Massachusetts Department of Transitional Assistance

TAFDC Case History for Domestic Violence Waiver Request

To be completed by Department Representative.
Check **one** box below.

- ❒ Initial DVWR
- ❒ Continuation of previously approved DVWR. Expiration date of previous waiver____/_____/________
- ❒ Previous DVWR was denied during______/_______(month/year). Client is now submitting an additional DVWR.
- ❒ Family Cap DVWR only

Name ______________________ Agency ID ______________________

Address ______________________ City/Town ______________________ ZIP ______________________

If the above is a teen parent, who does the teen parent live with?

Name/ YPP ______________________ Relationship ______________________ How long has the teen parent been residing here? ______________________

Household Information

Name	Age	DOB	Included in the grant	Relationship	Family Cap Child	Monthly Income (e.g. Wages, SSI, RSDI, Unemployment etc.)	
						Amount	Type
Grantee:			__Yes __No		N/A	$	
			__Yes __No		__Yes __No	$	
			__Yes __No		__Yes __No	$	
			__Yes __No		__Yes __No	$	
			__Yes __No		__Yes __No	$	
			__Yes __No		__Yes __No	$	

Benefit Information

____/____/_________
Most recent TAFDC Re/opening Date

Reason for Case Re/Application ______________________

____/____/_________
Most recent TAFDC Closing Date

Reason for Case Closing ______________________

____
# of Time-Limited Months Used

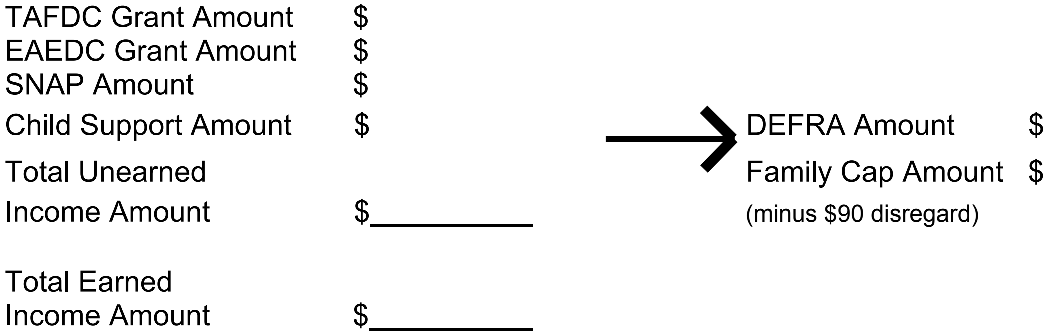
Time Limit Exemption Status:
- ❒ Nonexempt
- ❒ Exempt

Work Program Exemption Status:
- ❒ Nonexempt
- ❒ Exempt

Confidentiality Safeguards

Is the case coded for Heightened Level of Security (HLS)? __Yes __No

Monthly Household Income Information



TAFDC Grant Amount $
EAEDC Grant Amount $
SNAP Amount $
Child Support Amount $ → DEFRA Amount $
Family Cap Amount $
(minus $90 disregard)
Total Unearned Income Amount $__________

Total Earned Income Amount $__________

Housing History

Is the client the primary tenant? __Yes __No

If **no**, provide name and relationship of the person the client is living with. If not residing with anyone the housing type they are residing in (EA shelter, DV shelter, etc):

____

What is the monthly rent/mortgage amount? $ ____ Does the client have a subsidy? __Yes __No

If yes, what is type and amount of the subsidy? ____

Is the client homeless? __Yes __No

If **yes**, provide the current name of shelter/motel and entry date.

____ ______________________________
Shelter/Motel Name Entry Date Reason for homelessness

Disability History

Does the client receive SSI or RSDI? __Yes __No

Does the client have a pending disability determination with DES? __Yes __No

Has the client ever been approved by PRO? __Yes __No

If **yes**, what was the duration of the approval? ____/____/________ ____/____/________
Start Date End Date

Has the client been denied by DES? __Yes __No

If **yes**,__/____/__________ ____
Date of Denial Reason for denial

Child Support Good Cause

Does the client have/or is claiming good cause for not cooperating with Child Support? __Yes __No

If **yes**, for whom good cause has been given/is being claimed?

Child's Name ______________________________ Absent Parent's Name ______________________________

Child's Name ______________________________ Absent Parent's Name ______________________________

Child's Name ______________________________ Absent Parent's Name ______________________________

Time Limit Extension History

Has the client ever requested a time limit extension? __Yes __No

If **yes**, when was the request? What were the reasons for approval and duration or denial?____________________

____

____

Employment History

Is the client currently employed? __Yes __No

If **yes**, complete the following:

Name of Employer	Start Date	Hourly Wage	Hours per week	Occupation
____________________	____/____/______	__________	__________	______________

Please summarize the client's work history starting with most recent job.

Employer Name	Start Date	End Date	Hourly Wage	Weekly Hours	Occupation	Reason for Leaving

ESP History

Does the client have his/her diploma or equivalency? __Yes __No

If a teen parent, is teen parent currently in school, and equivalency program or YPP? __Yes __No

If yes, what is the name and location of the school or program?______________________________

Is the client currently participating in an ESP component? __Yes __No

If yes, provide the following information.

Activity Type	ESP Provider	Start Date	Expected End Date	Weekly Hours	# of Days per week	Expected Outcome of Activity

ESP History Summary
Example

Activity Type	ESP Provider	Start Date	Expected End Date	Weekly Hours	# of Days per Week	Expected Outcome of Activity
Employment Ready	Career Link (self- directed)	1/6/14	7/25/14	30	5	Employment
Employment Supports (Model III)	ATI/LARE	6/3//13	12/27/13	30	5	Pharmacy tech certificate/employment

Activity Type	ESP Provider	Start Date	Expected End Date	Weekly Hours	# of Days per Week	Expected Outcome of Activity

Child Care

Does the client receive child care services? __Yes __No

If **yes**, please identify the resource:

____

Is this the result of a DTA referral? __Yes __No

Summary/Additional Information

Provide a brief summary of the case history, the type of DVWR and reason for the request as well as any additional information that may be relevant.

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Case Manager Signature **Date** **Supervisor Signature** **Date**