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| *Pwogram pou Tibebe ak Timoun Piti Karolin Dinò* |  |

*Aplikasyon pou Revizyon Finansye ak Ajisteman pou Difikilte*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Enfòmasyon Kliyan:** | | | | | | | | | | | |
| Non Aplikan an: |  | | | | | | | Dat Aplikasyon an: | | |  |
| Adrès lari: |  | | | | | | | Non Timoun nan: | | |  |
| Vil, Eta, Kòd Postal: |  | | | | | | | Dat nesans timoun nan: | | |  |
| Telefòn lakay: |  | | | | | | | Kowòdinatè Sèvis: | | |  |
| Lòt Telefòn: |  | | | | | | |  | | |  |
|  | | | | | | | | | | | |
| **Enfòmasyon sou difikilte:** | | | | | | | | | | | |
| ***Kategori*** | | | | ***Dokimantasyon yo bay*** | | | | | | ***Efè Pèt ak/oswa Pri*** | |
| **Pèt Kay** | | | |  | | | | | |  | |
| **Pèt Travay** | | | |  | | | | | |  | |
| **Depans Medikal Ki Anpil** | | | |  | | | | | |  | |
| *(Tanpri gade FAQ sou Ajisteman Difikilte ITP pou plis enfòmasyon epi tache dokiman verifikasyon jan sa nesesè)* | | | | | | | | | | | |
| ***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 | | | | |