COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

Work and School Schedule

Case Name: _____ **Service Agent Staff Name:** _____
Case Number: _____ **Date:** _____
Date Form Due Back to Service Agent: _____

Employer Name: _____
Address: _____
City, ST, Zip: _____

Phone: _____

Work Schedule For_____							
Hours	Sun	Mon	Tues	Wed	Thur	Fri	Sat
AM/PM							
PM/AM							
School Schedule							
Hours	Sun	Mon	Tues	Wed	Thur	Fri	Sat
AM/PM							
PM/AM							

Explanation of varying work schedule _____
_____
_____

I understand I am responsible to report a change in my employment or educational activity that affects my eligibility or amount of child care benefits. Changes must be reported within ten (10) days of the day the change is known. Failure to report a change may result in an erroneous payment that I have to pay back.

Applicant/Active Client's Signature _____
Date _____

Return Form to:

Service Agent Staff Name: _____
Address: _____ _____ __ _____
Street City State Zip Code