Family Self-Sufficiency Application

Central Falls Family Self-Sufficiency Foundation: DOB__________________

Demographic Information:

SS#____-__-____

Applicants Name (last, First, I) ________________________________

Home Phone # ______________

Address (Street, City, State, Zip) ________________________________

Work Phone # ______________

Marital status

____Married
____Single
____Separated
____Divorced
____Widowed

Race

____ White, non Hispanic
____ Black
____Native American
____Hispanic
____Asian/Pacific Islander
____Other (explain)______________________________

Alternate Phone #

____
____

Education Part I :

High School Grade Completed (circle one):

1 2 3 4 5 6 7 8 9 **10** 11 12 GED

College Completed: 1 2 3 4

Degree Earned: yes no

Associates ____
Bachelors ____

Presently Enrolled In :

___ High School/GED
____College Courses
____Vocational School
____Apprentice Program.
_____other Training Program (s)
Where:___________________________

Date enrolled:______________________

Name of College or University:____
Year Graduated: ___________
Degree or Major:___________
Date Enrolled: ___________

Education Part II

Have you ever been enrolled in a Training Program?
____ Yes (if yes, list courses below indicating whether they were paid for from public or private source or both)
_____ No (if No, go to item 9)

Date when completed:______________________________

If you did not complete the course explain why not:
____
____
____
____
____
____
____

List Courses and Sponsoring Agency	Source of Funds	No. of Mos. In Course	Years Attended	Course Completed Yes/no/date
1.______				
2.______				
3.______				
4.______				
5.______				

Assistance:

Are you receiving AFDC? _____ yes ___._no $__________Monthly

Do you Receive Food stamps? _____ yes _____no $__________ Monthly

Do you receive Medical Assistance? _____ yes _____no

Are you enrolled in the Pathways Program _____yes ____ no

Employment History:

Are you Currently Employed: ____yes (if yes answer the questions below) ___ no

Date Started:__ _____ __
Date Ended: ________
Salary: _______________
Hourly Wage: __ _____per hr.

Name of Company: _____________________
Address:______________________________
____

Hours Worked: _________ Part-time
_________ Full-time

Job Title:____

Are you Currently Employed: ____yes (if yes answer the questions below) ___ no

Date Started:_________ Name of Company: ___________________________________
Date Ended: _________ Address:____
Salary: _______________ ____
Hourly Wage: __________ per hr.

Hours Worked: _________ Part-time Job Title:____

_________ Full-time

Are you Currently Employed: ____yes (if yes answer the questions below) ___ no

Date Started:_________ Name of Company: ___________________________________
Date Ended: _________ Address:____
Salary: _______________ ____
Hourly Wage: __________ per hr.

Hours Worked: _________ Part-time Job Title:____

_________ Full-time

Child Care:

Do you pay child care expenses? _________Yes (If Yes, complete information below)

_________ No (If No, go fill out the section below)

	Child's Name	Age	Type of Childcare In home/outside Home	Hrs per Week	Cost per week
1.					
2.					
3.					
4.					
5.					

List the names of children for whom you would need child care services if you took training courses or assume a full-time job.

1.__________________________________ 2.__________________________________

3. __________________________________ 4. __________________________________

Support Services:

What sources are currently being provided by an agency (i.e., daycare, transportation, counseling) to you and/or members of your household? (use additional sheets if necessary)

Agency   Agency address   telephone #   Name of Contact   How long

1. ____

2. ____

3. ____

Do you have any comments about these agencies? ______________________________

____

If you were selected to participate in the FSS program, what support services would you need?

____ Child Care	____ Other Counseling	____Job Training
____ Transportation Assistance	____ Basic Education	____ Job search
____ Medical Assistance	____ GED Assistance	____ Job Placement
____ Nutrition	____ Higher education	____ Job Preparedness
____ Budgetary	____ Career Counseling	____ Other (specify)
____ Drug/Alcohol Rehab or Counseling		______________________

What kind of Job would you like to have? Registered Nurse______________________________

Are there any reasons that would prevent you from starting training or work now? ____ yes ____ No

Explain: __Daycare might____

Do you require any accommodations for handicap accessibility? ________ yes ________ No
If yes, what accommodations do you need? ______________________________

Do you need TDD?TDY access to our staff? ____________ Yes __________ No

Signature:

I hereby certify and affirm under penalties of perjury that above statements are true and correct. I understand that Central Falls Housing Authority will verify the Statements herein, and I have no objection to inquires being made.

Warning!! Section 1001 of title of the US Code makes it a criminal offense to make willful false statements or misrepresentation to any department or agency of the U.S. as to any matter within its Jurisdiction.

______________________________ ______________________________
Signature of Applicant **Date**