

**TOWN OF ALEXANDRIA**

47 Washburn Rd., Alexandria, NH 03222

603-744-3220(P)

603-744-9461(F)

info@alexandrianh.com

## APPLICATION FOR BURIAL/CREMATION ASSISTANCE

If you are in need of assistance for the burial or cremation of a loved one from the Town of Alexandria's Welfare Office, please complete this application completely and return it to this office. Please be sure to include any supporting information or documentation. Originals will be returned to you if you do not provide copies.

Please print clearly:

Applicant Name: \_\_\_\_\_

Applicant Address: \_\_\_\_\_

\_\_\_\_\_

Applicant Phone(Home): \_\_\_\_\_

Applicant Phone(Cell): \_\_\_\_\_

Applicant Email: \_\_\_\_\_

You will receive an email from me when I have received your application.

If you have any questions, please contact me.

Jennifer Dostie  
Welfare Director  
Town of Alexandria  
jdostie@alexandrianh.com

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

**General Information:**

Name of the Departed: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security number \_\_\_\_\_ US Citizen? \_\_\_\_\_

Marital Status \_\_\_\_\_ Rent or Own? \_\_\_\_\_ How long at this address? \_\_\_\_\_

Spouse Name \_\_\_\_\_ SS# \_\_\_\_\_

Spouse address (if not same as applicant) \_\_\_\_\_

**Assistance Requested** \_\_\_\_\_

Reason for request \_\_\_\_\_

Has the departed applied for local assistance before? \_\_\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ Under what name? \_\_\_\_\_

**List below all persons living in the departed's household:**

| Full Name | Relationship | Date of Birth | Social Security # |
|-----------|--------------|---------------|-------------------|
| _____     | _____        | _____         | _____             |
| _____     | _____        | _____         | _____             |
| _____     | _____        | _____         | _____             |
| _____     | _____        | _____         | _____             |
| _____     | _____        | _____         | _____             |
| _____     | _____        | _____         | _____             |
| _____     | _____        | _____         | _____             |

**Military Service Records:**

Has the departed ever served in the military: \_\_\_\_\_ Veteran: \_\_\_\_\_ Branch: \_\_\_\_\_

Dates of service? \_\_\_\_\_ Does the departed have an Honorable Discharge?: \_\_\_\_\_

Was the departed receiving benefits: \_\_\_\_\_ How much? \_\_\_\_\_

**Departed/Immediate Family Member Assets:**

*In the line of father, mother, stepfather, stepmother, son, daughter, husband, or wife (RSA 165:19)*

**Provide information regarding accounts held by the departed and all immediate adult family members:**

| Name | Bank/Credit Union | Type of Account | Account Number | Balance |
|------|-------------------|-----------------|----------------|---------|
|      |                   |                 |                | \$      |
|      |                   |                 |                | \$      |
|      |                   |                 |                | \$      |
|      |                   |                 |                | \$      |
|      |                   |                 |                | \$      |

**Provide current value of any assets held by the departed and all immediate family 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                                   | \$ |
| Other Investments                      | \$ |
| Property Other than Primary Residence  | \$ |
| Motorcycles/Boats/Snowmobiles/ATVs/RVs | \$ |
| Other Assets (please list)             | \$ |

**Claims/settlements/income due to the departed or any immediate family members:**

|   |    |
|---|----|
| IRS Refund                              | \$ |
| Insurance Claim                         | \$ |
| Retroactive Disability Check            | \$ |
| Retroactive Unemployment Check          | \$ |
| Retroactive Worker's Compensation Check | \$ |
| Inheritance                             | \$ |
| Other Lump Sum Payment (Explain)        | \$ |

**Has the departed or any immediate family member in the line of father, mother, stepfather, stepmother, son, daughter, husband or wife consulted a lawyer regarding a possible lawsuit?**

☐ Yes ☐ No If yes, which family member(relationship & name): \_\_\_\_\_

Lawyer Name/Address \_\_\_\_\_

Reason \_\_\_\_\_

**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)     | _____ | _____        | _____              | _____          |
| Workers' Compensation           | _____ | _____        | _____              | _____          |
| Other: [                      ] | _____ | _____        | _____              | _____          |

**Liability for Support Information (Must complete this section – do not leave blank)**

Please provide the following information for all immediate family members in the line of father, mother, stepfather, stepmother, son, daughter, husband or wife, whether or not they reside in the departed's household. RSA 165:19

[illegible]

**Required Verifications:**

The Welfare Director requires the following documentation along with this application at the time of submission:

- Proof of residence in the Town of Alexandria of the departed (length of time and location)
- Copy of the bill from the funeral home
- Copy of all bank account statements from the departed and the applicant
- Verification of income and assets for the departed and the applicant
- Copy of the death certificate
- Copy of probate court orders – appointment of an executor of estate
- Family members must provide a sworn, notarized statement that they cannot assist financially with expenses. The sworn statement **MUST** be notarized by a Notary Public or Justice of the Peace. (Family members include: spouses, parents, siblings, children, and/or significant others).

I understand that failure to provide the indicated information may result in delay and/or denial of my request for burial/cremation assistance.

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Signature of person completing form

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Relationship to departed

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Date

## **Certifications/Signatures/Release of Information**

I understand I may be required to provide financial information to determine immediate family members ability to assist with the need, in the line of father, mother, stepfather, stepmother, son, daughter, husband or wife, whether or not they reside in the departed's household. Should a relation refuse to render such financial information when requested, such person or persons could be summoned to appear in court for determination of ability to assist. RSA 165:19.

I understand that immediate family members may be required to repay any assistance provided, if returned to an income status, and/or receive available financial resources, including income tax refund(s), which enables reimbursement without financial hardship. RSA 165:20-b.

I understand that if assisted, the municipality may place a lien against any property settlement or civil judgement for personal injuries (except any workers compensation settlement), received within six years of receiving municipal assistance. RSA 165:28-a.

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 a claim.

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 immediate family 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 crimes of Unsworn Falsification RSA 641:3, Theft by Deception RSA 637"4 and/or Identity Fraud 638:27, which can result in imprisonment.

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Signature of person completing form

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Relationship to departed

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Date

## Release of Information

I/We \_\_\_\_\_ authorize any relative, physician, lawyer, banker, landlord, insurance company, mental health professional, school official or other person or organization having information concerning my/our circumstances to furnish such information to the Town of Alexandria Welfare Office. I/We also authorize the IRS, Social Security Administration, any State or County Division of Health and Human Service, Division of Children Youth and Families, Division of Adult and Elderly, NH Legal Assistance, City/Town Welfare Department, Homeless Shelter, Department of Employment Security, Veteran's Administration and Fuel Assistance, or any non-profit agency to release information from their files to the Town of Alexandria Welfare Office.

I also waive my right to privacy and confidentiality contained in my file and/or any information received by the Town of Alexandria Welfare Office and authorize to release such information to other agencies to the extent that such release is made to further my application for, or receipt of, assistance from that agency. This authorization shall expire 180 days from the date it is signed.

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Signature of person completing form

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Relationship to departed

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Date



## Family Member Statement

Departed: \_\_\_\_\_

I, \_\_\_\_\_, am unable to assist financially with  
burial/cremation expenses for the above named individual.

\_\_\_\_\_  
Signature of person completing form

\_\_\_\_\_  
Relationship to departed

\_\_\_\_\_  
Date

Subscribed and sworn to before me:

\_\_\_\_\_  
(Notary Public/Justice of the Peace)

My commission expires: \_\_\_\_\_