



WV DEPARTMENT OF HEALTH & HUMAN RESOURCES APPLICATION FOR CHILD CARE SERVICES

DATE _____

- NEW APPLICATION RE-APPLICATION
 CLOSED OVER 90 DAYS? YES NO

I. INSTRUCTIONS

Please complete this form in order to apply for child care services. **Be sure to sign and date the form and attach any information which is requested.** If your application is not signed and dated, it cannot be processed. New applicants must contact the office listed below to schedule an appointment to complete the application process. Please return form to:

Agency _____ Phone _____
 Address _____ Worker _____

II. IDENTIFYING INFORMATION - Head of Household/ Applicant

Name _____ Sex M F
 _____ Last First Mi _____ Maiden

Social Security # _____ Birth date ____ / ____ / ____

Marital Status Married Single Divorced Separated Live-in Other _____

Are you a US citizen? Yes No

Mailing Address _____ City _____ State _____

Zip _____ County _____ Phone _____ Business/Message _____

Home address if different from above _____

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
 Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
 Asian
 Black/African American
 Native Hawaiian/other Pacific Islander
 White

III. OTHER FAMILY MEMBERS

1. Name _____ Sex M F
 _____ Last First Mi _____ Maiden

Social Security # _____ Birth date ____ / ____ / ____

Relationship to Head of Household _____

Is this person a US citizen? Yes No

Is this a child who needs care? Yes No

Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
 Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
 Asian
 Black/African American
 Native Hawaiian/other Pacific Islander
 White

III. OTHER FAMILY MEMBERS - continued

2. Name _____ Sex M F
Last First Mi Maiden

Social Security # _____ Birth date ____ / ____ / ____

Relationship to Head of Household _____

Is this person a US citizen? Yes No

Is this a child who needs care? Yes No

Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/other Pacific Islander
- White

3. Name _____ Sex M F
Last First Mi Maiden

Social Security # _____ Birth date ____ / ____ / ____

Relationship to Head of Household _____

Is this person a US citizen? Yes No

Is this a child who needs care? Yes No

Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/other Pacific Islander
- White

4. Name _____ Sex M F
Last First Mi Maiden

Social Security # _____ Birth date ____ / ____ / ____

Relationship to Head of Household _____

Is this person a US citizen? Yes No

Is this a child who needs care? Yes No

Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/other Pacific Islander
- White

III. OTHER FAMILY MEMBERS - continued

5. Name _____ Sex M F
_____ Last First Mi _____ Maiden

Social Security # _____ Birth date ____ / ____ / ____
Relationship to Head of Household _____

____ Is this person a US citizen? Yes No
Is this a child who needs care? Yes No
Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/other Pacific Islander
- White

6. Name _____ Sex M F
_____ Last First Mi _____ Maiden

Social Security # _____ Birth date ____ / ____ / ____
Relationship to Head of Household _____

____ Is this person a US citizen? Yes No
Is this a child who needs care? Yes No
Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/other Pacific Islander
- White

7. Name _____ Sex M F
_____ Last First Mi _____ Maiden

Social Security # _____ Birth date ____ / ____ / ____
Relationship to Head of Household _____

____ Is this person a US citizen? Yes No
Is this a child who needs care? Yes No
Is this a special needs child? Yes No

Ethnicity (must choose one)

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin

Race (check all that apply)

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/other Pacific Islander
- White

IV. REASON FOR NEEDING CHILD CARE

The following information will show why you need child care. Please follow the directions below to enter the information in the following table.

1. List adult's name.
2. Is this a WV WORKS participant? Put Y or N.
3. Why does this person need care? Enter working, school or training or CPS Plan.
4. Enter name of employer or school.
5. Enter date this person started working or attending school.
6. Enter the adult's phone number at work or school.
7. Enter the days and hours this person works or attends school.

1. Name of Adult	2. WV WORKS Participant? Y or N	3. Reason For Care	4. Employer Name or School Name	5. Starting Date	6. Phone Number	7. Schedule (Days & Hours)
1.						
2.						
3.						

VERY IMPORTANT REMINDER! DON'T FORGET

You must verify school attendance with a LETTER FROM THE SCHOOL and a copy of your most recent grades. If child care is part of a CPS safety or treatment plan, a copy of the plan must be received which lists days and hours care is requested and any special requirements such as a waiver of fee payment.

V. PROVIDER INFORMATION

The chart below asks for information on your provider. If you have a provider in mind, please enter your children's names and the name, address, and phone number of the provider used for each child. The R&R staff will help you determine column 6.

1. Your children's first names.
2. Name of the provider for each child.
3. Provider's address -street, city and zip.
4. Provider's phone.
5. If the provider is related to your child - aunt, uncle, grandparent, etc.
6. Type of care: (a) Day care center caring for over 13 children; (b) in home provider by special approval of R&R on limited basis only; (c) registered family day care home for 4-6 children; (d) registered family day care home for 1-3 children; (e) family day care facility caring for 7-12 children; (f) an unlicensed after school program operating less than 4 hours daily; and (g) a relative home caring only for related children.

