

Louisiana Department of Children and Family Services  
 Child Care Assistance Program

<b>OFFICE USE ONLY</b>	
SSN _____	
Worker _____	
<input type="checkbox"/> New Application	
<input type="checkbox"/> Redetermination	
_____ Redet M/Y	

Application for Child Care Assistance

1. **IDENTIFYING INFORMATION:** This form should be completed by the parent or other household member who is responsible for paying child care costs.

PLEASE PRINT ALL INFORMATION

NAME: LAST	FIRST	MIDDLE INITIAL
HOME ADDRESS: STREET	APT. NO.	CITY PARISH ZIP
MAILING ADDRESS: STREET/ P.O. BOX	APT. NO.	CITY PARISH ZIP
TELEPHONE #S: HOME: ( )	WORK: ( )	OTHER PHONE: ( )

2. **HOUSEHOLD COMPOSITION:** For this program, a household includes these individuals who live together: Head of Household, Head of household's legal or non-legal spouse, and all dependent children under age 18. List yourself first, then other household members with the oldest members listed first.

NAME (FIRST, MI, LAST)	RELATIONSHIP TO YOURSELF	BIRTH DATE	RACE	SEX	(OPTIONAL) SSN	MARITAL STATUS
	Self					

Is anyone listed above pregnant?  Yes  No If yes, list the person's name and due date.  
 Name: \_\_\_\_\_ Due Date: \_\_\_\_\_

Is any adult or parent listed above disabled?  Yes  No If yes, list the person's name and attach verification of disability (doctor's statement, etc) Name: \_\_\_\_\_

Are all children listed above U. S. citizens?  Yes  No If no, list their names: \_\_\_\_\_

3. **CHILDREN NEEDING CARE:** List the times each day that child care is needed for each child (if school-aged children need care both before and after school, list both times; example: 7:00 to 8:00 and 3:30 to 6:00). **NOTE:** If you have not yet selected a child care provider, enter the child's name, age, time each day care is needed, and check the type of care that you plan to use.

NAME OF CHILD	AGE	TYPE OF CARE ONE PER CHILD	NAME/ADDRESS/PHONE# OF PROVIDER	PROVIDER / CHILD RELATIONSHIP	TIME NEEDED EACH DAY	COST OF CARE
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				

4. List children from Item 3 who attend/will attend Head Start, Pre-Kindergarten, Kindergarten, or school this year: \_\_\_\_\_

5. Are immunizations current on all children in need of child care?  Yes  No If no, list their names: \_\_\_\_\_

6. **PERSONS WHO ARE EMPLOYED:** Enter the name of each parent and person age 18 and over listed in # 2 (on the reverse side) who is working. List ALL jobs (working means full-time, part-time, temporary, self-employment, or odd-job employment, even if the job has just started or will end soon). **Send in check stubs for the 4 most recent pay periods (for each person who is employed).** If check stubs are not available, we will supply a form for the employer to complete to verify earnings for the 4 most recent pay periods.

PERSON EMPLOYED	NAME AND ADDRESS OF EMPLOYER	EMPLOYMENT BEGIN DATE	WORK HOURS/WEEK	WORK DAYS/WEEK	GROSS AMOUNT EARNINGS	HOW OFTEN PAID

7. **OTHER TYPES OF INCOME:** Check the appropriate column next to the type of income that you or any member of your household receives or has applied for. **Send in proof of any income that is checked.**

SOURCE OF INCOME	RECEIVES	APPLIED FOR	PERSON WHO APPLIED/RECEIVES	AMOUNT RECEIVED	HOW OFTEN
A. Child Support					
B. Alimony					
C. Unemployment Benefits					
D. SSI-Supplemental Security Income					
E. Social Security Benefits					
F. Veteran's Benefits					
G. Retirement Benefits					
H. Other Disability Benefits					
I. Adoption Subsidy					
J. Other Income Type (contributions, etc.)					

8. **PERSONS WHO ARE IN SCHOOL OR TRAINING:** Enter the name of each parent and person age 18 and over listed in #2 (on the reverse side) who is attending a job training or educational program. **Send in verification of school or job training attendance, including the number of hours in class each week and the anticipated date of completion.**

PERSON IN TRAINING	NAME AND ADDRESS OF SCHOOL	CLASS HOURS/WEEK	CLASS DAYS/WEEK	ANTICIPATED COMPLETION DATE

9. **CASH ASSISTANCE FROM FITAP (Family Independence Temporary Assistance Program):** Does any member of your household receive FITAP, or has anyone's FITAP case been closed within the past 2 months?  Yes  No If yes, is/was this person receiving child care assistance?  Yes  No If either question above is answered yes, list the name(s) of the person(s) receiving assistance: \_\_\_\_\_

10. **SPECIAL NEEDS:** Does any child, under age 18, need specialized child care because of a physical, mental, or emotional condition?  Yes  No If yes, who? \_\_\_\_\_ For what type of condition? \_\_\_\_\_

Is any child receiving SSI or other disability benefits?  Yes  No If yes, send copy of award letter or copy of a recent check.

