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 ☐ MALE ☐ 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 CARE	AGE AT TIME OF DISCHARGE FROM OUT-OF-HOME
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 ☐ YES ☐ 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? ☐ YES ☐ NO	TEMPORARY ASSISTANCE	FUTURES	FOOD STAMPS ☐ YES ☐ 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? ☐ YES ☐ 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? ☐ YES ☐ 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

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

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