

Town Of Lee
Welfare Department
Mast Road
Lee, NH 03824
Phone (603)969-8251
Fax (603)659-7202

LEE WELFARE APPLICATION

INSTRUCTIONS/INFORMATION

To apply for any assistance from the Lee Welfare Department you must FULLY COMPLETE the following application. All documentation requested is required to complete the application process. A decision cannot and will not be made until all documentation requested has been supplied.

As you complete your request for General Assistance, we ask you to remember that Local Town Welfare is not a hand out but designed to be a safety net that is not automatic, ongoing or indefinite and is solely funded through local taxpayer's property tax dollars. It by law requires that you cooperate with the Welfare Official and take responsibility for your own personal behavior and actions.

If you are currently not working or not working full time, you will be required to complete an extensive job search, defined as at least 5 job contacts and day and provide signed confirmation from the perspective employer. You may also be required to participate in the Town's Workfare Program. If you are physically or mentally unable to work you will need to have medical documentation completed by your physician.

If you recently left employment, you will need to have your previous employer complete the employment form. You will also have to apply for unemployment whether or not you may think you are eligible and have the employment office form completed. If you are currently working you will need to provide the last 4 weeks paycheck stubs or the income verification from completed by your employer.

You will be expected to do everything in your power to live within your income by adjusting your financial situation to eliminate the need for General Assistance. You will be required to provide this office with ongoing verification of information requested. The purpose of this office is to assist you in becoming self-supporting and self-sufficient.

RESPONSIBILITIES OF EACH APPLICANT AND RECIPIENT

AT THE TIME OF THE INITIAL APPLICATION AND AT ALL TIMES THEREAFTER THE APPLICANT/RECIPIENT HAS THE FOLLOWING RESPONSIBILITIES:

1. To provide accurate, complete and current information concerning needs and resources as well as the whereabouts and circumstances of relatives who may be responsible under RSA 165:19.
2. To notify the Welfare Official or his/her designate within 72 hours when a change in needs or resources may affect eligibility for continuing assistance.
3. Within 7 days of application, to apply for and utilize any benefits or household resources, public, or private, that will reduce or eliminate the need for Town General Assistance.
4. To keep all appointments as scheduled and to return all information that is needed within the specified time frames so that once assistance is granted, no lapse in benefits such as TANF checks or Food Stamps will occur.
5. To notify the Welfare Official within 72 hours of a change of address and any change in the members of the household.
6. To diligently search for employment and provide verification of applications for employment when requested, following a determination of eligibility for assistance. You must ACCEPT ANY employment offer following a determination of eligibility. Refusal to accept employment is grounds for denial or sanction.
7. To provide a doctor's statement if any work eligible adult in the household claims an inability to work due to medical problems.
8. To participate in the welfare workfare program if physically and mentally able, following a determination of eligibility for assistance.
9. To keep appointments as scheduled for Town Welfare knowing that if you are more than 15 minutes late you will be considered a no show and may not be eligible for rescheduling for 7 calendar days for your missed appointment date.

A RECIPIENT'S ASSISTANCE MAY BE TERMINATED OR SUSPENDED FOR FAILURE TO FULFILL ANY THESE RESPONSIBILITIES WITHOUT REASONABLE JUSTIFICATION.

NAME _____ DATE _____

SERVICE(S) REQUESTED _____

VERIFICATIONS REQUIRED FROM APPLIANTS FOR WELFARE

You will need to bring the following documentation with you for all your appointments. Photocopies are acceptable. A decision cannot and will not be made until all documentation requested has been supplied.