1. Child	2. Provider Name	3. Provider Address	4. Provider Phone #	5. If Related, How?	6. Type of Care (Official Use Only)

VI. Resource and Referral

1. Please check below if you were provided any of the following information about child care services.

- | | |
|--|--|
| <input type="checkbox"/> A list of legally operating child care providers | <input type="checkbox"/> Resource and referral counseling |
| <input type="checkbox"/> Written material on types of care and quality of care | <input type="checkbox"/> Checklist of health & safety concerns |
| <input type="checkbox"/> Copies of child care regulations | <input type="checkbox"/> Information on child care provider complaint policy |

VII. Other

1. Did you receive a Child Health Insurance Program Application (CHIP) ? Yes No Family has coverage
 2.. Were you given an opportunity to register to vote? Yes No already registered to vote

VIII. INCOME VERIFICATION

Please enter the name of the head of the household in the column marked "Your Name"

- Please enter the name of other adults or children in your home who receive income.
- Go down the column under your name and look at the income types. For example, number one is wages. Enter the amount of your wages and how often you receive it. Go down each row and enter any income you receive from other sources.
- If you have a second job, enter your name on the second column, then enter your wages from your second job on that line.
- If other people in your home have income, enter their names in one of the columns and then go down the chart and enter that income on the row that shows the type of income.

Names of Household → Members	Your Name:		Other:		Other:		Other:	
	Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often
LIST BELOW THE GROSS AMOUNT AND HOW OFTEN INCOME IS RECEIVED BY YOURSELF AND OTHER HOUSEHOLD MEMBERS								
Income Type								
1. Wages (Gross)								
2. TANF Benefits								
3. Social Security								
4. Veteran's Benefits								
5. Workers Compensation								
6. Disability Benefits								
7. Unemployment Compensation								
8. Retirement Benefits								
9. Farm Self Employment								
10. Alimony, Interest Income, Other								
11. Child Support								
12. Food Stamps (Not considered income)								
13. Housing Assistance (Not considered income)								
14. Other								

VERY IMPORTANT REMINDER! DON'T FORGET

For each person who works you must attach either: (1) copies of that person's most recent pay stubs for at least one month's time or (2) a letter from the employer which shows monthly gross income or hourly wage and average number of hours worked weekly. If income varies and there have been no changes in hourly wage or salary, three months of pay stubs may be sent in. If a person is self-employed, net income must be reported and verified by business and/or tax records.

If you receive child support you must send in either: (1) a copy of your divorce or child support decree, or (2) a copy of monthly child support checks, or (3) a written statement from the absent parent showing the amount of monthly support payments.

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(12-08-04)

CASE NAME _____

IX. SIGNATURE: Please read the statements below and sign and date the form.

In signing this form, I understand that:

I am requesting that child care assistance be provided for my children.

If I receive more benefits than I am entitled to receive, whether through my fault or through an error on the part of the agency, I must repay the extra benefits received.

The information I have given is true and complete to the best of my knowledge. I agree to allow the agency to contact me or anyone else in order to verify my eligibility for child care.

I agree to report any change within 5 working days which would affect my eligibility for child care services. If I intentionally do not report changes or if I give false information, I can be prosecuted for fraud or perjury.

I agree to complete sign in and out procedures required by my provider and to sign only for days that I use care. I will be responsible for payment to the provider for any care which is not approved for child care assistance. Intentional misuse of services may result in legal action for repayment and prosecution for fraud.

I have the right to request a hearing or file a grievance if I am not satisfied with a decision regarding my child care assistance or if I feel that I have been discriminated against because of race, color, national origin, religion, or sex. I may have an attorney present at a hearing but the attorney's costs will not be paid by the agency.

I agree to allow the agency to obtain information from the Social Security Administration if that information is provided and used according to the Social Security Act and the Privacy Act of 1974.

Staff of the West Virginia Department of Health and Human Resources and/or its specified contract agency are responsible for the provision of child care assistance, and I give my consent for information about myself and my family to be exchanged as needed between the Department and the contract agency.

_____ Signature

_____ Date

*****FOR AGENCY USE ONLY*****

Income Computations			Disposition
A. Earned Income	B. Earned Income	C. Unearned Income	1. Disposition of Application/Renewal
Gross Amounts	Gross Amounts	Gross Amounts	<input type="checkbox"/> Approved for day care services effective ____/____/____ at a fee of \$ ____ per day per child <input type="checkbox"/> Application Withdrawn <input type="checkbox"/> Application Denied <input type="checkbox"/> Service to be closed as of ____/____/____
1. \$ _____	1. \$ _____	1. \$ _____	
2. \$ _____	2. \$ _____	2. \$ _____	
3. \$ _____	3. \$ _____	3. \$ _____	
4. \$ _____	4. \$ _____	4. \$ _____	
5. \$ _____	5. \$ _____	5. \$ _____	
a. Total \$ _____ /No. of stubs = \$ _____	Total \$ _____ /No. of stubs \$ _____	a. Total \$ _____ /No. of stubs = \$ _____	<input type="checkbox"/> Certificate Mailed ____/____/____ <input type="checkbox"/> Written Closure Notice Sent ____/____/____
b. Multiply by monthly conversion = \$ _____	b. Multiply by monthly conversion = \$ _____	b. Multiply by monthly conversion = \$ _____	
c. Total of above columns \$ _____ (Total Monthly Gross Income)			_____/_____/_____ (Worker Signature) / (Date)

CCR&R Agency _____ Address _____
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 (12-08-04)