



**CITY OF MARTINSVILLE/HENRY COUNTY (TANF) ASSISTANCE**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**STREET ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_  
**STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_  
**TELEPHONE NUMBER:** ( ) \_\_\_\_\_ **MESSAGE NUMBER ( )** \_\_\_\_\_  
**DATE OF BIRTH:** \_\_\_\_\_  
**SOCIAL SECURITY NUMBER:** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
**RACE PLEASE CHECK:** NATIVE AMERICAN \_\_\_\_\_ ASIAN \_\_\_\_\_ BLACK/AFRICAN AMERICAN \_\_\_\_\_  
WHITE/CAUCASIAN \_\_\_\_\_ NATIVE HAWAIIAN/PACIFIC ISLANDER \_\_\_\_\_ OTHER \_\_\_\_\_

Status: Single  Married  Divorced  Separated  Widowed

1. UTILITY ASSISTANCE  RENTAL ASSISTANCE

**PLEASE CHECK YOUR HARDSHIP: GIVE DETAILED EXPLANATION OF THIS HARDSHIP BELOW**

<input type="checkbox"/> 1. JOB LOSS	<input type="checkbox"/> 4. LOSS OF HOME - SUCH AS FIRE, EVICTION, STORM
<input type="checkbox"/> 2. MEDICAL EMERGENCY	<input type="checkbox"/> 5. LOSS INCOME EXAMPLES: SSI, DISABILITY, SOC SEC
<input type="checkbox"/> 3. DEATH	<input type="checkbox"/> 6. OTHER

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. HOW DO YOU PLAN TO PAY ((UTILITY OR RENT)) NEXT MONTH?**

\_\_\_\_\_  
\_\_\_\_\_

3. WILL/HAVE YOU RECEIVE FUEL ASSISTANCE? YES \_\_\_\_\_ NO \_\_\_\_\_  
4. HAVE YOU RECEIVED HELP HERE BEFORE? YES \_\_\_\_\_ NO \_\_\_\_\_  
5. PAST DUE AMOUNT \$ \_\_\_\_\_  
6. CAN YOU CONTRIBUTE FUNDS TOWARD THIS ACCOUNT? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, PLEASE LIST THE AMOUNT YOU CAN CONTRIBUTE \$ \_\_\_\_\_



PITTSYLVANIA COUNTY COMMUNITY ACTION INC  
 348 N MAIN ST \* PO BOX 1119  
 CHATHAM VIRGINIA 24531  
 EVERLENA ROSS, EXECUTIVE DIRECTOR



**SOURCES OF INCOME**  
**DOLLAR AMOUNT**

**JOB** WEEKLY \$ \_\_\_\_\_  
**EARNINGS** BI-WEEKLY \$ \_\_\_\_\_  
 MONTHLY \$ \_\_\_\_\_

**GOVERNMENT BENEFITS**

TANF \$ \_\_\_\_\_  
 SOCIAL SECURITY \$ \_\_\_\_\_  
 SSI \$ \_\_\_\_\_  
 VETERAN BENEFITS \$ \_\_\_\_\_  
 DISABILITY \$ \_\_\_\_\_  
 UNEMPLOYMENT \$ \_\_\_\_\_

**OTHER INCOME**

RETIREMENT \$ \_\_\_\_\_  
 OTHER INCOME \$ \_\_\_\_\_  
 RECEIVE CHILD SUPPORT \$ \_\_\_\_\_

**PENDING CHILD SUPPORT CASE**

YES \_\_\_\_\_ NO \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY**

SNAP AMOUNT \$ \_\_\_\_\_  
 FUEL ASSISTANCE \$ \_\_\_\_\_  
 MEDICAID \_\_\_\_\_  
 MEDICARE \_\_\_\_\_  
 WIC \$ \_\_\_\_\_  
 EMPLOYER INSUR \_\_\_\_\_

**\*\*MONTHLY EXPENSES\*\***

RENT \$ \_\_\_\_\_  
 MORTGAGE \$ \_\_\_\_\_  
 CELL PHONE \$ \_\_\_\_\_  
 MEDICAL \$ \_\_\_\_\_  
 CAR PAYMENT \$ \_\_\_\_\_  
 INS MED/CAR \$ \_\_\_\_\_  
 CABLE \$ \_\_\_\_\_  
 DAY CARE \$ \_\_\_\_\_  
 CREDIT CARDS \$ \_\_\_\_\_

I authorize Pittsylvania County Community Action, Inc. to contact and share information with any source necessary to process this application. Pittsylvania County Community Action, Inc. , if contacted we will verify any assistance that you received. I certify that I have read and understand the attached guidelines. I also certify that the information provided is true and I understand if I give false or misleading information, my request will be denied, and may be referred for prosecution, if warranted.

SIGNATURE OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_

**~~LEARN ABOUT FINANCIAL FREEDOM~~**

IN ORDER TO RECEIVE SERVICE IN THE FUTURE YOU WILL BE REQUIRED  
 TO ATTEND A ONCE A WEEK CLASS FOR SIX (6) WEEKS ON  
 "HOW TO MANAGE YOUR FINANCES"

SIGNATURE OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_