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| *Programa Infantes-Niños Menores de Tres Años de Carolina del Norte*  |       |

*Solicitud de Revisión Financiera y Ajuste por Penuria*

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| **Información del Niño:** |
| Nombre del Solicitante:  |       | Fecha de Solicitud: |       |
| Dirección: |       | Nombre del Niño: |       |
| Ciudad, Estado, Código Postal: |       | Fecha de Nacimiento del Niño: |       |
| Teléfono de casa: |       | Coordinador de Servicios: |       |
| Otro Teléfono: |       |       |       |
|  |
| **Información de Penuria:** |
| ***Categoría*** | ***Documentación Provista*** | ***Secuelas de la Pérdida y/o Costo*** |
| **Pérdida de Casa** |       |       |
| **Pérdida de Trabajo** |       |       |
| **Costos Médicos Considerables** |       |       |
| *(Por favor consultar FAQ Ajuste por Penuria de ITP para más información y adjunte la documentación de verificación que se requiere)* |
| ***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 |