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| *Programa Infantes-Niños Menores de Tres Años de Carolina del Norte* |  |

*Solicitud de Revisión Financiera y Ajuste por Penuria*

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| **Información del Niño:** | | | | | | | | | | | |
| Nombre del Solicitante: | |  | | | | | Fecha de Solicitud: | | | |  |
| Dirección: | |  | | | | | Nombre del Niño: | | | |  |
| Ciudad, Estado, Código Postal: | |  | | | | | Fecha de Nacimiento del Niño: | | | |  |
| Teléfono de casa: | |  | | | | | Coordinador de Servicios: | | | |  |
| Otro Teléfono: | |  | | | | |  | | | |  |
|  | | | | | | | | | | | |
| **Información de Penuria:** | | | | | | | | | | | |
| ***Categoría*** | | | | ***Documentación Provista*** | | | | | | ***Secuelas de la Pérdida y/o Costo*** | |
| **Pérdida de Casa** | | | |  | | | | | |  | |
| **Pérdida de Trabajo** | | | |  | | | | | |  | |
| **Costos Médicos Considerables** | | | |  | | | | | |  | |
| *(Por favor consultar FAQ Ajuste por Penuria de ITP para más información y adjunte la documentación de verificación que se requiere)* | | | | | | | | | | | |
| ***For CDSA Business Office Use Only*** | | | | | **Date Completed Application Received:** | | | | | | |
| Current AGI: | | | Current SFS Percentage: | | | | | | Date of Previous Determination: | | |
| Current Gross Cap: | | | | | Adjusted AGI (if applicable): | | | | | | |
| Recommend Adjustment as outlined below: | | | | | DO NOT recommend adjustment; maintain current SFS%. | | | | | | |
| **Adjusted SFS%:** |  | | | | Reason(s) not approved: | | | | | | |
| **Gross Cap:** |  | | | |  | | | | | | |
| **Date Recommended:** |  | | | |  | | | | | | |
| **Adjustment Time Frame:** |  | | | |  | | | | | | |
| **Required Review Date:** |  | | | |  | | | | | | |
|  | | | | | | | | | | | |
| ***For CDSA Director’s Use Only*** | | | | | | | | | | | |
| Approve Adjustment as recommended above | | | | | Decline adjustment; maintain current SFS%. | | | | | | |
| Approve adjustment with changes below | | | | | Reason(s) not approved: | | | | | | |
| **Adjusted SFS%:** |  | | | |  | | | | | | |
| **Gross Cap:** |  | | | |  | | | | | | |
| **Date Recommended:** |  | | | |  | | | | | | |
| **Adjustment Time Frame:** |  | | | |  | | | | | | |
| **Required Review Date:** |  | | | |  | | | | | | |
|  | | | | | |  | |  | | | |
| CDSA Director’s Signature | | | | | |  | | Date | | | |