

**BRAZOS VALLEY COUNCIL OF GOVERNMENTS  
HOUSING CHOICE VOUCHER PROGRAM APPLICATION  
ATTACHMENT FOR FAMILY SELF-SUFFICIENCY**

**Individual Employment Plan (IEP)**

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

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

**SECTION I: GOALS AND OBJECTIVES**

*Identify participant's employment goals and associated achievement objectives (be specific)*

Employment Goals: \_\_\_\_\_

\_\_\_\_\_

Goal Occupation: \_\_\_\_\_

Target Wage: \_\_\_\_\_

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

Skill requirements to meet Occupation Goal: \_\_\_\_\_

\_\_\_\_\_

***Objectives to reach Occupational Goals:***

Objective 1:	Target Completion date:
Objective 2:	Target Completion date:
Objective 3:	Target Completion date:
Objective 4:	Target Completion date:
Objective 5:	Target Completion date:

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**SECTION II: WORK HISTORY** *List work history in chronological order (most recent first)*

Are you (head of household) currently employed?  Y  N If yes fill out information below.

Place of employment: \_\_\_\_\_

Position held: \_\_\_\_\_

Income: \_\_\_\_\_  weekly  bi-weekly  full time  part time

**Employment dates:** From: \_\_\_\_\_ To: \_\_\_\_\_  Current

If unemployed, what type of income do you receive? \_\_\_\_\_

**List previous jobs:**

	Job # 1	Job # 2	Job # 3
Please list all jobs in the last five years.			
Place employed			
Position held			
Income (weekly, bi-weekly)			
Employment dates			
Reason position ended			
Please explain any gaps in employment			

**SECTION III: TRANSFERABLE SKILLS**

Skill	Place obtained	Years

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**Are any other family members employed? ( ) Yes ( ) No If yes, please complete:**

Family Member	Job	Rate of pay	How often?
			( ) Hour ( ) Week
			( ) Hour ( ) Week
			( ) Hour ( ) Week

**SECTION IV: EDUCATION**

Education	Public School	Business School	College	GED
School Name				
Dates Attended				
Grade Completed				
Graduated				
Field of Study				
Degree/Certificate				

**SECTION IV: FAMILY**

Please list all family members who live in your housing unit, including the head of household. Give the relationship of each family member to the head of household.

Family Members	Name of Family Member	Relationship to Head	Age	Sex	Ethnicity
Head of Household		Self			

\*Ethnicity – choose one: White, African American, Hispanic, American Indian, Alaskan Native or Asian/Pacific Islander

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Is anyone in your household 18 years or older currently in school or a training program? ( ) Yes ( ) No.  
If yes, please fill in the information below.

<b>Family Member</b>	
<b>School/Program</b>	
<b>Address</b>	
<b>Phone #</b>	
<b>Enrollment Date</b>	
<b>Expected Completion Date</b>	
<b>Degree Certificate Expected</b>	

<b>Family Member</b>	
<b>School/Program</b>	
<b>Address</b>	
<b>Phone #</b>	
<b>Enrollment Date</b>	
<b>Expected Completion Date</b>	
<b>Degree Certificate Expected</b>	

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**SECTION V: NEEDS ASSESSMENT**

**Assess all items for assistance the individual may need to successfully participate. Check category where assistance may be needed and identify solutions.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Housing                        | <input type="checkbox"/> Transportation    | <input type="checkbox"/> TAA Subsistence      |
| <input type="checkbox"/> Food/clothing                  | <input type="checkbox"/> Medical/health    | <input type="checkbox"/> Other/Specify: _____ |
| <input type="checkbox"/> Job-related materials/supplies | <input type="checkbox"/> Child/family care |   |
|   | <input type="checkbox"/> Legal             |   |

**Please check any items below that you consider a current need (check as many as apply):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Need a better job     | <input type="checkbox"/> Need better transportation        | <input type="checkbox"/> Need child care          |
| <input type="checkbox"/> More money for bills  | <input type="checkbox"/> Need a doctor for health problems | <input type="checkbox"/> Need food assistance     |
| <input type="checkbox"/> Want to finish school | <input type="checkbox"/> Need help to be a better parent   | <input type="checkbox"/> Need job training        |
| <input type="checkbox"/> Need counseling       | <input type="checkbox"/> Need help managing money          | <input type="checkbox"/> Other, please list below |

