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| *Programme pour nourrissons et tout-petits de Caroline du Nord* |  |

*Application de l’ajustement en cas de difficultés et bilan financier*

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| **Information du client:** | | | | | | | | | | | |
| Nom du demandeur: |  | | | | | | Date de l’application: | | | |  |
| Adresse : |  | | | | | | Nom de l’enfant: | | | |  |
| Ville, État, Code postal: |  | | | | | | Date de naissance de l’enfant: | | | |  |
| Téléphone de domicile : |  | | | | | | Coordonnateur de services: | | | |  |
| Autre téléphone : |  | | | | | |  | | | |  |
|  | | | | | | | | | | | |
| **Information sur les difficultés:** | | | | | | | | | | | |
| ***Catégorie*** | | | | ***Documentation fournie:*** | | | | | | ***Effet de la perte et/ou du coût*** | |
| **Perde de domicile** | | | |  | | | | | |  | |
| **Perte de l’emploi** | | | |  | | | | | |  | |
| **Frais médicaux énormes** | | | |  | | | | | |  | |
| *(Veuillez consulter les Questions Fréquemment Posées (FAQ) concernant l'ajustement des difficultés de ITP pour plus d'informations et attachez les documents de vérification nécessaires)* | | | | | | | | | | | |
| ***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 | | | |