1. You must provide Proof of identification for each member of the household. This can be a birth certificate, a social security card, or a picture I.D. _____
2. Proof of Residence. This is either a completed Welfare rental form or a lease. _____
3. Proof of Income. Examples include: current months paycheck stubs, statement from employer with net and gross amounts for past month, Workers Comp Papers, Unemployment Compensation, check stub from social security or TANF. All sources of income including gifts, and if you have just started a new job a statement from the employer as to hourly rate, hours per week and date and amount of anticipated first net paycheck. _____
4. Proof of all allowable bills that you are paying (basic needs including rent, electric food, heat, babysitters for work, Rx.). _____
5. Proof that you have applied for the following: TANF, FOOD STAMPS, WORKERS COMPENSATION, UNEMPLOYMENT COMPENSATION, SOCIAL SECURITY, WIC, APTD, MEDICARE AND OR MEDICAID AND FUEL ASSISTANCE. _____
6. Proof of any personal property (I.E. TRAILERS, MOBILE HOMES, JET SKI'S, A.T.V'S, BOATS, SNOW MOBILES, MOTOCYCLES, LAND etc.). _____
7. Proof of any Cash Resources. Current statements of any bank accounts for all members of household including children. _____
8. Doctor's statement of disability or reason for leave from work. This should include diagnosis and list of medications prescribed clearly identify what condition each medication is used to treat, as well as anticipated length of disability and return to work date. _____
9. Proof that parent or spouse can not help you financially including federal tax returns see RSA 165:19. _____
10. Complete list of any other sources of income or financial help you have received during the past four weeks from any and all sources such as a church, charitable group, loan from family member or friends, loan from institutions, winnings from Bingo or lotteries, fuel assistance, trust funds, money borrowed/withdrawn from retirement accounts, CAP. _____
11. Other case specific documentation: _____

It is very important that applicants are aware of the laws regarding welfare fraud and therefore understand and expect that the Town of Lee will pursue all criminal remedies including prosecution to the full extent of the law as well as:

ANY PERSON MAY BE DEINIED OF TERMINATED FROM GENERAL ASSISTANCE AND OR PROSECUTED FOR A CRIMINAL OFFENSE, WHO BY MEANS OF INTENTIONALLY MAKING FALSE STATEMENTS OR INTENTIONAL MISREPRESENTATION OR BY IMPERSONATION OR THE WILLFULLY FRAUDULENT ACT OR DEVICE OBTAINS OR ATTEMPTS TO OBTAIN ANY ASSISTANCE TO WHICH HE/SHE IS NOT LEGALLY ENTITLED.

The above responsibilities and list of verifications have been read and I believe that I understand my responsibilities fully when completing this application for Town Welfare/General Assistance.

Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____

Welfare Application Town of Lee

NAME _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ TODAY'S DATE _____

CURRENT ADDRESS _____

HOW LONG AT THIS ADDRESS _____

PREVIOUS ADDRESS (past 2 years) _____

PHONE NUMBER _____ TOTAL# HOUSEHOLD OCCUPANTS _____

LIST BELOW ALL PEOPLE LIING AT THIS RESIDENCE//AND OR HOUSEHOLD
NAME BIRTHDATE/AGE RELATIONSHIP SS#

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

CURRENTLY EMPLOYED? _____ ARE YOU A CITIZEN? _____

EMPLOYER NAME _____ PHONE # _____

EMPLOYER

ADDRESS _____

DATES OF EMPLOYMENT _____ JOB TITLE _____

MARITAL STATUS _____ LAST FULL GRADE COMPLETED _____

LIST THE NAMES AND ADRESSES OF YOUR PARENTS PER RSA 165.19

1. _____

2. _____

WHY ARE YOU REQUESTING GENERAL ASSISTANCE FROM TOWN WELFARE? _____

WHAT TYPE OF ASSISTANCE ARE YOU REQUESTING? _____

PLEASE IDENTIFY THE SOURCE OF REFERRAL TO THIS OFFICE:

- | | | | |
|---------------------|------------------|------------------|------------|
| 1.SELF | 4.SOCIAL SCURITY | 7. MENTAL HEALTH | 10.DES |
| 2.NH HOSPITAL | 5.FAMILY/FRIEND | 8.VET. ADMIN. | 11. OTHER |
| 3. MEDICAL SERVICES | 6.SCHOOL | 9.JUSTICE SYSTEM | 12.SHELTER |

