

**FAYETTE COUNTY
PREVENTION, RETENTION, AND CONTINGENCY PROGRAM (PRC) APPLICATION**

For Agency Use Only

Name of Applicant	Present Address	Case Number	
Social Security Number		Date Sent	Date Returned
Telephone Number Where You Can Be Reached	County	Unique ID	

1. Have you ever received any type of public assistance from a Job & Family Services Department? Yes No If yes, the county Job & Family Services, the type of assistance received and the date received? _____
2. Explain what you need and estimate the amount you are requesting. _____
3. Give the name of other agencies you have contacted for help. _____
4. Have any other agencies helped you with this need? Yes No If yes, name the agency and tell how you were helped. If no, tell why you were not helped. _____
5. Is anyone in your household presently under a sanction or disqualification from any Job & Family Services program? Yes No If yes, give the name and the date the sanction or disqualification began. _____
6. Has anyone in your household quit or refused a job in the last 90 days? Yes No If yes, give name, the date of the quit Or refusal, and the reason for the quit or refusal. _____
7. Are you currently involved with a child protective services system? Yes No If yes, give the name of the agency _____

8. Complete the chart below for anyone living in your home, including yourself. You are required to verify all income for all members of your household.

Name	Relationship	SSN	DOB	Source of Income	Monthly Amt. Of Income
1.					\$
2.					\$
3.					\$
4.					\$
5.					\$
6.					\$
7.					\$
8.					\$

If you are eligible, the agency will limit assistance under this program to the actual documented amount of need.

Signature of Applicant	Date
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For Agency Use Only
PREVENTION, RETENTION, AND CONTINGENCY PROGRAM (PRC) FOR STATE MODEL

No. of Adults _____ Children _____ Case No. _____

Date Application received (mm/dd/yr) _____ 30 day budget period (mm/dd/yr) _____ to (mm/dd/yr) _____

Request. List the benefits and/or services requested and the amount need for each.

Benefit or Service	Amount Needed	Benefit or Service	Amount Needed
1.	\$		\$
2.	\$		\$
3.	\$		\$
4.	\$		\$
5.	\$		\$

Reason For Need: _____

Community Resources. List the community resources explored to meet this need. If any are utilized, complete the chart.

Agency	Amount	Benefit/Service
1.	\$	
2.	\$	

Income.

Source	Amount Available In Budget Period	Verification
1.	\$	
2.	\$	
3.	\$	
4.	\$	
5.	\$	
6.	\$	

Total _____ (Compare to 100%, 150%, 200%, or 400% of Federal Poverty Guideline)

* **PRC Approved.** Complete chart. Check/Warrant # (Date) _____ (___/___/___) Check/Warrant Amount \$ _____

Item/Service Provided	Date of Approval	Amount Paid	Vendor's Name and Address
		\$	
		\$	
		\$	

* **PRC Denied** Date of denial (mm/dd/yr) _____ Date Notice of Denial of Application sent (mm/dd/yr) _____

Reason for Denial: _____

Signature of Caseworker	Date	Signature of Supervisor	Date
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Fayette County Department of Job and Family Services

Supportive Services Self-Declaration for Eligibility

Supportive Service

1. Gross amount of income earned/received in past 30 days

\$ _____ Source _____

\$ _____ Source _____

\$ _____ Source _____

\$ _____ Source _____

2. If declaring "0" income, please explain how basic needs were met:

3. Do you have a Medicaid Card?

Yes _____ Medicaid Card# _____

No _____

Signature of Applicant_ Date

Witness Signature

