

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 #

_____, Central Falls, RI 02863

Marital status

Race

Alternate Phone #

____ Married
____ Single
____ Separated
____ Divorced
____ Widowed

____ White, non Hispanic
____ Black
____ Native American
____ Hispanic
____ Asian/Pacific Islander
____ Other (explain) _____

Education Part I :

High School Grade Completed (circle one):

Presently Enrolled In :

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

____ High School/GED

____ College Courses

College Completed: 1 2 3 4

____ Vocational School

____ Apprentice Program.

Degree Earned: yes no

____ other Training Program (s)

Where: _____

Associates _____

Bachelors _____

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: _____

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

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?

- | | | |
|---|--|---|
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Other Counseling | <input type="checkbox"/> Job Training |
| <input type="checkbox"/> Transportation Assistance | <input type="checkbox"/> Basic Education | <input type="checkbox"/> Job search |
| <input type="checkbox"/> Medical Assistance | <input type="checkbox"/> GED Assistance | <input type="checkbox"/> Job Placement |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Higher education | <input type="checkbox"/> Job Preparedness |
| <input type="checkbox"/> Budgetary | <input type="checkbox"/> Career Counseling | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> 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