HAVE YOU EVER REQUESTED WELFARE ASSISTANCE BEFORE? _____
DATES OF ASSISTANCE _____
TYPE OF ASSISTANCE _____

CURRENT BENEFIT/INCOME AMOUNTS AND DATES OF APPLICATION

STATE WELFARE _____
TANF _____
SOCIAL SECURITY _____
APTD _____
SSDI _____
OAA _____
VETERANS BENEFITS _____
UNEMPLOYMENT COMPENSATION _____
WORKERS COMPENSATION _____
MEDICAL _____
CHILD SUPPORT _____
SETTLEMENTS _____
ALIMONY _____
PRIVATE DISABILITY INSURANCE _____
PENSION _____
NATIONAL GUARD _____
TRUST FUND _____
WEEKLY PAY CHECK _____
TAX REFUNDS _____
OTHER PAY CHECK _____
OTHER INCOME _____
FOOD STAMPS _____

RESOURCES FOR THE HOUSEHOLD:

AMOUNT	LOCATION	OWNER OF RESOUC
CASH	_____	_____
SAINGS	_____	_____
CHECKING	_____	_____
CHILD SUPPORT	_____	_____
STOCKS/BONDS	_____	_____
PENSIONS/RETIREMENT SAVINGS	_____	_____
LIFE INSURANCE	_____	_____
LIST ALL VEHICLES	_____	_____
OTHER ASSETS (I.E. TRAILERS, MOBILE HOMES, JET SKI'S, A.T.V'S, BOATS, SNOW MOBILES, MOTOCYCLES, LAND etc.)	_____	_____
	_____	_____

DOCUMENTATION FOR ALL RESOURCES WILL BE REQUIRED TO COMPLETE APPLICATION. EXAMPLES OF ACCEPTABLE DOCUMENTATION INCLUDE: COMPLETE CURRENT BANK STATEMENTS WITHIN 30 DAYS, COURT ORDER FOR CHILD SUPPORT PENSION STATEMENTS, LIFE INSURANCE POLICIES, VEHICLE REGISTRATIONS AND OR TITLES, MORTGAGE STATEMENTS, PROPERTY ASSESSMENT STATEMENTS. FAILURE TO PROVIDE THIS DOCUMENTATION WILL BE RESULT IN APPLICATION CONSIDERED AS NON-COMPLETE AND A DELAY IN PROCESSING AND DETERMINATION OF ASSISTANCE.

PLEASE KEEP IN MIND THAT IT IS UNLAWFUL FOR ANY APPLICANT OR RECIPIENT TO KNOWLINGLY MAKE FALSE REPRESENTATION ERBALLY OR IN WRITITNG, OR BY OMISSION AS TO HIS/HER CIRCIMSTANCES. (NH RSA 641:3) ANYONE WHO DOES SO MAY BE SUBJECT TO CRIMINAL PROSECUTION FOR SUCH ACTIONS, AND MAY FORFEIT CONFIDENTIALITY PROTECTION FOR PROSECUTION PURPOSES.

MONTHLY EXPENSES:

RENT \$ _____ PER WEEK MONTH BI-MONTHLY

DATE LAST PAID _____ AMOUNT PAID ON THAT DATE _____

UTILITIES INCLUDED IN RENT? *Circle* NONE HEAT ELECTRICITY WATER

NAME OF LANDPERSONS MUST BE THE LEGAL PROPERTY OWNERS OF RECORD.

ADDRESS

PHONE

MONTHLY EXPENSES:

RENT/ MORTGAGE	\$ _____
FOOD	_____
ELECTRICITY	_____
HEAT	_____
WATER	_____
COOKING GAS	_____
PERSRIPTIONS	_____
MISC	_____

TOTAL \$ _____

WORK RECORD FOR APPLICANT FOR PAST YEAR:

EMPLOYER DATES OF EMPLOYMENT TYPE WORK WAGES REASON TERMINATED

WORK RECORD FOR CO-APPLICANT FOR PAST YEAR:

EMPLOYER DATES OF EMPLOYMENT TYPE WORK WAGES REASON TERMINATED

WORK RECORD FOR OTHER HOUSEHOLD (ADULT) MEMBER FOR PAST YEAR:

