

**LOUDOUN COUNTY DEPARTMENT OF FAMILY SERVICES  
HOUSING CHOICE VOUCHER DIVISION  
102 HERITAGE WAY, NE, SUITE 103  
LEESBURG, VA 20176  
703-777-0353  
703-737-8895 FAX**



**LOUDOUN COUNTY DEPARTMENT OF FAMILY SERVICES  
FAMILY SELF SUFFICIENCY APPLICATION**

Date \_\_\_\_\_

**A. DEMOGRAPHIC INFORMATION**

1. Applicant's Legal Name (Last, First, MI)		Home Phone #
2. Address (Street, City State, Zip)		Work Phone #
Mailing Address (if different)		
3. Marital Status ___ Married ___ Single ___ Separated ___ Divorced ___ Widowed	4. Race – (Use Race Listed Below) ___ 1. White, Caucasian ___ 2. Black ___ 3. American Indian ___ 4. Hispanic ___ 5. Asian ___ 6. Other	Emergency Phone Number & Name  _____  _____

**B. EDUCATION**

5. Highest School Grade Completed: (circle one)  1 2 3 4 5 6 7 8 9 10 11 12 GED  College 1 2 3 4	6. Presently enrolled in: ___ High School GED ___ College Courses ___ Vocational School ___ Apprentice Program (Describe) _____ ___ Other Training Program(s) (Describe) _____
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7. Have you ever been enrolled in a training or vocational course?

\_\_\_ Yes (if YES, list courses below indicating whether they were paid for from public or private sources, or both)

\_\_\_ No, (if NO, go to item 9)

\_\_\_ Date when completed \_\_\_\_\_

\_\_\_ If you did not complete the course, why not? \_\_\_\_\_

List Courses and Sponsoring Agency (if known)	Source of Funds		Number Months In Course	Years Attended	Course Completed	
	Public	Private			Yes-Date	No
(1)						
(2)						
(3)						
(4)						
(5)						

8. What resources are currently being provided by any agency (i.e., daycare, transportation, counseling) to you and/or members of your household? (Use additional sheets if necessary)

AGENCY	AGENCY ADDRESS	TELEPHONE NUMBER	SERVICE PROVIDER	PERIOD OF SERVICE
(1)				
(2)				
(3)				
(4)				

Do you have any comments about these providers?

**C. HOUSEHOLD COMPOSITION AND INCOME**

9. If you are currently employed, list current job/occupation – if you do not have a job currently, write None

Salary \$ _____ Per Wk.	Employer
Salary \$ _____ Per Hr.	Occupation
Hours: Part Time _____ Full Time _____	How Long Employed in this Position?  YEARS MONTHS

10. List previous four jobs held (if you have never been employed write N/A)

Salary \$ _____ Per Wk.	Employer
Salary \$ _____ Per Hr.	Occupation
Hours: Part Time _____ Full Time _____	How Long Employed in this Position?  YEARS MONTHS
Salary \$ _____ Per Wk.	Employer
Salary \$ _____ Per Hr.	Occupation
Hours: Part Time _____ Full Time _____	How Long Employed in this Position?  YEARS MONTHS
Salary \$ _____ Per Wk.	Employer
Salary \$ _____ Per Hr.	Occupation
Hours: Part Time _____ Full Time _____	How Long Employed in this Position?  YEARS MONTHS

11. Are there any reasons that would prevent you from starting training or work now? ___ YES ___ NO		
12. List People living in your household:		
NAME (first, last)	RELATIONSHIP	DATE OF BIRTH
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
13. Do you receive food stamp benefits? ___ YES ___ NO If yes, how much is your monthly contribution towards food stamps? \$		
14. Do you receive medical assistance? ___ YES ___ NO		
15. Are there any other adults (over 18 years of age) family members who will want to participate in the Family Self Sufficiency Program? ___ YES ___ NO		

**D. CHILD CARE**

16. Do you pay child care expenses? ___ YES (if yes, complete information below.) ___ NO (if no, go to item 18)					
Child's Name	Age	Type of Child Care		Hrs Per Wk	Cost Per Wk
		In Home	Outside Home		
(1)					
(2)					
(3)					
(4)					
17. List the names of children for whom you would need child care services if you took training courses or assume a full-time job.					
(1)	(4)				
(2)	(5)				
(3)	(6)				

E. SUPPORT SERVICES NEEDS

18. If you were selected to participate in this program, what support services would you need?		
<input type="checkbox"/> Child Care	<input type="checkbox"/> Transportation Assistance	<input type="checkbox"/> Medical Care Assistance
<input type="checkbox"/> Education/GED Assistance	<input type="checkbox"/> Job Training	<input type="checkbox"/> Job Search
<input type="checkbox"/> Job Placement	<input type="checkbox"/> Career Counseling	<input type="checkbox"/> Other Counseling
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Reading Skills	<input type="checkbox"/> Math Skills
<input type="checkbox"/> Budgetary	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Job Preparedness
<input type="checkbox"/> Drug/Alcohol Rehab or Counseling		
19. What kind of a job would you like to have?		
20. Do you require any accommodations for handicap accessibility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what accommodations do you need?		
21. Do you need TDD/TDY access to our staff? <input type="checkbox"/> YES <input type="checkbox"/> NO		

F. SIGNATURE (Please read and sign below)

I HEREBY CERTIFY AND AFFIRM UNDER PENALTIES OF PERJURY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT. I UNDERSTAND THAT THE HOUSING AGENCY OF LCDFS WILL VERIFY THE STATEMENTS HEREIN, AND I HAVE NO OBJECTIONS TO INQUIRIES BEING MADE.	
<b><u>WARNING!!</u></b> SECTION 1001 OF TITLE 18 OF THE U.S. CODE MAKES IT A CRIMINAL OFFENSE TO MAKE WILFUL FALSE STATEMENTS OR MISREPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE U.S. AS TO ANY MATTER WITHIN ITS JURISDICTION.	
_____	_____
Signature of Applicant	Date