



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 CHILDREN'S DIVISION
CHAFEE PROGRAM SUPPORT APPLICATION

**TO BE COMPLETED
 BY APPLICANT**

NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RACE		
CURRENT ADDRESS				
CITY		STATE	ZIP CODE	
TELEPHONE NUMBER		MESSAGE PHONE (IF APPLICABLE)		
NAME OF HEAD OF HOUSEHOLD		HOW MANY RESIDE IN CURRENT HOUSEHOLD		
RELATIONSHIP TO HOUSEHOLD MEMBERS		DATE RELEASED FROM CD CUSTODY CARE	AGE AT TIME OF DISCHARGE FROM OUT-OF-HOME CARE	
ADDRESS OF LAST OUT-OF-HOME CARE PLACEMENT			WHAT COUNTY ARE YOU ORIGINALLY FROM	
LAST SCHOOL GRADE COMPLETED	NAME OF SCHOOL	DATE OF GRADUATION	DATE OF HISET	
ARE YOU CURRENTLY EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	PLACE OF EMPLOYMENT			
EMPLOYER'S ADDRESS			EMPLOYER'S TELEPHONE NUMBER	
NO. OF HOURS WORKED PER WEEK	WEEKLY SALARY	JOB DUTIES/RESPONSIBILITIES		
LANDLORD'S NAME (IF APPLICABLE)			LANDLORD'S TELEPHONE NUMBER	
MONTHLY RENT	YOUR PORTION OF THE RENT	DATE DUE		
MONTHLY UTILITY BILLS	YOUR PORTION OF THE UTILITY BILLS	DATE DUE		
MONTHLY TELEPHONE BILL	YOUR PORTION OF THE TELEPHONE BILL	DATE DUE		
DID YOU/DO YOU RECEIVE MONEY FROM SOMEONE ELSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	TEMPORARY ASSISTANCE	FUTURES	FOOD STAMPS <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER SOURCES
HOW DID YOU PAY RENT THIS MONTH?				
HOW DID YOU PAY YOUR UTILITY BILL?				
HOW DID YOU PAY YOUR TELEPHONE BILL?				
HOW DID YOU PAY FOR FOOD?				
WHAT OUTSTANDING BILLS DO YOU HAVE?				
DO YOU HAVE TRANSPORTATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT IS YOUR TRANSPORTATION?		
WHAT ARE YOUR CURRENT HEALTH CONCERNS OR MEDICAL NEEDS?				
DO YOU HAVE HEALTH INSURANCE OR A MEDICAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF HEALTH PLAN		
DATE OF LAST PHYSICAL		DATE LAST SEEN BY DOCTOR FOR OTHER REASONS		
WHAT ACCESS TO MEDICAL CARE DO YOU HAVE IN YOUR AREA?				
WHAT MEDICATIONS DO YOU TAKE REGULARLY? WHAT IS YOUR MENTAL HEALTH DIAGNOSIS?				

ARE YOU CURRENTLY ATTENDING HIGH SCHOOL, ON THE JOB TRAINING, VOCATIONAL SCHOOL OR COLLEGE/UNIVERSITY?

YES NO

IF SO, WHAT AND WHERE?

WHAT ARE YOUR EDUCATIONAL GOALS?

WHAT JOB SKILLS ARE YOU INTERESTED IN?

WHAT COMMUNITY/FAMILY RESOURCES HAVE YOU LOOKED INTO OR USED?

WHEN WAS YOUR LAST COMMUNITY/FAMILY CONTACT?

WHAT OTHER RESOURCES HAVE YOU USED?

WHAT ARE YOUR NEEDS RIGHT NOW?

WHERE DO YOU SEE YOURSELF IN ONE MONTH?

SIX MONTHS?

ONE YEAR?

FIVE YEARS?

WHAT RESOURCES WILL YOU NEED TO GET THERE?

WHAT ARE YOUR STRENGTHS?

WHAT ARE YOUR HOBBIES?

DO YOU HAVE: STATE ID CARD CERTIFIED COPY OF BIRTH CERTIFICATE CALENDAR FOR WRITING DOWN APPOINTMENTS
 DRIVER'S LICENSE SOCIAL SECURITY CARD EMERGENCY PHONE LIST

WHAT WOULD YOU LIKE FOR THE CHAFEE FOSTER CARE INDEPENDENCE PROGRAM TO DO FOR YOU?

ARE YOU WILLING TO ACCEPT PERSONAL RESPONSIBILITY FOR ASSISTING IN THE DESIGNING OF A PLAN WHICH WILL HELP MEET YOUR NEEDS AS YOU STRIVE FOR INDEPENDENCE?
 YES NO

APPLICANT SIGNATURE _____ DATE _____

CHAFEE SPECIALIST/STAFF: CONFIRM AGE OF YOUTH UPON DISCHARGE FROM OUT-OF-HOME CARE

CURRENT AGE OF YOUTH _____ AGE OF YOUTH AT DISCHARGE _____ CONFIRMATION SOURCE _____

SUPPORT APPLICATION APPROVED NOT APPROVED

EXPLAIN WHY NOT APPROVED

ATTACH COPY OF COOPERATIVE AGREEMENT NEGOTIATED WITH YOUTH _____ DATE FIRST COOPERATIVE AGREEMENT UPDATE DUE (WITHIN 90 DAYS) _____

SUBSEQUENT UPDATES

SPECIALIST SIGNATURE/CS STAFF _____ DATE _____ AREA/COUNTY _____

