

West Virginia Department of Health and Human Resources

APPLICATION FOR CONTINUED SUPPORT SERVICES

Please give us the following information and answer the questions.

Name: _____

Social Security Number: _____

Address: _____

Home Phone: _____ Best time to call? _____

Work Phone: _____ Best time to call? _____
(If you can receive calls)

1. Have you or your children who live with you received cash assistance from the WV DHHR in the past 6 months? Yes No

2. Do you work, either full-time or part-time? Yes No

Employer: _____

Job Title: _____

3. Who is living in your home? _____

4. What is the total gross (amount before taxes) monthly income of your household?

5. Do any children in your home have income? Yes No
If so, age of child with income and income amount. _____

6. Do you have a financial need for any of the following services? Yes No
Clothing, Professional License, Licenses to Drive, Transportation Costs, Tools/Equipment, Vehicle Repair, Vehicle Insurance, Personal/Other. If so, provide the information asked for about each service.

CLOTHING

Type of clothing needed for your job: _____

Cost: _____

You must show that the amount requested will cover what you need.

PROFESSIONAL LICENSE

Type of license needed for your job: _____
Cost: _____

You must provide proof of the cost.

LICENSES TO DRIVE

Type: Standard
 Chauffeurs
 CDL

Cost: _____

TRANSPORTATION COSTS

To receive transportation payments, you must submit a time sheet each month.

**THIS FORM IS DUE BY THE 5TH DAY OF THE FOLLOWING MONTH
IN WHICH YOU HAVE THE EXPENSE.**

TOOLS/EQUIPMENT

What tools are necessary for your job: _____

Cost: _____

**You must provide proof that the tools/equipment
are needed and receipts or estimates.**

VEHICLE REPAIR

Amount needed to make the vehicle roadworthy: _____

What repairs are needed to make the car roadworthy? _____

You must provide an estimate of the cost of repairs.

VEHICLE INSURANCE

Insurance is limited to minimum liability coverage unless a bank lien requires additional coverage.

Name of Insurance Company: _____

Cost: _____

You must show an insurance quote or bill.

PERSONAL AND OTHER EXPENSES RELATED TO EMPLOYMENT

What other job related expenses do you have? _____

Cost: _____

You must show that the amount requested will cover what you need.

This form is your application for Support Service payments to continue after your monthly WV WORKS benefit stops. **You must complete this form prior to issuance of a payment.** *Except for ongoing transportation expenses, you must speak with your WV WORKS Worker to discuss your need for payment.* If you have questions before your Worker contacts you, please call: _____

If these payments are not used for their intended purpose, future support service payments will be reduced to recoup the amount misused.

By signing this form, you are certifying that the information is correct to the best of your knowledge and that you understand that there are penalties prescribed by law for deliberately providing false information to obtain benefits. These penalties were explained to you at the time of application or redetermination for your eligibility for a monthly cash assistance payment.

Signature of Applicant

Date

For Office Use Only

___ Approved.

Date Action Taken _____

___ Denied.

Reason _____
