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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 | | | | |