WORK FIRST EMERGENCY ASSISTANCE APPLICATION

County Name: _____
Date of Application: _____

Applicant Name: _____

Address: _____ Telephone: _____

_____

Case/ Reference No.: _____ Worker's Name: _____

HOUSEHOLD: List all household members requesting Emergency Assistance:

(Non-applicant household members are not required to provide a social security number, immigrant /citizenship status)

Name	Date of Birth	Sex	Social Security No. (if included in application)	U.S.Citizen Or Qualified Immigrant	Relationship

Does the household include a child who meets the Work First age requirement? ☐ Yes ☐ No

Is the child living with an adult who meets the Work First kinship requirement? ☐ Yes ☐ No

Has anyone listed on the EA Application ever received EA? ☐ Yes ☐ No If yes, when: _____

Does anyone live in the home that is not listed on the EA Application? ☐ Yes ☐ No

If yes, is the individual(s) a roomer/boarder? ☐ Yes ☐ No

Document the applicant's statement regarding individual(s) excluded from the EA Application:

_____

_____

_____

Describe the emergency/crisis situation:

_____

_____

The North Carolina Division of Social Services does not discriminate against any person on the basis of race, color, national origin, disability, sex, religion or age in the admission, treatment, or participation in its programs, services and activities, or in employment.

RESOURCES: List all resources owned by the individuals listed on the EA Application.

Name	Cash On Hand	Checking Account	Savings Account
Sub-Totals			

Total Resources (**Add sub-totals**) $_____ Resource eligible for EA? ☐ Yes ☐ No

INCOME: List below the gross earned and unearned income for each household member.

Name	Income Type	Source	Gross Monthly Amount
		Total Countable Income	

Income eligible ☐ Yes ☐ No (**Income limits 150% or 200% of Federal Poverty Limit**)

Disposition: ☐ Approved ☐ Withdrawn ☐ Denied

Reason denied: _____

_____

ASSISTANCE PROVIDED*: List below the assistance provided through Work First EA.

***Limited to non-recurring, short-term benefits designed to deal with a specific episode of need.**

Paid To	Date Authorized	Check Amount	Purpose
	Total EA		

Document referrals made to agencies/community resources for additional assistance to help alleviate the emergency:

_____

_____

_____

Your Rights: You have the right to appeal for a hearing if you were denied the right to apply, if you believe the amount of your assistance is incorrect, or if your application was denied. You have the right to withdraw your application.

Applicant Statement: I understand that it is against the law for me to make false statements and that I am subject to prosecution if I do. I declare under penalty of perjury (and being subject to prosecution under 28 U. S. C. § 1746) that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I certify, under penalty of perjury, that all persons for whom I am applying are U.S. citizens or qualified immigrants. I give the agency permission to verify any information necessary to determine my eligibility for Emergency Assistance.

Applicant's Signature: _____ Date: _____

Caseworker's Signature: _____ Date: _____