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| *Programme pour nourrissons et tout-petits de Caroline du Nord* |       |

*Application de l’ajustement en cas de difficultés et bilan financier*

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| --- |
| **Information du client:** |
| Nom du demandeur:  |       |  Date de l’application: |       |
| Adresse : |       | Nom de l’enfant: |       |
| Ville, État, Code postal: |       | Date de naissance de l’enfant: |       |
| Téléphone de domicile : |       | Coordonnateur de services: |       |
| Autre téléphone : |       |       |       |
|  |
| **Information sur les difficultés:** |
| ***Catégorie***  | ***Documentation fournie:*** | ***Effet de la perte et/ou du coût*** |
| **Perde de domicile** |       |       |
| **Perte de l’emploi** |       |       |
| **Frais médicaux énormes** |       |       |
| *(Veuillez consulter les Questions Fréquemment Posées (FAQ) concernant l'ajustement des difficultés de ITP pour plus d'informations et attachez les documents de vérification nécessaires)* |
| ***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 |