## VOTER REGISTRATION:

Any citizen in the State of Louisiana who has met the voter registration requirements and applies for public assistance must be provided the opportunity to register to vote.

If you are not registered to vote where you live now, would you like to apply to register to vote? Yes  No

If you do not check either box, we will assume that you do not want to register to vote at this time.

Please note that the information you give to the agency will remain confidential and will be used only for voter registration purposes. Applying to register or refusing to register to vote will not affect the amount of assistance or services that you may receive from the Department of Children and Family Services. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Contact your worker if you need help.

You may file a complaint if you believe that someone has interfered with your:

- right to register to vote,
- right to decline to register to vote,
- right to privacy in deciding whether to register to vote,
- privacy in applying to register to vote, or
- right to choose your own political party or other political preference.

You may file a complaint with: Louisiana Secretary of State, P.O. Box 94125, Baton Rouge, LA 70804-9125.  
1-800-825-3805

## RIGHTS AND RESPONSIBILITIES:

The fact that you are applying for or receiving assistance from this agency means you have certain rights and responsibilities.

You have the right to confidentiality -- that means that the information given by you will not be released without your written consent, except to agencies and officials as allowed by law. We do not discriminate in the delivery of services. This means you will not be treated differently from others because of your race, color, sex, age, disability, religious beliefs, nation origin or political beliefs. If you think you have been discriminated against, you can file a complaint which will be investigated and appropriate action will be taken.

A decision will be made on your application **within 30 days** after the date the application is received. You will receive written notice of the decision. You can request a Fair Hearing to have the Department of Children and Family Services review the decision of the Economic Stability office handling your case if you think it is not fair. You or your representative may request a Fair Hearing, orally or in writing, if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose.

**AGREEMENT:** I agree to let the office know within ten days if any of the following changes occur. I understand that I must report changes that occur after I send in my application, as well as changes that occur after I am determined eligible.

- Change in Address
- Change in Members of my Household, including anyone who moves in or out
- Change in employment, including an interruption for at least three weeks, a change of employer, or a change in the number of hours worked
- Change in income if household's gross monthly income changes more than \$100 in earned income or \$50 in unearned income
- Change in job training or educational program, including an interruption for at least three weeks, a change of programs, or a change in the number of hours of attendance
- Change in Child Care Providers or Provider's Type
- Change in location of where care is being provided
- Change in Days or Hours Child(ren) are in the child care provider's care
- Beginning or ending of disability

If I am in a Supplemental Nutrition Assistance Program (SNAP) household, I understand I am only responsible for reporting within 10 days the following:

- Change of child care providers.
- A child receiving child care benefits moves out of the home or is no longer in the child care provider's care.
- Interruption of at least three weeks, or termination of employment, training, or education for any parent or adult household member.

In addition, as a SNAP household, I am responsible for reporting changes in gross monthly income which result in the household's income exceeding the gross income limit for SNAP. This change must be reported no later than the 10<sup>th</sup> of the month following the month in which the change occurred.

Providing false information, withholding information, or failing to report any of the changes as described above is subject to penalty under the law. If providing false information or withholding information causes an overpayment for child care, you may be required to repay the amount of ineligible benefits made on your behalf. If you purposely fail to report any information that causes ineligible benefits to be made on your behalf, fraud charges may be brought against you and you may be disqualified from participating in the program.

Social Security Numbers are not required for Child Care Assistance eligibility and eligibility cannot be denied for failure to provide Social Security Numbers.

I give permission to the Agency to contact whomever necessary to verify my need for assistance. In addition, I hereby waive the confidentiality of my name and Social Security Number, if provided, so that information may be furnished to employers, government agencies, and any other parties deemed necessary in order to verify my income and need for assistance, or for data collection or statistical purposes.

With my signature below, I certify that I have read and understand my rights and responsibilities. I hereby declare that the times care is needed as listed in item 3 are the times when I and any other Training or Employment Mandatory Participant are working and/or attending a job training or educational program or traveling to and from these activities. I certify under penalty for perjury that all information given on this application form is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal or Non-Legal Spouse

\_\_\_\_\_  
Date

---

---

**OFFICE USE ONLY  
CLARIFICATIONS:**