NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FTHA APPLICATION
Independent/Verification Check List

NAME OF APPLICANT:	COUNTY:

EMPLOYMENT

DATE	PERSON/COMPANY CONTACTED (Incl. Telephone #)	RESULT

INCOME

DATE	PERSON/COMPANY CONTACTED (Incl. Telephone #)	RESULT

PERSONAL REFERENCES

DATE	PERSON/COMPANY CONTACTED (Incl. Telephone #)	RESULT

Indicate below if a criminal background check was determined to be necessary and if so note the outcome.

DATE	PERSON/COMPANY CONTACTED (Incl. Telephone #)	RESULT

Completed By: _____

Date: _____ LDSS: _____

*Attach additional sheets if necessary