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| *North Carolina Infant-Toddler Program* |       |

*Financial Review and Hardship Adjustment Application*

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| **Client Information:** |
| Name of Applicant:  |       | Date of Application: |       |
| Street Address: |       | Child’s Name: |       |
| City, State, Zip: |       | Child’s Birth Date: |       |
| Home Phone: |       | Service Coordinator: |       |
| Other Phone: |       |       |       |
|  |
| **Hardship Information:** |
| ***Category*** | ***Documentation Provided*** | ***Effect of Loss and/or Cost*** |
| **Loss of Home** |       |       |
| **Loss of Job** |       |       |
| **Extensive Medical Costs** |       |       |
| *(Please see ITP Hardship Adjustment FAQ for more information and attach verification documentation as required)* |
| ***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 |