EMPLOYER DATES OF EMPLOYMENT TYPE WORK WAGES REASON TERMINATED

AS OF AUGUST 1, 1995- ANY PERSON WHO QUILTS A PLACE OF EMPLOYMENT WITH OUT ANOTHER VERIFIABLE JOB TO GO TO AND OR WITHOUT VERIFIABLE CAUSE WITHIN THE 60 DAY PERIOD BEFORE FILING AN APPLICATION FOR ASSISTANCE SHALL BE INELIGIBLE FOR ASSISTANCE FOR 90 DAYS FROM THE DATE OF TERMINATION OF EMPLOYMENT. PER STATE OF NH LAW

HAS ANYONE IN YOUR HOUSEHOLD BEEN CONICTED OF A CRIME?_____

DOES ANYONE IN YOUR HOUSEHOLD HAVE A LAWSUIT PENDING?_____

NAME OF LAW FIRM AND ADDRESS_____

DOES ANY MEMBER OF THE HOUSEHOLD EXPECT TO RECEIVE AN INCOME TAX REFUND OR EARNED INCOME CREDIT IN THE NEXT 45 DAYS?_____

AVAILABLE INCOME

HOURLY WAGE \$ _____ WAGES PER WEEK _____

HOURS WORKED PER WEEK _____

AVAILABLE INCOME- CO APPLICANT

HOURLY WAGE \$ _____ WAGES PER WEEK _____

HOURS WORKED PER WEEK _____

AVAILABLE INCOME OTHER ADULT HOUSEHOLD MEMBER

HOURLY WAGE \$ _____ WAGES PER WEEK _____

HOURS WORKED PER WEEK _____

VEHICLE (S)

DO YOU OWN A VEHICLE (S)? _____ NUMBER OF HOUSEHOLD
VEHICLES _____

MAKE _____ MODEL _____ YEAR _____

IS THERE A PAYMENT ON THIS VEHICLE? _____ AMOUNT \$ _____

WHERE (TOWN) IS THIS VEHICLE REGISTERED? _____

MAKE _____ MODEL _____ YEAR _____

IS THERE A PAYMENT ON THIS VEHICLE? _____ AMOUNT \$ _____

WHERE (TOWN) IS THIS VEHICLE REGISTERED? _____

MAKE _____ MODEL _____ YEAR _____

IS THERE A PAYMENT ON THIS VEHICLE? _____ AMOUNT \$ _____

WHERE (TOWN) IS THIS VEHICLE REGISTERED? _____

FAMILY HISTORY

NAME OF SPOUSE, EX-SPOUSE OR ESTRANGED

SPOUSE _____ AGE _____

ADDRESS OF ABOVE _____

SOCIAL SECURITY NUMBER _____

DATE AND PLACE OF MARRIAGE _____

DATE AND PLACE OF SEPERATION OR

DIVORCE _____

NAME OF CO-APPLICANT SPOUSE EX-SPOUSE OR ESTRANGED SPOUSE
AGE

ADDRESS OF ABOVE

SOCIAL SECURITY NUMBER

DATE AND PLACE OF MARRIAGE

DATE AND PLACE OF SEPERATION OR
DIVORCE

I UNDERSTAND THAT THE TOWN OF LEE MAY RECOVER THE AMOUNT OF ASSISTANCE PROVIDED ONCE I HAVE RETURNED TO AN INCOME STATUS, WHICH WOULD ALLOW ME TO REIMBURSE THE TOWN OF LEE WITHOUT HARDSHIP. I UNDERSTAND THAT A LIEN WILL BE PLACED ON MY HOME OF TRAILER FOR ANY ASSISTANCE PROVIDED.I HEREBY AFFIRM THAT ALL THE INFORMATION STATED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT I MAY BE SUBJECT TO THE PENALTIES FOR MATERIAL MISREPRESENTATION.

