

Temporary Assistance for Needy Families

Disaster Relief Application

The goal of this program is to provide disaster related services for TANF eligibles which will enhance quality of life. In order for us to fund the services through this program, we must ask you to complete the following questions. Complete the chart below for anyone living in your home, including yourself. **You are required to verify all income received in the 30 days prior to the application date.**

Name	SS#	DOB	Relationship to Applicant	Source of Income	Monthly Amount of Income
Street Address			Home Phone		
City, State, Zip			Work Phone		

1. Applicant and all Assistance Group (AG) members are residents of Highland County? Yes No
2. Does the applicant currently have a minor child(ren) residing in the home? Yes No
3. Are you a non-custodial parent that is cooperating with the Child Support Enforcement Agency? Yes No
(If yes, please include the child's name and information above.)
4. All AG members are citizens or lawful resident aliens? Yes No
5. Does any AG member have an outstanding OWF or PRC fraud overpayment? Yes No
6. Are any AG members currently ineligible for Food Stamps due to Intentional Program Violation? Yes No
7. Has any AG member been found to have fraudulently misrepresented their residence to obtain benefits in two or more states (within the last ten years)? Yes No

The total gross income must be equal to or less than the 200% monthly Federal Poverty Guideline amount for appropriate household size.

Family Size/AG	Monthly Income
1	\$1,552.00
2	\$2,082.00
3	\$2,612.00
4	\$3,142.00
5	\$3,672.00
6	\$4,202.00
7	\$4,732.00
8	\$5,262.00

I am applying for TANF funded services available through the Highland County Department of Job and Family Services. For reporting purposes, I understand that my application and information will be shared with the Ohio Department of Job and Family Services and the Highland County Department of Job and Family Services.

I hereby certify that the above is an accurate statement of my household income. I understand that this application will be used in applying for federal programs. I further understand that should I be denied services, I have the right to a County Conference by calling (937) 393-4278 ext. 215.

Signature of Applicant _____ Date _____

FOR AGENCY USE ONLY

HIGHLAND COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES

Date Application Received (mm/dd/yr) _____ (The budget period is for the 30 days prior to the date of application.)

Income		
Source	Total Amount Available In Budget Period	Verification

Total income of 30 days prior to date of application. _____ (Compare to 200% of Federal Poverty Guideline)

DETERMINATION OF CASEWORKER:

Approved and eligible.

Approved - Date approval sent _____

Denial - Date denial sent _____

Reason for Denial: _____

Signature of eligibility determiner/Contract Provider

_____ Date _____

HIGHLAND COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES

Adult Disaster Assistance

The goal of this program is to provide disaster related services for **non-TANF** eligibles which will enhance quality of life. In order for us to fund the services through this program, we must ask you to complete the following questions. Complete the chart below for anyone living in your home, including yourself. **You are required to verify all income received in the 30 days prior to the application date.**

Name	SS#	DOB	Relationship to Applicant	Source of Income	Monthly Amount of Income
Street Address			Home Phone		
City, State, Zip			Work Phone		

1. Applicant and household members are residents of Highland County? G Yes G No **AND**
2. Is individual aged 55 or older and childless? G Yes G No **AND/OR**
3. Is individual childless and in receipt of disability benefit payments such as SSI, SSDI, VA Disability, PERS Disability? G Yes G No
(If yes, please state which disability assistance received _____)
4. Has individual been adversely affected by the emergency condition? G Yes G No **AND**
5. Is individual in need as defined by Highland County (**at or below 200% of FPG**)? G Yes G No

The total gross income must be equal to or less than the 200% monthly Federal Poverty Guideline amount for appropriate household size.

Family Size/AG	Monthly Income
1	\$1,552.00
2	\$2,082.00
3	\$2,612.00
4	\$3,142.00
5	\$3,672.00
6	\$4,202.00
7	\$4,732.00
8	\$5,262.00

I am applying for non-TANF, Adult Disaster Assistance funded services available through Highland County Department of Job and Family Services. For reporting purposes, I understand that my application and information will be shared with the Ohio Department of Job and Family Services and the Highland County Department of Job and Family Services.

I hereby certify that the above is an accurate statement of my household income. I understand that this application will be used in applying for federal programs. I further understand that should I be denied services, I have the right to a County Conference by calling (937) 393-4278 ext. 215.

Signature of Applicant _____ Date _____

FOR AGENCY USE ONLY

HIGHLAND COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES

Date Application Received (mm/dd/yr) _____ (The budget period is for the 30 days prior to the date of application.)

Income		
Source	Total Amount Available In Budget Period	Verification

Total income of 30 days prior to date of application. _____ (Compare to 200% of Federal Poverty Guideline)

DETERMINATION OF CASEWORKER:

Approved and eligible.

Approved - Date approval sent _____

Denial - Date denial sent _____

Reason for Denial: _____

Signature of eligibility determiner/Contract Provider

_____ Date _____