





1860 SW Fountainview Blvd., Suite 200• Port St. Lucie, FL 34986  
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### Exhibit B

#### **Questionnaire and Certification**

1. What is the legal status of the child(ren)?

- In Home
- Voluntary
- Dependency

2. What is the current placement/living arrangement?

- In Home
- Relative
- Non-Relative
- Licensed Foster Care

3. Describe in detail the emergency situation which places the child at risk of removal or need for emergency funding.

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4. Indicate the goods/services necessary to alleviate the emergency of this family.

SERVICE NEEDED	LENGTH OF SERVICE (if applicable)	COSTS
	TOTAL COST REQUESTED:	\$

5. *Community Resources should be exhausted before requesting from the CBC.* List each resource contacted, who DCM/parent/caregiver spoke with, and what the response given for requested services?

- 1)
- 2)
- 3)

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6. How will the services requested above either prevent removal of the child(ren) from the custodial parent/guardian or promote the reunification with the parent?

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7. What steps has the family taken and how are they contributing to remedy their emergency?

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8. Please describe how the family will maintain the new circumstances that will prevent the need for additional emergency support? (I.e. Monthly rent/utilities payment maintained through new employment, medication costs maintained through obtaining Medicaid or insurance etc.)

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9. Please describe how the family will maintain the new circumstances that will prevent the need for additional emergency support? (I.e. Monthly rent/utilities payment maintained through new employment, medication costs maintained through obtaining Medicaid or insurance etc.)

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**CERTIFICATION**

I, \_\_\_\_\_ Dependency Case Manager/Protective Investigator in Circuit 19 attest to the following:

- The information provided in this packet is accurate and true to the best of my knowledge.
- The cost of this request is less than the cost of placing child into licensed foster care.
- Without these approved funds, the child(ren) can and will be removed from parents or the current caregiver OR they will not be reunified with parents.
  
- All community resources have been exhausted. Funds provided by Devereux are the last resort for this family's needs to be satisfied.
  
- The family can maintain their situation after using the approve funds to resolve their immediate emergency.

Worker Signature \_\_\_\_\_

Date\_\_\_\_\_

Supervisor Signature \_\_\_\_\_

Date\_\_\_\_\_

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# Application/Request for Emergency Funding

- 1 FSFN Case Name and Number \_\_\_\_\_  
 2 Family's Current Address \_\_\_\_\_  
 3 Family's Contact Number \_\_\_\_\_

NAME (Last, First Middle Initial)	DOB	Benefits Receiving (Circle all that apply)
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA
		AFDC    Medicaid Foodstamps    SSI/SSA

Combined Monthly Bills	\$	*Please ensure the balance leftover can sustain the family's needs
Rent (or proposed rent)	\$	
Total	\$	
Monthly Income	\$	
Balance Leftover	\$	

A. Is there an emergency situation which puts the child at risk? YES    NO

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B. Is there one or more child(ren) under the age of 18 living in the home? YES    NO

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C. Is the child currently living with or has lived with a relative in a home maintained for the child with the last six months? YES    NO

Relative Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
 Date last living with the above named relative \_\_\_\_\_

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D. Was the emergency caused by an employable child's or parent's refusal to accept employment or training for employment. YES    NO

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E. List type and amount of resources immediately available to meet the emergency.

\_\_\_\_\_

\_\_\_\_\_

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F. Did the child's family have sufficient resources immediately accessible to provide for the emergency? YES    NO



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**Cost Avoidance Calculation**

List separately if you estimate that some of the children would have unequal projected placement costs.

