



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 DIVISION OF FAMILY SERVICES  
**CHAFEE FOSTER CARE INDEPENDENCE 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 DFS CUSTODY		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 GED	
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? \$	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
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**CFCIP SPECIALIST/STAFF: CONFIRM AGE OF YOUTH UPON DISCHARGE FROM OUT-OF-HOME CARE**

CURRENT AGE OF YOUTH	AGE OF YOUTH AT DISCHARGE	CONFIRMATION SOURCE
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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)
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SUBSEQUENT UPDATES

SPECIALIST SIGNATURE/CS STAFF	DATE	AREA/COUNTY
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