FARM FOUNDATION INC.

"Moving Children Forward"

Financial Assessment

Phone (910) 485-3332

Fax (910) 485- 1453

The following assessment will be used to verify and assess that your income meet's your family needs; without relying on the income paid as a therapeutic foster parent.

Applicant Name: _____

Monthly Income: $_____

Employment: _____

Check ALL Income that apply:

	Child Support
	Unemployment
	Alimony
	Retired
	Hobbies
	SSI Supplemental Security Income
	Other _____

Applicant Name: _____

Monthly Income: $_____

Employment: _____

Check ALL Income that apply:

	Child Support
	Unemployment
	Alimony
	Retired
	Hobbies
	SSI Supplemental Security Income
	Other _____

Total family monthly income: _____

DEBITS	**Monthly Payments**
Home Mortgage/ Rent	**$**
Car Payments	**$**
Loans	**$**
Monthly Expenses (food, utilities etc.)	**$**
Other (accounts, credit cards etc.)	**$**
Payments to the Court (Child support, Alimony etc.)	**$**

Total monthly debits._____

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Is there any other financial information you would like to discuss: Yes_____ No_____

If yes, please explain:

_____

_____

_____

Agreement

I, _____ certified information in this statement is true. I understand, in providing false information, it may be grounds for exclusion as a therapeutic foster parent.

Applicant Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

Office Use Only

Financial Assessment can be completed and signed by licensing specialist as reported by parent on the following: Licensing Specialist Signature: _____ Date:_____