- A. Projected length of stay or extension (# of days or months). \_\_\_\_\_
- B. Number of children in family at risk of placement. X \_\_\_\_\_
- C. Unit cost of placement for each child (indicate daily or monthly rate.) X \_\_\_\_\_
- D. Total projected costs of placement or extension of placement. = \_\_\_\_\_

**(Formula to calculate the Cost Avoidance Calculation: A x B x C = D "projected placement costs avoided")**

TOTAL ANTICIPATED PLACEMENT COSTS (D) \_\_\_\_\_

TOTAL COST OF SERVICES REQUESTED \_\_\_\_\_

Is the total cost of services greater that the amount of available resources? Yes or No

**CURRENT DCF FOSTER BOARD AND RCG RATES**

Item	Age 0-5	Age 6-12	Age 12 - 17
Foster Care Board Rate	\$457.95	\$469.68	\$549.74
Relative Caregiver Payment	\$242	\$249	\$298

Worker Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor \_\_\_\_\_ Date \_\_\_\_\_

**FINANCE DEPARTMENT AUTHORIZATION**

The request for emergency funding is: APPROVED DENIED

Authorizing Signature \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

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# Request for TANF Funds/Eligibility Determination – 2018/2019

**Eligibility Requirement:** To be eligible for the TANF funds: the child/family income must be less than 200% of the federal poverty level; the child must be living in the home of a parent or other specified relative; the individual must be a United States citizen or qualified non-citizen; and the child/family must be residing in Florida.

**Region/CBC Agency:** \_\_\_\_\_  
(Enter Region name [or name of CBC servicing the area] in which child/family reside)

**Date of Request:** \_\_\_\_\_  
(Date Form Initiated)

**Table 1: Information on Children and Adults in Household.**

#	Name	Social Security #	Date of Birth	Citizen or Qualified Non-citizen
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**1) Is (are) child(ren) living with a parent or other specified relative?**

- YES If Yes, continue with item #2; list name of relative and relationship to child:  
 NO If No, child is not eligible for TANF.

**2) Is (are) child(ren) residing in Florida?**

- YES If Yes, continue with item #3.  
 NO If No, child is not TANF eligible.

**3) Is the family currently receiving temporary cash assistance under WAGES or the Relative Caregiver Program?**

- YES If Yes, *financial criteria met*; submit to supervisor/designee for TANF eligibility determination.  
 NO If No, continue with item #4.

**4) Family Income. Information obtained from:**

- Parent/Relative (check one):  Self declaration or  Documented: \_\_\_\_\_  
List documentation [i.e., pay stub, etc.]
- Collateral Source: \_\_\_\_\_  
List the source

*Using information obtained from the parent or specified relative or through available/collateral contact information, make the "best determination possible" of the family's gross income. When income information is not obtained from the family, it may be obtained from the employment history of responsible adults or any prior determination of eligibility for public assistance [i.e., Food Assistance, Temporary Cash Assistance (WAGES), etc.].*

If Item #4 above is checked, this section must be completed:

Determine: (A) What is the family size? \_\_\_\_\_  
 (B) Estimated Family Income: \$\_\_\_\_\_ per  month  year

**Table 2: 200% of the FPL by family size (effective date: July 1, 2018\*)**  
 (For households larger than 10, add \$720 per month or \$8,640 per year for each additional household member.)

HOUSEHOLD SIZE AND FAMILY INCOME										
Household size	1	2	3	4	5	6	7	8	9	10
Monthly Income	2,024	2,744	3,464	4,184	4,904	5,624	6,344	7,064	7,784	8,504
Yearly income	24,280	32,920	41,560	50,200	58,840	67,480	76,120	84,760	93,400	102,040

\*Federal Poverty Guidelines: 2018 Federal Poverty Guidelines (FPG) annual income levels are published in the Federal Register of January 23, 2018.

**SIGNED:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
(Date Form Completed)

**Based on the household information above, the family income is: (check one)**

- Less than 200% of the FPL ... **CHILD/FAMILY IS ELIGIBLE**  
 At or above 200% of the FPL ... **CHILD/FAMILY IS INELIGIBLE**

**SIGNED:** \_\_\_\_\_  
Supervisor or Designee

**Date:** \_\_\_\_\_

Child(ren)'s eligibility was entered into FSFN on (the date): \_\_\_\_\_ Person entering information: \_\_\_\_\_