**1. Please check the different agencies you have visited or received services from in the last six months.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Health Dept./Clinic | <input type="checkbox"/> Job Training Program        | <input type="checkbox"/> Mental health center     |
| <input type="checkbox"/> Food Pantry         | <input type="checkbox"/> Head Start (children)       | <input type="checkbox"/> Dept. of Human Services  |
| <input type="checkbox"/> Community College   | <input type="checkbox"/> Alcohol or drug program     | <input type="checkbox"/> Free meals program       |
| <input type="checkbox"/> Shelters            | <input type="checkbox"/> Children's services program | <input type="checkbox"/> Vocational / Tech School |
| <input type="checkbox"/> Other: _____        |  |   |

**2. Do you speak English?**  Yes  No If no, what language is spoken? \_\_\_\_\_

**3. Do other family members speak English?**  Yes  No

**4. Do you have a high school diploma or GED?**  Yes  No

**5. If you were to get a job or change your job, would you need help finding someone to watch your children?**  Yes  No

**6. Do you now work with a person or a case manager who helps you and your family find the services you need?**  Yes  No

If yes, please list their name and the agency he/she works for: \_\_\_\_\_

**7. Are you currently receiving Case Management Service from any agency?**  Yes  No

If yes, what agency? \_\_\_\_\_

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**8. What are the two biggest problems you are facing now?**

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**9. What are the two or three biggest problems currently faced by your family?**

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**RESOURCE NEEDS IDENTIFIED (OFFICE USE ONLY)**

Agency Referral	Name, phone number and deadline date

**APPLICANT CERTIFICATION**

I hereby certify that all of the information above about me/us is true and correct. I also understand that all changes in the income of any household member, and any changes in the number of household members must be reported to HCVP and FSS in writing IMMEDIATELY.

\_\_\_\_\_  
SIGNATURE OF HEAD OF HOUSEHOLD

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF SPOUSE

\_\_\_\_\_  
SIGNATURE OF OTHER ADULT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF OTHER ADULT

**Warning! Title 18, Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.**

Please return to: BVCOG, HCVP, P.O. Drawer 4128, Bryan, Texas 77805  
Housing Phone: 979-595-2801 Fax: 979-595-2813

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**FSS SELF-SUFFICIENCY 50058 QUESTIONNAIRE**

**CHECK ALL APPLICABLE: (check means YES – blank means NO)**

- |   |   |
|---|---|
| 1. Employed? _____<br>a. Date of employment _____<br>b. Full time or Part time _____                                      | 5. Medicaid/Children’s Health Insurance Program _____ |
| 2. Receive TANF? _____<br>a. Food Stamps _____  | 6. Earned Income Tax Credit _____                     |
| 3. Childcare assistance _____<br>a. Provided by _____<br>b. Number of children in care _____                              |   |
| 4. Grants for school _____<br>a. Diploma _____      Certification Certificate _____<br>b. GED _____          Degree _____ |   |

**JOB BENEFITS: (current job)**

- 1. Health Insurance \_\_\_\_\_
- 2. Retirement \_\_\_\_\_
- 3. Other Benefits \_\_\_\_\_

**SERVICES NEEDED:**

- 1. GED \_\_\_\_\_
- 2. High School \_\_\_\_\_
- 3. College \_\_\_\_\_
- 4. Vocational Training \_\_\_\_\_
- 5. Job Search/Placement \_\_\_\_\_
- 6. Job Retention \_\_\_\_\_
- 7. Transportation \_\_\_\_\_
- 8. Health Services \_\_\_\_\_
- 9. Alcohol/Prevention \_\_\_\_\_
- 10. Mentoring \_\_\_\_\_
- 11. Homeownership/Counseling \_\_\_\_\_
- 12. Childcare \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\* This form is required to properly fill out the 50058 form submitted to the HUD via the MTCS/PIC program. Accuracy is very important. If you do not understand please request assistance from your FSS Coordinator.