735-2964**. The request shall be made within 30 days after the notice of decision is issued, and subject to the provisions of He-C 201.03.