

FAMILY SELF SUFFICIENCY APPLICATION
Pickaway Metropolitan Housing Authority

Date _____

HOUSEHOLD DEMOGRAPHIC AND COMPOSITION

Applicant's Name: _____

Address: _____

Mailing Address (if different): _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Emergency Phone # and Name _____

Married?: Yes _____ No _____

Please list all family members who will be living in your housing unit:

NAME (first, last)	Relationship	Age	Sex
1.	Self		
2.			
3.			
4.			
5.			
6.			
7.			

Are there any other adult family members who will want to participate in the Family Self Sufficiency Program? Yes _____ No _____

EDUCATION

Highest School Grade Completed (circle one): 1 2 3 4 5 6 7 8 9 10 11 12 GED/ College 1 2 3 4

Presently enrolled in: _____ High School GED
 _____ College Courses
 _____ Vocational School
 _____ Apprenticeship Program (Describe) _____
 _____ Other Training Program (Describe) _____

Have you ever been enrolled in a training or vocational course? (example: computer class)

_____ Yes (if Yes, list courses on the following page indicating whether they were paid for from public or private sources, or both)

_____ No

_____ Date when completed _____

_____ If you did not complete the course, why not? _____

FAMILY SELF SUFFICIENCY APPLICATION
Pickaway Metropolitan Housing Authority

List Courses	Source of Funds:		Number of Months in Course	Years/qrt.s Attended	Course Completed:	
	Public	Private			Yes – Date	No

HOUSEHOLD INCOME

If you are currently employed, list current job/occupation. If not currently employed write N/A.

Salary \$ _____ per week	Employer: Occupation:
Hours: Part Time _____ Full Time _____	How Long Employed in this Position? Years: _____ Months: _____

List Previous four jobs held (if you have never been employed write N/A)

1. Salary \$ _____ per week	Employer: Occupation:
Hours: Part Time _____ Full Time _____	How Long Employed in this Position? Years: _____ Months: _____
2. Salary \$ _____ per week	Employer: Occupation:
Hours: Part Time _____ Full Time _____	How Long Employed in this Position? Years: _____ Months: _____
3. Salary \$ _____ per week	Employer: Occupation:
Hours: Part Time _____ Full Time _____	How Long Employed in this Position? Years: _____ Months: _____
4. Salary \$ _____ per week	Employer: Occupation:
Hours: Part Time _____ Full Time _____	How Long Employed in this Position? Years: _____ Months: _____

Are any other family members currently employed? Yes _____ No _____

If yes, please fill out the following information:

Family Member	Job	Rate of Pay (indicate per hour/wk)	
		\$ _____	Per _____

FAMILY SELF SUFFICIENCY APPLICATION
Pickaway Metropolitan Housing Authority

Are there any reasons that would prevent you from starting training or work now? _____

What resources are currently being provided by any agency (i.e., daycare, transportation, counseling) to you and/or members of your household?

Agency	Resource (food stamps, etc.)

Do you have any comments about these providers? _____

CHILD CARE

Do you pay child care expenses: Yes _____ (if yes, complete information below) No _____

Child's Name	Age	Type of Child Care: <u>In Home</u>	<u>Outside</u>	Hrs. Per/week	Cost Per/ week
			<u>Home</u>		

List the names of children for whom you would need child care services if you took training/school courses or assume a full-time or part-time job: _____

Please check the different agencies you have visited or received services from in the last six months.

- | | | |
|---|-----------------------------|------------------------|
| _____ Health Department, doctor or clinic | _____ PICCA | _____ Shelter |
| _____ JOBS One-Stop | _____ Job Training Prog. | _____ Mental Health |
| _____ Food Pantry | _____ Head Start | _____ PCJFS |
| _____ PARS (Alcohol/drug Prog.) | _____ Free Meals Prog. | _____ Children's Serv. |
| _____ Vocational/Tech school | _____ Community College | _____ Childcare/CCC |
| _____ ABLE (GED assistance) | _____ Transportation Assist | _____ Reading Skills |
| _____ Career Counseling | _____ Other (list) _____ | |

Do you receive food stamp benefits? _____ If yes, how much is your monthly benefit? _____

Do you receive Medicaid? (Healthy Start, Healthy Family...) _____

FAMILY SELF SUFFICIENCY APPLICATION
Pickaway Metropolitan Housing Authority

Will you need any of the above resources in the near future or resources that are not listed? Please
list: _____

Do you now work with one person or a case manager who helps you and your family find the services you need? _____ Yes _____ No
If yes, please list the person's name and agency: _____

What are the two or three biggest problems that YOU and/or YOUR FAMILY are facing now? _____

What kind of job would you like to have? _____

Do you require any accommodations for handicap accessibility? _____ Yes _____ No

If yes, what accommodations do you need? _____

Do you need TDD/TDY access to our staff? _____ Yes _____ No

SIGNATURE (Please read and sign below)

I HEREBY CERTIFY AND AFFIRM UNDER PENALITIES OF PERJURY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT. I UNDERSTAND THAT THE PICKAWAY METRO HOUSING AUTHORITY WILL VERIFY THE STATEMENTS HEREIN, AND I HAVE NO OBJECTIONS TO INQUIRIES BEING MADE.

WARNING!! SECTION 1001 OF TITLE 18 OF THE U.S. CODE MAKES IT A CRIMINAL OFFENSE TO MAKE WILFUL FALSE STATEMENTS OR MISREPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE U.S. AS TO ANY MATTER WITHIN ITS JURISDICTION.

Signature of Applicant

Date