

**FAMILIES IN TRANSITION**  
**P.O. Box 321 -- Benicia, CA 94510 -- Hot Line: 707-645-3000**  
**www.familiesintransition.org**

**APPLICATION FOR ASSISTANCE**

(All information is kept confidential)

Date: \_\_\_\_\_

NAME: \_\_\_\_\_ SS# \_\_\_\_\_

Current Address \_\_\_\_\_  
Street City Zip

How long have you resided at the above address: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work: \_\_\_\_\_

Name of your Landlord \_\_\_\_\_ Phone # \_\_\_\_\_

Landlord address \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_

Is spouse working? \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Are you disabled? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Previous address: \_\_\_\_\_  
Street City Zip

How long did you live at this address: \_\_\_\_\_ Why did you move \_\_\_\_\_

Members of your family living with you: \_\_\_\_\_ Please detail below:

<u>Relationship</u>	<u>Age</u>	<u>Sex</u>	<u>School Name</u>	<u>Disability</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What is your present need: \_\_\_\_\_

Reason for this need: \_\_\_\_\_

Have you used our services in the past? \_\_\_\_\_ Date: \_\_\_\_\_ How ? \_\_\_\_\_ Did you repay? \_\_\_\_\_

Are you working? \_\_\_\_\_ Name of your last employer \_\_\_\_\_

Phone # \_\_\_\_\_ Employed for how long? \_\_\_\_\_

If unemployed, reason for ending employment \_\_\_\_\_ When did it end? \_\_\_\_\_

List 3 other previous employers, their phone #s, and dates of employment.

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

What is your educational/vocational background: \_\_\_\_\_

Are you currently seeking employment? \_\_\_\_\_

List companies with which you have filed work applications:  
\_\_\_\_\_  
\_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_ Phone # \_\_\_\_\_

Do you have transportation? \_\_\_\_\_ Type of vehicle \_\_\_\_\_

Driver's License # \_\_\_\_\_ Do you have child care: \_\_\_\_\_

In case of an emergency, contact: \_\_\_\_\_ at \_\_\_\_\_

**Monthly Budget Information:**

Income from:		Household expenses:		Current (c) Behind (b)
Job(s)	_____	Rent you pay*	_____	_____
AFDC	_____	PG&E	_____	_____
Disability	_____		_____	_____
Unemployment	_____	Water	_____	_____
Pension	_____	Phone	_____	_____
SSI	_____	Other	_____	_____
Social Security	_____	Cable	_____	_____
Other	_____	Food you pay*	_____	_____
		Child Care	_____	_____
Total Income .....	\$ _____	Medical Expenses	_____	_____
		Car Insurance	_____	_____
		Car Payments	_____	_____
		Fuel for Car	_____	_____
		Clothing	_____	_____
		Credit Cards	_____	_____
		Entertainment	_____	_____
		_____	_____	_____
		Other	_____	_____
		Total Expenses:	\$ _____	

Summary:

Monthly Income \$ \_\_\_\_\_

Minus Monthly Expenses \$ \_\_\_\_\_

Difference: \$ \_\_\_\_\_

\* Do not include portion paid by Housing  
Section 8, or amount of Food Stamps.

Authority,

How are you planning to cover/spend the difference? \_\_\_\_\_

I hereby give my permission to Families in Transition to verify the above information. I also hereby give my consent to release this information, and I understand that completion of this application does not constitute acceptance in the program.

Signed: \_\_\_\_\_

Date \_\_\_\_\_

Interviewed by \_\_\_\_\_

Date \_\_\_\_\_

Recommendation \_\_\_\_\_

## FAMILIES IN TRANSITION OF BENICIA

The following criteria must be met by applicants in order to receive assistance from FIT:

1. Be a Benicia resident for at least 3 months. Prospective clients must complete FIT's application form and be interviewed by a FIT liaison person to determine eligibility and needs. The liaison works closely with the client to ensure that the program requirements are met and eliminate the possibility of duplicating services being provided by other organizations or agencies.
2. FIT's liaison and Executive Committee must be convinced that FIT's financial assistance at the time will be a stabilizing factor for the applicants and that the applicants, once the immediate crisis is taken care of, can afford to remain where they are living. This assurance is established by the completion of a budget and the development of a controlled expense plan.
3. School-age children must be enrolled and attending school in Benicia or approved homeschooling.
4. Clients must apply for county or state benefits, if they are eligible.
5. Clients, if able, must be actively searching for a job.
6. No domestic violence, no substance abuse, and no criminal activity while receiving assistance.
7. Clients are advised that FIT's assistance is a one-time assistance.
8. Clients must sign below to declare that all of the above requirements are met, and that a prepayment plan is acceptable and will comply with such plan.

I declare that I meet the conditions stipulated above and that I will make every effort to repay the amount FIT is providing in accordance with the payment plan, of which I received a copy.

---

Signature

---

Date

**FAMILIES IN TRANSITION  
PO BOX 321  
BENICIA CA 94510 --- HOT LINE (707-645-3000)**

As agreed, here is a payment plan for you to repay FIT. Your repayment will enable us to help others. Thank you.

PAYMENT PLAN

Name: \_\_\_\_\_

Total Amount: \$ \_\_\_\_\_ Prepayment Amount \$ \_\_\_\_\_

Be Paid:      Monthly                      Weekly                      Quarterly

	<u>Date Paid</u>	<u>Balance</u>
January	_____	\$ _____
February	_____	\$ _____
March	_____	\$ _____
April	_____	\$ _____
May	_____	\$ _____
June	_____	\$ _____
July	_____	\$ _____
August	_____	\$ _____
September	_____	\$ _____
October	_____	\$ _____
November	_____	\$ _____
December	_____	\$ _____

Please send payments by mail to the address shown at the top of this page. Make sure your name is also written on the envelope so we can keep track of your payments.

We hope your situation will be stable soon. Please contact us to let us know how you are doing. Thank you.

Treasurer

**This page for FIT's Treasurer**

**FAMILIES IN TRANSITION  
PO BOX 321  
BENICIA CA 94510 --- HOT LINE (707-645-3000)**

As agreed, here is a payment plan for you to repay FIT. Your repayment will enable us to help others. Thank you.

PAYMENT PLAN

Name: \_\_\_\_\_

Total Amount: \$ \_\_\_\_\_ Prepayment Amount \$ \_\_\_\_\_

Be Paid:      Monthly                      Weekly                      Quarterly

	<u>Date Paid</u>	<u>Balance</u>
January	_____	\$ _____
February	_____	\$ _____
March	_____	\$ _____
April	_____	\$ _____
May	_____	\$ _____
June	_____	\$ _____
July	_____	\$ _____
August	_____	\$ _____
September	_____	\$ _____
October	_____	\$ _____
November	_____	\$ _____
December	_____	\$ _____

Please send payments by mail to the address shown at the top of this page. Make sure your name is also written on the envelope so we can keep track of your payments.

We hope your situation will be stable soon. Please contact us to let us know how you are doing. Thank you.

Treasurer

**This page for client**