

Charlotte Area Fund, Inc.
General Application For Services

Date: _____ Social Security No. (Last 4 digits) _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Primary Phone #: _____ Cell/Alt. Phone #: _____

Gender: M F Race: _____ Date of Birth: _____

Emergency Contact Name: _____ Phone#: _____

Contact Address: _____ City: _____ State Zip: _____

Please Circle All That Apply

Housing Status: Homeowner / Private Renter / Homeless / Subsidized Housing / Transitional/ Shelter

Education Level:

- 0 - 8th
- 9th - 12th (non-graduate)
- High School Graduate
- High School Equivalency Diploma, i.e. GED
- College (non-graduate)
- College/Technical (Graduate)
- Post Graduate

Family Type:

- Single Parent (female)
- Single Parent (male)
- Two-Parent Household
- Single Person
- Two Adults (No Children)
- Other:

Family/Household Size:

- One
- Two
- Three
- Four
- Five
- Six
- Seven
- Eight or More

of Applicant's Tax Dependents _____

Family/Household Members

Name	DOB	Relationship to Client	Last 4 Digits of SS#	Income Amt/Period	Source
Applicant					

Household Source of Income and Monthly Amount:

- No Income
- Employment Wages \$ _____ per _____
- Retirement / Pension \$ _____ per _____
- Social Security \$ _____ per _____
- SSI \$ _____ per _____
- TANF \$ _____ per _____
- Unemployment \$ _____ per _____
- VA \$ _____ per _____
- Child Support \$ _____ per _____
- Food Stamps \$ _____ per _____
- Other \$ _____ per _____
- Total:** \$ _____

- Disabled:** Yes / No
- Health Insurance:** Yes / No
- Veteran:** Yes / No
- Medicaid** Yes / No
- Farmer** Yes / No
- Seasonal Farmworker** Yes / No
- Migrant Farmworker** Yes / No

Employment Information: Circle All That Apply

- Unemployed (seeking a job)
- Underemployed (seeking better job)
- Employed (Full-Time @30+ hours/wk)
- Employed (Part-Time @<30 hours/wk)

Employment History (most recent): Please attach a resume if available

Current/Previous Employer: _____	Hours/week: _____
Address: _____	Phone #: _____
Job Title: _____	Job Start Date: _____
Rate of Pay: _____	Job End Date: _____
Previous Employer: _____	Hours/week: _____
Address: _____	Phone #: _____
Job Title: _____	Job Start Date: _____
Rate of Pay: _____	Job End Date: _____
Previous Employer: _____	Hours/week: _____
Address: _____	Phone #: _____
Job Title: _____	Job Start Date: _____
Rate of Pay: _____	Job End Date: _____

Special Training/Skills: 1. _____ 2. _____ 3. _____
4. _____ 5. _____

CAF General Application For Services

Services Needed: Circle All That Apply

- | | | |
|------------------------------|--------------------------|--------------------|
| 1. Employment | 5. Medicine | 9. Housing Repairs |
| 2. Rent/Mortgage Assistance | 6. Bill Assistance | 10. Other _____ |
| 3. Emergency Food | 7. Training Skills | |
| 4. Transportation Assistance | 8. Education Enhancement | |

SELF-DECLARATION OF INCOME

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE TOTAL INCOME FOR MY FAMILY/HOUSEHOLD WAS \$ _____ AND DID NOT EXCEED \$ _____ FOR THE PAST 12 MONTHS.

CERTIFICATION AND WAIVER OF PRIVACY RIGHTS STATEMENT

I further certify that all information provided herein is true to the best of my knowledge. I am aware that this information is subject to review and verification and I may have to provide documents to support it. I am aware that I may be denied assistance if I am found ineligible. I am aware that I may be prosecuted if I have knowingly given false information in order to receive assistance. I have been notified of my right to appeal any denial of service or assistance for which I may be eligible, and the procedure for appeal.

I allow release of information contained herein for purposes of verification.

Applicant's Signature: _____	Date: _____
Interviewer's Signature: _____	Date: _____

Statement of Eligibility

Persons who apply to the Charlotte Area Fund, Inc. for services must be at or below income limits set for each program. Based on the information you have provided CAF, I have determined you are:

- ELIGIBLE**
- INELIGIBLE due to one or more of the following:**
 - Over income status per income guidelines.
 - Voluntary Withdrawal/Customer Requested Case Be Closed
 - Proof of Eligibility Not Provided/Required Information Not Provided
 - Other _____

This determination may be changed if additional information verifies that your income is over/under the income guidelines for eligibility.

_____ CAF Staff Signature	_____ Title
_____ Date	

PROCEDURES FOR REQUESTING AN APPEAL IF YOU ARE DENIED SERVICES

1. If for any reason a customer/client is denied services, a written notice must be sent to the customer/client within **10 days** from the date of the denial. The written notice will include reasons for denial of assistance, the opportunity to submit additional written information that may favorably determine eligibility, and the deadline for submitting such information. Where feasible, the CAF staff member and supervisor should speak with the individual to provide further explanation of the reasons for denial.
2. If not satisfied with the explanation provided, the customer/client may appeal the decision by submitting a written appeal and support documents within **7 days** to the following address:

**Programs Director
Charlotte Area Fund, Inc.
PO Box 34188
Charlotte, NC 28234-4188**

The customer/client may request a hearing to provide additional information for re-evaluation of the individual's eligibility determination. The hearing will be held within **7 days** of the written request to the agency. Prior to the hearing or at the time of the hearing, the customer/client should provide additional information for the over-rule of the denial.
3. Once the new/updated information is received and reviewed by the Programs Director, the customer/client will be notified in writing within **7 days** after the hearing of the appeal decision regarding the eligibility status for the service previously denied.
4. If the customer/client is not satisfied with the Programs Director's decision, the customer/client may appeal the verdict by submitting a written appeal and support documents within **7 days** of receipt of the Programs Director's decision to the Executive Director at the above address. The Executive Director will review the information and notify the customer/client within **7 days** after receipt of the information of the appeal decision regarding the eligibility status for the service previously denied.
5. If the customer/client is dissatisfied with the decision of the Executive Director, the customer/client may submit a final written request for an appeal within **7 days** of receipt of the Executive Director's verdict to the Charlotte Area Fund, Inc. Board of Directors for a decision regarding the denied services. The Board of Directors will review the information and notify the customer/client within **14 business days** after receipt of the information of their appeal decision regarding the eligibility status for the service previously denied. The Board of Directors' decision is final.