

Name of Household Member Receiving Income	Employment or Self-Employment Gross Weekly Income and Employer Name	Weekly Unemployment Benefits	Social Security/SSI Monthly Benefits	K-TAP Monthly Income	Child Support Monthly Income	Other Income List-Type and Monthly Amount
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Does anyone in your household have any other earnings/income or receive any money not listed above? Yes No
 If yes, list type and amount monthly: _____

Does anyone help you pay your bills? Yes No If yes, list name and monthly amount: _____

WARNING: Section 1001, of Title 18 of the U.S. code, makes it a criminal offense to make willful false statements or misrepresentation to any department or agency of the United States as to any matter within its jurisdiction.

IV. Household Assets:

Does anyone in your household have a checking account? Yes No
 Balance \$ _____ Bank Name: _____

Does anyone in your household have a savings account? Yes No
 Balance \$ _____ Bank Name: _____

Does anyone in your household own real estate or property? Yes No
 Type _____ Value _____ Address _____

Does anyone in your household have any of the following: Money Market Account? Yes No; Certificate of Deposit? Yes No; IRA Account? Yes No; Stocks? Yes No; Bonds Yes No; Other (list) _____

Has anyone in your household disposed of an asset for less than Fair Market Value in the past two years? Yes No
 If yes, please list _____

V. Preferences:

This agency gives a preference to households that are DCBS referrals and current clients of Liberty Place, Eastern Scholar House, & RRH clients. Homeless, families with special needs, domestic violence and physical or mentally disabled.

Does your household qualify for this preference? Yes No

VI. Potential Deductions

A. Childcare

Does your household have un-reimbursed child care expenses? Yes No If yes, please give details:
 Provider Name: _____ Provider Phone Number: _____
 Provider Address: _____
 List of Children in Care: _____
 Monthly Amount Paid by Household: \$ _____

B. Medical/disability expenses

Does your household have un-reimbursed medical/disability expenses? Yes No If yes, please give details: _____

APPLICATION FOR ASSISTANCE
Kentucky River Foothills Development Council, Inc.

(1) Provider Name: _____	Provider Phone Number: _____
Provider Address: _____	
Monthly Amount Paid by Household: \$ _____	
(2) Provider Name: _____	Provider Phone Number: _____
Provider Address: _____	
Monthly Amount Paid by Household: \$ _____	

(If additional space is needed, attach an additional sheet.)

VII. Conflict of Interest
Are you an employee or board member of this agency? Yes No

Are you related to an employee or board member of this agency? Yes No

If yes to either question above, please explain:

VIII. Signatures/Certification of True and Correct Information

Upon the return of this completed application, this agency will begin processing your application for assistance. Some programs may have a waiting list, and if so, you will be placed on that list. If you do not qualify, you will be notified in writing.

All adult members of household, 18 years old or older, must sign this application.

I/We hereby certify all information given on this application is true and correct, and that I/we have not knowingly withheld any fact or circumstances which would, if disclosed, affect this application unfavorably. I/We hereby authorize inquiries to be made to verify the information given in this application.

_____ (Applicant Signature)	_____ (Date)
_____ (Spouse Signature)	_____ (Date)

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You may return your application by:
e-mail to padams@foothillscap.org
Fax – 606-723-8208
Mail to KRFDC – 100 Tyler Lane, Irvine, KY 40336

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

**TITLE VI NOTICE OF PROTECTIONS AGAINST
DISCRIMINATION**

In accordance with KRS 344.015, Kentucky River Foothills Development Council, Inc. operates its programs without regard to race, religion, color, sex, age, sexual orientation, national origin, disability, marital status, veteran status, political affiliation, or gender identity.

To request or receive additional information on discrimination obligations, including complaint procedures, please contact the person listed below:

EEO/Affirmative Action Officer:

**Brian Mullins
309 Spangler Drive
Richmond, KY 40475
859-624-2046**

Local Title VI Coordinator:

**Keith Long
309 Spangler Drive
Richmond, KY 40475
859-624-2046**

To file a discrimination complaint, the written complaint must be filed within 5 days of the alleged discrimination. To accommodate limited English proficient individuals, oral complaints to be documented and/or translated may also be given at the above address.

Please Sign and date that you have been notified of your rights regarding Title VI Notice of Protection Against Discrimination, Civil Rights Act of 1964.

Signature

Date