

## Intent to Apply for Child Care Assistance

**In order to protect your application date, you must complete this form and return it as soon as possible.**

### Part I – Right To Apply

**If you live in Kentucky and want to apply for the Child Care Assistance Program, follow these steps:**

- Complete this form and submit it to the local Child Care Service Agent.
- Once this form is received, an interview will be scheduled to complete the application process.
- To begin the application process, complete Parts I, II and III of this form.

If you are eligible, benefits are provided from the date you return this form. Please return this form and all required verifications, as soon as possible.

Your Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

County \_\_\_\_\_ Telephone Number \_\_\_\_\_ [ ] Yours [ ] Nearby

If your mailing address is different from your street address, write it below:

\_\_\_\_\_  
(Mailing Address) (City) (State) (Zip Code)

D.O.B. \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Race \_\_\_\_\_

Highest Educational Level \_\_\_\_\_ Marital Status \_\_\_\_\_ (S, M, D, W, Sep.)

Sign Here \_\_\_\_\_  
(Your Name) (Date)

Do you have a physical or mental condition that requires you to have special accommodations during your application interview, such as needing a sign language interpreter? [ ] Yes [ ] No

If Yes, what do you need? \_\_\_\_\_

We can get a **free** interpreter for your interview if you have trouble speaking English.

Do you need an interpreter during your interview? [ ] Yes [ ] No

If yes, what language? \_\_\_\_\_

## Part II – Household Member Information

### Applicant Section

List all of the children who live in your home for whom you want to receive benefits. They are considered part of the application. Anyone for whom you do not want to receive benefits is not considered part of the application and should be listed in the next section.

First Name / M. I. / Last Name	Social Security #	Relation to you	Birth Date	Sex M or F

### Others In Home Section

List any other children or adults who live with you in this section.

First Name / M. I. / Last Name	Social Security #	Relation to you	Birth Date	Sex M or F

## Part III – Rights, Responsibilities, Signature

### Applicant Rights

- I understand that a decision will be made on this application within thirty (30) days. I will be notified in writing of the decision.
- The Department for Community Based Services (or its designated contract agency) will comply with the provisions of the Civil Rights Act, Section 504 of the Rehabilitation Act, Americans with Disabilities Act of 1990, and Title IV-A, IV-B, IV-C, IV-E and XX of the Social Security Act regarding service programs for children, families, and adults.
- If I am dissatisfied with any agency action, I understand I have the right to request an informal dispute resolution and/or a service appeal before an impartial hearing officer. I further understand that I may be represented by an attorney or other spokesperson at all proceedings related to the service appeal process.
- I understand that Social Security numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to Social Security, IRS, SSI, wage records, unemployment insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits. This information will be disclosed to other agencies only as permitted by law.
- If benefits are paid on my behalf in error, I will be required to pay the overpaid amount.
- If I am convicted for fraudulently receiving benefits, I will not be eligible to receive child care benefits in accordance with 922 KAR 2:020.

Sign Here \_\_\_\_\_ Today's Date \_\_\_\_\_

If you are dissatisfied with the action taken, you may request an administrative hearing in accordance with 922 KAR 1:320, Service Appeals, within thirty (30) calendar days from the date of this notice by submitting a Child Care Service Appeal Request (DCC-88) to the Office of the Ombudsman, 275 East Main Street, 1E-B, Frankfort, KY 40621. **IF YOU SUBMIT A WRITTEN REQUEST FOR AN ADMINISTRATIVE HEARING, PLEASE ATTACH A COPY OF THE NOTICE OF ADVERSE ACTION.**

For resolution of a matter not subject to review through an administrative hearing, you may submit an informal dispute resolution to your Service Agent.