MCDJFS PREVENTION, RETENTION AND CONTINGENCY APPLICATION

Applicant _____ Date of Application _____

Street Address _____ Case Number _____

City, State, Zip _____ Phone Number _____

LIST ALL HOUSEHOLD MEMBERS BELOW:

NAME	SSN	RELATIONSHIP	AGE	DOB	SOURCE OF INCOME	MONTHLY INCOME
		SELF				

WHY DO YOU NEED ASSISTANCE? _____

WHAT SERVICE/BENEFIT DO YOU NEED? _____

ARE YOU CURRETNLY EMPLOYED? YES ____ NO ____ EMPLOYER NAME _____

PARENT/GUARDIAN SIGNATURE_____DATE_____

*********************AGENCY USE ONLY*********************

TANF GUIDELINE: 200% FPL

SERVICE/BENEFIT	APPROVE	AMOUNT TO VENDOR	DENY	REASON

WAS PROXY ELIGIBILITY USED: YES: _____ NO: _____

IF YES, SELECT PROGRAM: TANF: _____ SNAP: _____ MEDICAID: _____ CHILD CARE: _____

CASE MANAGER: _____ DATE: _____

SUPERVISOR: _____ DATE: _____