

Application for Subsidized Child Care Assistance

DATE: _____

ALL REQUIRED VERIFICATIONS (income, class schedule, etc.) **MUST BE RECEIVED WITHIN THIRTY (30) DAYS** of the application. Without complete verification, your application will be denied.

APPLICANT INFORMATION:

Last Name	First Name	Middle Initial	DOB	Marital Status	Sex
Social Security Number		Race	Case Number		
Home Address		Mailing Address		Phone Number	
				County of Residence	
Other Responsible Adult's Name	Social Security Number	DOB	Race	Marital Status	Sex

CHILD(REN) NEEDING CARE:

CHILD'S NAME	Social Security Number	DOB	SEX	RACE	Citizen	RELATIONSHIP TO APPLICANT	ELIGIBILITY TYPE

OTHERS LIVING IN THE HOME:

Last Name	First Name	Middle Initial	Relationship to Applicant	Date of Birth	Social Security Number



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EMPLOYMENT/TRAINING INFORMATION:

Wages or Self-Employment:

Head of Household: Last, First MI

Employer's Name	Employer's Address	Employer's Phone #	Hours Per Week	Hourly Wages	Monthly Wages

Responsible Adult: Last, First MI

Employer's Name	Employer's Address	Employer's Phone #	Hours Per Week	Hourly Wages	Monthly Wages

TRAINING:

Student's Name	Place of Training	Hours Per Week	Term/Semester Starting Date	Term/Semester Ending Date	Phone Number	What education pursuing

UNEARNED INCOME:

INCOME TYPE	YES	NO	AMOUNT	How Often Received	Who Receives
Child Support	<input type="checkbox"/>	<input type="checkbox"/>			
Alimony	<input type="checkbox"/>	<input type="checkbox"/>			
Public Assistance (KTAP, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Railroad Retirement	<input type="checkbox"/>	<input type="checkbox"/>			
SSA /RSDI (Social Security)	<input type="checkbox"/>	<input type="checkbox"/>			
SSI (Supplemental Security Income)	<input type="checkbox"/>	<input type="checkbox"/>			
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>			
Veterans Benefits	<input type="checkbox"/>	<input type="checkbox"/>			
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>			
Other (Interest, Dividend, Pension, Annuity)	<input type="checkbox"/>	<input type="checkbox"/>			

FAMILY ASSISTANCE:

Food Stamp	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Housing Assistance (Section 8)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY DEDUCTIONS (CHILD SUPPORT OR SELF-EMPLOYMENT BUSINESS EXPENSES):

Adult's Name	Type of Deduction	Amount	Frequency Paid

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Applicant Responsibilities

- You must provide any documentation required for your worker to determine your eligibility. If your case is approved, you must complete an annual redetermination of eligibility.
- You must work an average of twenty (20) hours per week if you are approved to receive child care services as a low income, working family. If you receive KTAP, the worker who assists you with your KTAP benefits and Kentucky Works requirements will advise you as to the number of hours you must participate in work or work related activities. Two (2) parent families must work a combined average of forty (40) hours per week with neither parent working less than an average of five (5) hours a week unless one (1) adult is verified as mentally or physically unable to provide care for the children.
- You must report any change in your situation to your worker within ten (10) days of the change becoming known to you. Changes which must be reported include:
 - Start or end of a job;
 - Change of employer or extra jobs;
 - More or less hours worked;
 - Increase or decrease in pay;
 - More or less people in your household;
 - Self employment;
 - Schedule change for day care;
 - Start or end of educational activity;
 - Child care provider changed;
 - Mailing address and where you live;
 - Marital Status; or
 - Start or end receipt of unearned income.
- You must ensure your child attends child care according to provider policies, and the Child Care Agreement. Documentation is required for a child's extended absence.
- You are responsible for provider charges exceeding the total daily payment (overage charges), for payment of a family co-pay and for payment for days the children are absent from care which are not payable by the cabinet according to the provisions of 922 KAR 2:160. Failure to pay your co-pay to your provider may result in the loss of your Child Care Assistance.
- You may be responsible for payment of fees charged by your child care provider.
- You will not be allowed to make more than three (3) provider changes per year (twelve (12) month period).
- Unless there is a court order, or a documented disability, Child Care Assistance will be terminated on the child's thirteenth (13th) birthday.
- If you choose to use In-Home Child Care, you are responsible for all applicable employee benefits for the child care provider.
- If benefits are paid on your behalf in error, you will be required to pay the overpaid amount in accordance with 922 KAR 2:020.

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.

SIGNATURES

I understand that within thirty (30) days I shall be notified of my eligibility to receive child care. I have been assured by the Cabinet for Health and Family Services (or its designated contract agency) of its intention to 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.

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I certify all entries have been read by me or to me and are correct and true to the best of my knowledge and belief. I declare, under penalty of perjury, that the child(ren) requesting assistance are U.S. citizens or are admitted under an approved alien status. I understand information on this application is used to determine if I am eligible for benefits from the Department for Community Based Services. I understand if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I have also read, or had read to me, the explanation of my rights and obligations as a Department for Community Based Services applicant.

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.

Signature of Applicant: _____ Date: _____

Signature of Service Agent Staff: _____ 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.