

PART A—TO BE COMPLETED BY APPLICANT OR REPRESENTATIVE Attach sheets as necessary **Please type or print neatly.**

1	YOUR NAME—Last, First, Middle Initial	COUNTY OF RESIDENCE	TELEPHONE NUMBER
	ADDRESS—Street, Apt.#, City, State, Zip	SCHOOL DISTRICT	TOWNSHIP

2 Please explain briefly why you are applying for these services/benefits: _____

3 Has anyone in your household applied for, or is anyone receiving cash assistance, Medicaid, food stamps or TANF? If yes, please provide:

INDIVIDUALS NAME (First Last)	COUNTY	TYPE OF ASSISTANCE
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HOUSEHOLD MEMBERS: Please list the members of your household. Starting with yourself, also list your spouse, and all minor children.

4	1	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YY)	MARITAL STATUS
		LAST NAME	RELATIONSHIP	SEX (M/F)	AGE
	2	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YY)	MARITAL STATUS
		LAST NAME	RELATIONSHIP	SEX (M/F)	AGE
	3	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YY)	MARITAL STATUS
		LAST NAME	RELATIONSHIP	SEX (M/F)	AGE

5 Does anyone on this application use an alias or maiden name? If yes, list the individual's name and the alias/maiden name used.

NAME (First and Last)	ALIAS/MAIDEN NAME
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EMPLOYMENT: Please list gross earned income (before deductions) from a job for anyone included on this application who is working. Include self-employment.

6	1	WHO IS WORKING?		EMPLOYER NAME/INCOME SOURCE		EMPLOYER ADDRESS (Street, City, State, Zip)			
		Start Date (MM/DD/YY)	HOURS/WEEK	PAY RATE	HOW OFTEN PAID? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly	GROSS MONTHLY PAY	HIGHEST GRADE COMPLETED?	
	2	WHO IS WORKING?		EMPLOYER NAME/INCOME SOURCE		EMPLOYER ADDRESS (Street, City, State, Zip)			
		Start Date (MM/DD/YY)	HOURS/WEEK	PAY RATE	HOW OFTEN PAID? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly	GROSS MONTHLY PAY	HIGHEST GRADE COMPLETED?	
	3	WHO IS WORKING?		EMPLOYER NAME/INCOME SOURCE		EMPLOYER ADDRESS (Street, City, State, Zip)			
		Start Date (MM/DD/YY)	HOURS/WEEK	PAY RATE	HOW OFTEN PAID? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly	GROSS MONTHLY PAY	HIGHEST GRADE COMPLETED?	

7 **CERTIFICATION:**

1. I authorize and request the disclosure to the Fulton County Partnership, Inc. or its authorized agent to verify any information that may be desired concerning residence, employment, income, or any other information I have given concerning this application for the Employment Transportation Assistance Program (ETAP). I understand that the information obtained will be used only for purposes directly related to my eligibility for the Employment Transportation Assistance Program.
2. I authorize release of information to _____ involved in providing any services for which I may be eligible.
3. I understand my social security number may be used to check the information on this application and in computer matches with other agencies.
4. I understand that I may follow the grievance procedure if I do not agree with the decision made on this application.

I certify that the information provided on this application is true and correct under penalty of perjury.

SIGNATURE

DATE

PART B—TO BE COMPLETED BY FULTON COUNTY PARTNERSHIP, INC.

FAMILY SIZE	GROSS MONTHLY INCOME:	GROSS ANNUAL INCOME:	235% INCOME LIMIT FOR FAMILY		
TANF STATUS		APPLICATION DATE	EMPLOYEE REVIEW BY (Name)	REVIEW DATE	
<input type="checkbox"/> CURRENTLY TANF <input type="checkbox"/> NEVER TANF <input type="checkbox"/> TANF ELIGIBLE					
ELIGIBILITY					
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> NOT ELIGIBLE, REASON: _____					
CERTIFICATION					
ELIGIBILITY DETERMINED BY:		SIGNATURE: _____		DATE: _____	

PART C— COMMENTS

