



**Arkansas Department of Human Services
Division of Children & Family Services
Assessment for Income Assistance**

I. HOUSEHOLD COMPOSITION

Casehead _____ Case # _____
 _____ SSN _____
 _____ Number of minor children in the household.
 _____ Number of children in foster care, if applicable.
 _____ Number of other adults residing in the household. Please list their relationship: _____

II. REASON FOR ASSISTANCE

- Prevention of foster care placement.
- Reunification of a child who is in foster care.

Describe the family's situation/problems:

III. FAMILY'S SERVICES HISTORY

Income Assistance services only. Please specify the dates, amounts and types (items) of Income Assistance services previously given by DCFS:

<u>Date</u>	<u>Amount</u>	<u>Type</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other DCFS Services:

- Protective Services
- Support Services
- Foster Care Services
- Other, please specify: _____

IV. FAMILY'S FINANCIAL RESOURCES

	Current	Future
Salary/Wages (net monthly amount)		
AFDC		
SSI (Supplemental Security Income)		
Social Security (SSA)		
Housing/Utility Assistance (HUD)		
Food Stamps		
Other (specify)		
TOTAL		

v. FAMILY'S EXPENSES (specify amount for each item)

_____ Housing Cost
 _____ Utilities
 _____ Food

v. **FAMILY'S EXPENSES (specify amount for each item)**

_____ Household Items (Specify): _____
_____ Other expenses (obligations): specify the items and the monthly obligations: _____
_____ Total Amount of Expenses

VI. **INCOME ASSISTANCE REQUEST (specify amount for each item)**

_____ Housing
_____ Food
_____ Utilities: _____ Gas _____ Electricity _____ Water
_____ Medical (less than \$100)
_____ Clothing
_____ Household Goods
_____ Transportation
_____ Other (requires Area Director's approval): _____
_____ Total Amount Requested

VII. **COMMUNITY RESOURCES EXPLORED (list)**

VIII. **PLAN FOR MAINTENANCE (discuss how the family will be able to maintain and meet their own needs in the future)**

IX. **DETERMINATION OF NEED**

The assessment of the family's resources and needs and exploration of other available resources indicates that the children in this family are at risk of entering or remaining in substitute care if Income Assistance is not provided.

Caseworker's Signature _____ Date _____

X. **DISPOSITION OF REQUEST**

Approved Denied Reason _____ Amount Approved _____

County Supervisor's Signature _____ Date _____

Approved Denied Reason _____ Amount Approved _____

Area Director's Signature _____ Date _____