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

ALL ADULT HOUSEHOLD MEMBERS MUST SIGN THE APPLICATION

I AUTHORIZE AND REQUEST ANY RELATIVE, PHYSICIAN, COUNSELOR, MENTAL HEALTH WORKER, LAWYER, BANKER, INSURANCE COMPANY, LOCAL WELFARE OFFICE OR ANY OTHER ORGRANIZATION OR PERSON HAVING INFORMATION CONCERNING MY ELIGIBILITY FOR ASSISTANCE TO FURNISH SUCH INFORMATION TO THE WELFARE DIRECTOR. I HAVE THE RIGHT TO REVIEW SUCH INFORMATION IF I AM NOT SATISFIED WITH THE DECISION. I AUTHORIZE THE TOWN OF LEE WELFARE DIRECTOR OR THEIR AGENT TO RELEASE INFORMATION AS REQUIRED TO THE SOCIAL SECURITY OFFICE SCHOOL PERSONNEL, COMMUNITY ACTION PROGRAM OR ANY PERSON OR ORGANIZATION IN ORDER TO CONDUCT WELFARE BUSINESS.

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

ALL ADULT HOUSEHOLD MEMBERS MUST SIGN APPLICATION

WELFARE WORK PROGRAM

When you are receiving Town Welfare/General Assistance, you will be required to participate in the Workfare program through the Welfare Department. If you have a medical problem that limits the type of duties that you can perform, you will need a medical statement to verify them. If you are physically or mentally unable to participate on the Workfare program, you will need a medical statement to verify this. The medical statement should state the length of time you will need to be excused from the program and for what reason.

While you are on the Workfare Program, you will be expected to perform your duties in a courteous and respectful manner. You are to show respect for the supervisor, and you are expected to do your duties as instructed. If you are dismissed from the Workfare program for any reason (ex. See below), you will be suspended from receiving benefits for 7 days and you will be expected to make up the missed work time before you can apply for future benefits. If you are dismissed for a second time in the period of 6 months, the suspension period will be for 14 days and until lost time has been made up.

Examples of dismissal reasons:

1. Use of foul language
2. Showing disrespect to the Supervisor
3. Refusal to perform the work as instructed
4. Not reporting to work on time or under the influence of alcohol or a substance.
5. Causing a disruption of the work flow

The Workfare program as stated above has been discussed with me and I agree to participate on the Workfare program if requested and assigned to do so. I am aware that willful non-compliance of the Workfare Program will result in disqualification for General Assistance,

Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____

Medical screening for Welfare-Workfare Participation Program

1. Do you have any problems with your knees, back, shoulders or hands? Yes No

Please explain _____

2. Do you have any serious disease now? Yes No

If yes please explain briefly _____

3. Have you been hospitalized for accident/illness Yes No When _____

What type _____

4. Have you ever-received worker's compensation for injuries on the job? Yes No

If yes please briefly explain date and type of injury? _____

5. Have you had a physical exam recently? Yes No

Doctors name _____

6. Do you have a valid driver's license? Yes No

7. Do you have a police record? Yes No If yes explain _____

8. In case of emergency please notify _____

9. Do you take any medications? Yes No _____

10. Do you feel that you physically to join in the participation program? Yes No

I hereby affirm that all the information stated above is true to the best of my knowledge and belief and that I may be subject to the penalties for material misrepresentations, and falsification of any un-sworn document. False representation will affect eligibility or may terminate the amount of assistance I receive and will result in court action.

Signature **Date**

Date: _____

I _____ of _____ social security Number _____, do hereby, swear that I will hold harmless now and forevermore, the Town of Lee, its Board of Selectman, any employee of Town and member of any Town Board, for any medical expenses, loss of time or any difficulty involving a problem with my _____ which occurred prior to my participation in workfare with the Lee.

Witness

Signature of Workfare Participant

The opportunity to do workfare participation has been provided to the above with our knowledge. _____

If you object to signing the above, please explain _____

Income Status

**Income
Monthly Income**

TANF _____
SSI _____
CHILD SUPPORT _____
FOODSTAMPS _____
PAYCHECK _____
WORKERS COMP _____
MISC _____

Total Monthly Income _____

**Expenses
Monthly Output**

Rent _____
Heat _____
Electricity _____
Phone _____
Childcare _____
Doctors _____
Food _____
Car _____
Misc. _____

Total Monthly Output _____

TOTALS

Total Income _____
Total Expense _____
Funds Left _____

Town Of Lee
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Landlord Form

Welfare Rental Verification Form

To the Client: Take this form to your landlord and have him completely fill out all the information needed. **Do not complete this form yourself.**

