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| ***نارتھ کیرولینا انفینٹ-ٹوڈلر پروگرام*** |  |

***مالیاتی جائزہ اور مشکل ایڈجسٹمنٹ کی درخواست***

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| **کلائنٹ کی معلومات:** | | | | | | | | | | | |
| درخواست دہندہ کا نام: |  | | | | | | | درخواست کی تاریخ: | | |  |
| اسٹریٹ کا پتہ: |  | | | | | | | بچے کا نام: | | |  |
| شہر، ریاست، زپ: |  | | | | | | | بچے کی تاریخ پیدائش: | | |  |
| گھر کا فون: |  | | | | | | | سروس کوآرڈینیٹر: | | |  |
| دیگر فون: |  | | | | | | |  | | |  |
|  | | | | | | | | | | | |
| **مشکلات کی معلومات:** | | | | | | | | | | | |
| ***زمرہ*** | | | | ***فراہم کردہ دستاویزات*** | | | | | | ***نقصان اور/یا لاگت کا اثر*** | |
| **گھر سے محرومی** | | | |  | | | | | |  | |
| **ملازمت چھوٹنا** | | | |  | | | | | |  | |
| **وسیع طبی اخراجات** | | | |  | | | | | |  | |
| *(براہ کرم مزید معلومات کے لیے ITP مشکلات کو ایڈجسٹ کرنے سے متعلق اکثر پوچھے جانے والے سوالات دیکھیں اور ضرورت کے مطابق تصدیقی دستاویزات منسلک کریں)* | | | | | | | | | | | |
| ***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 | | | | |