



TRANSITIONAL SUPPORT ELIGIBILITY and/or Education Training Vouchers (ETV) Funds APPLICATION

USE OF FEDERAL FUNDS

- Attending an eligible institution of higher education part-time:
Use ETV funds first (Can be used for 21 & 22 year olds)
Use Chafee second (Cannot be used for 21 & 22 year olds)
- Adopted at age 16 or 17 and attending any institution of higher education part time:
Use ETV
- Not attending an institution of higher education, but has a Transition Plan:
Use Chafee

Clear

SECTION A: APPLICANT CERTIFICATION

The information I am supplying in this application is true, complete and correct. To the best of my knowledge and belief, I am eligible for this program as defined under Florida law.

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Applicant's Signature _____

Date _____

NOTICE: If you purposely give false information on this form, you may be subject to a fine or imprisonment or both under Section 837.06, Florida Statutes.

SECTION B: DEMOGRAPHIC INFORMATION

It is your responsibility to keep this information current. Should your contact information change please contact _____ at _____.

Questions marked with an asterisk (*) require a response.

1. Social Security Number: _____

NOTICE: Pursuant to the Privacy Act of 1974 [Public Law 93-579], you are not required to provide us social security number(s). However, if you give us your social security number we can determine your eligibility for assistance or services faster and more accurately. Social security numbers are used by the Department for identity verification, income and eligibility verification, and other purposes related to administration of our programs.

2. *First Name: _____ MI: _____ *Last Name: _____

3. Home Phone #: _____ Work Phone #: _____ If applicable, enter "ext." and extension number

4. Email Address: _____

5. *Street Address/PO Box: _____ Apt #: _____

6. *City: _____ *State: _____ *County: _____ *Zip Code: _____

If you were adopted, do not answer #7 and #8; skip to #9.

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7. *At the time of your 18th birthday, will you be or were you adjudicated dependent and in the legal custody of the State of Florida? (Documentation attached) ☐ Yes ☐ No

8. *Did you spend or will you have spent at least 6 months living in foster care before reaching your 18th birthday? ☐ Yes ☐ No

Only answer #9 and #10 if you were adopted through the Florida foster care system.

9. *Were you adopted through the Florida foster care system at age 16 or 17? ☐ Yes ☐ No

10. *Date of your finalized adoption: _____

11. *Date of Birth: _____

12. Gender: ☐ Male ☐ Female

SECTION C: TRANSITION PLAN

In order to be eligible to receive Transitional Support Services, each young adult must demonstrate that the services requested are critical to the young adult's own efforts to achieve self-sufficiency and to develop a personal support system.

For evidence of the young adult's efforts to achieve self-sufficiency, please refer to the attached Transition Plan.

SECTION D: SERVICES TO BE PROVIDED

The following services will be provided to this young adult in order to assist in achieving their plan for achieving self-sufficiency: (These services may include financial, housing, counseling, employment, education and other services.)

Projected Date of Transition Plan achievement (subject to change): _____

Date of next review of the Transition Plan: _____

Reviewing Authority Signature

Title

Date

Approval Administrator (if different from above)

Title

Date

SECTION E: PAYMENT INFORMATION (if receiving Transitional Support Cash Assistance)

If approved, I direct the Department to release funds in the following manner: *(select just one option)*

- ☐ I elect to have my current foster/group home parent or provider receive 100% of the transitional support funds payable in their name for my room, board, and/or expenses.

Name transitional support funds should be payable to: _____

Address: _____

City: _____ State: _____ Zip Code: _____

OR

- ☐ I elect to have my monthly transitional support funds payment in 2 (two) separate checks. One check payable to my current foster/group home parent or provider in the amount of \$_____, and another check payable to me in the amount of \$_____.

Name transitional support funds should be payable to: _____

Address: _____

City: _____ State: _____ Zip Code: _____

OR

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- ☐ I elect to receive 100% of the monthly transitional support funds payment amount payable directly to me in my name for my room, board and/or expenses.

I am aware that I may request to change my pay out option at any time but it will take 30 to 45 days for the change to take effect.

Signature of Young Adult/Transitional Support Recipient

Date