To the Landlord: This form is used to document who is living in the household. Complete the whole form and return it to the client. **Do not let the client complete this form. Intentional misrepresentation of the household content to assist in Welfare Fraud will be considered Falsification of an Un-sworn Document and will be prosecuted under penalty of the law.**

Tenants Name (s): _____

Tenants

Address _____

Names of all people residing at this residence _____

Number of Bedrooms _____ Date occupancy began _____

Rent Amount _____ Per _____

Rent Includes: Heat _____ Electric _____ Gas _____ Water _____ Other _____

Amount of Deposit Paid _____ By Whom _____

Date last rent paid _____ Amount Paid _____

Is there a government subsidy paid on the tenant's behalf? If Yes give amount frequency and type _____

Is there back rent due? _____ How much? _____

ARE YOU IN ANY WAY RELATED TO THE TENANTS? _____

If you are not incorporated your Social Security number is needed for a yearly 1099 form for IRS.

Social Security number _____

Landlords Signature _____

Telephone Number _____

Landlords Address _____

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MEDICAL REPORT

To the Physician:

_____ has applied to the town of Lee Welfare Department for financial aid to meet his/her basic living needs of rent, food and utilities. It is customary for the participants who are not working to participate in the Town's Workfare Program to work off some of their account balance while they are unemployed. This work can be yard work, street sweeping, dusting in the library, stuffing envelopes and filling etc. This client has stated she/he cannot do any work at all for any length of time. Your completion of this form will verify that the participant is totally disabled at this time.

Thank you for cooperation for completing this form.

1. Is this person disabled? Yes No
2. Please state the diagnosis in order in importance.

3. Is this person able to perform any type of work i.e. filling, yard, work, street sweeping, light housekeeping?

4. Is there a restriction on the amount of time this person can work each day? _____

5. What date did the incapacity start? _____

6. What date is it expected to end _____

DATE

PHYSICIANS SIGNATURE

I hereby request the release by a doctor, hospital, or clinic to the Lee Welfare Department, any information regarding my medical attention, medical history or hospitalization.

Date

Signature of Patient

Town Of Lee
Welfare Department
Mast Road
Lee, NH 03824
Phone (603)969-8251
Fax (603)659-7202

Date: _____

To: _____

RE: _____ who has reported to us that he/she no longer is employed by you or your company.

In order that we may determine his /her eligibility for General Assistance, would you be kind enough to complete the information below and return it to our office as soon as possible?

Your cooperation is greatly appreciated.

Employee home address: _____

Social Security Number _____

1. Date of termination _____

Is this permanent: _____ or temporary _____

2. Reason for termination:

_____ Voluntary (resignation, etc)

_____ Terminated,

Reason(s) _____

_____ Laid Off

_____ Retired

_____ Other

3. Date of last paycheck? _____

Net amount? _____

4. Did the this employee receive money, or will be receiving money, from any other source at the time of termination, such as severance pay, vacation pay, sick pay, workman's compensation, retirement plan or other? _____

If so how much? _____

Signature and Title

Phone Number

Town Of Lee
Welfare Department
Mast Road
Lee, NH 03824
Phone (603)969-8251
Fax (603)659-7202

Date _____

To: _____

RE: _____

The above named person has applied to the Town of Lee for assistance. This person has indicated that he/she is working for you and that he/she will be out of work due to _____ for _____.

The following information is needed to determine this person's eligibility for assistance. Your assistance in completing this form is greatly appreciated.

Welfare Director 659-5414

1. Is this person covered for financial benefits from insurance coverage during this absence time?
2. Does this person have any sick or vacation time that can be used during this absence?
3. Please indicate the last date this person will be receiving a paycheck during this absence _____ Pay check net amount? _____
4. Other _____

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Income Verification Form

To Whom It May Concern:

_____ has applied for assistance from the Town of Lee to meet his/
her basic living needs. He/she has stated that he/she is employed by you. The
following information is needed to determine his/her eligibility for assistance.

Please indicate both gross and net earnings for the last 4 weeks of employment.

PAYCHECK DATE	GROSS EARNINGS	NET EARNINGS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supervisors Signature

Company Name

Address

Phone