

PLEASE PRINT IN ALL CAPITAL LETTERS

APPLICATION FOR CHILD CARE SUBSIDY

NEW
 RECERTIFICATION

OFFICE USE ONLY	Case #:	Application Date: ____/____/____
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Section 1 APPLICANT	LAST Name <i>(Please include any aliases or maiden names in parentheses):</i>			FIRST Name:			M.I.:			
	ADDRESS Residence:				APT. #:	CITY/BOROUGH:	STATE:	ZIP CODE:		
	ADDRESS Mailing <i>(if different than above):</i>				APT. #:	CITY/BOROUGH:	STATE:	ZIP CODE:		
	TELEPHONE <i>(Work):</i> () _____			TELEPHONE <i>(Home):</i> () _____			TELEPHONE <i>(Cell or Other):</i> () _____			
	Do you receive PA? <input type="checkbox"/> YES <input type="checkbox"/> NO PA #: _____			Do you receive Medicaid? <input type="checkbox"/> YES <input type="checkbox"/> NO MA #: _____			What is your primary language?			

Please fill out the information below for your entire household. List yourself first, followed by everyone who lives with you.

Section 2 FAMILY MEMBERS	#	LAST Name <small>(PLEASE INCLUDE ANY ALIASES OR MAIDEN NAMES IN PARENTHESES)</small>	FIRST Name	M.I.	RELATIONSHIP	DOES THIS PERSON NEED CHILD CARE? YES/NO	BOTH OF CHILD'S PARENTS RESIDE IN THE HOME? YES/NO	DATE OF BIRTH MM/DD/YY	SEX M/F	HISPANIC OR LATINO? YES/NO	RACE <small>(SEE LEGEND BELOW)</small>	SOCIAL SECURITY NUMBER <small>(OPTIONAL)</small>	
	1.					SELF							
	2.												
	3.												
	4.												
	5.												
	6.												

RACE: 1. Native American *or* Alaskan Native 2. Asian 3. African American/Black 4. Native Hawaiian/Pacific Islander 5. Caucasian/White

For additional family members, please attach a separate sheet.

Include information for any spouse/other parent of the children applying for care who lives in the home.

Section 3 EMPLOYMENT	APPLICANT'S EMPLOYER Name:			Hours per week:	Tel #: () _____
	ADDRESS:		CITY/BOROUGH:	STATE:	ZIP CODE:
	APPLICANT'S Scheduled Days and Hours of Employment <i>(i.e.: Mon – Fri, 9 a.m. – 5 p.m.):</i>			Does Job have a Rotation Shift? <input type="checkbox"/> YES <input type="checkbox"/> NO Does Job Require O/T? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	SPOUSE/OTHER PARENT EMPLOYER Name:			Hours per week:	Tel #: () _____
	ADDRESS:		CITY/BOROUGH:	STATE:	ZIP CODE:
	SPOUSE/OTHER PARENT Scheduled Days and Hours of Employment <i>(i.e.: Mon – Fri, 9 a.m. – 5 p.m.):</i>			Does Job have a Rotation Shift? <input type="checkbox"/> YES <input type="checkbox"/> NO Does Job Require O/T? <input type="checkbox"/> YES <input type="checkbox"/> NO	

OFFICE USE ONLY
Family Size: _____

Section 4 CHILD/ FAMILY NEEDS	Are you requesting child care primarily so that you can work? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is the child for whom you are requesting care living with someone other than his/her mother or father? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If not, please read the instruction section titled "Child/Family Needs" and write your reason for care here: _____		Does your child have any conditions that require special help or attention? <input type="checkbox"/> YES <input type="checkbox"/> NO	
			Does your child have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Please complete income information for yourself **AND** anyone applying with you. See instructions for documentation requirements.
(This includes children in need of care, their parents, step-parent and any other children under the age of 18 in household.)

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Section 5 OTHER INCOME EARNINGS	ITEM	GROSS INCOME	TYPE OF DOCUMENTATION	OFFICE USE MONTHLY CALCULATIONS	
	APPLICANT: Job earnings before deductions. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other	\$			
	SPOUSE/OTHER PARENT: Job earnings before deductions. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other				
	For all other income/benefits please itemize below. Include the amount for yourself AND your spouse AND child(ren) who live with you.	INCOME	FOR OFFICE USE ONLY		
	Alimony and/or child support. (Received) <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other		DOCUMENTATION	CALCULATIONS	
	Unemployment and/or worker's compensation. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other				
	Net income from self-employment and/or rental income. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other				
	BENEFITS: Social Security, SSI, Disability, Retirement and/or Pensions & Annuities. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other				
OTHER INCOME/BENEFITS (Check All That Apply): <input type="checkbox"/> Cash or monetary assistance through the Temporary Assistance to Needy Families (TANF) program or Public Assistance (PA). <input type="checkbox"/> Housing voucher or cash assistance. <input type="checkbox"/> Food stamps. <input type="checkbox"/> Other federal cash income programs (such as SSI).					
TOTAL INCOME:		\$			

Section 6 PROVIDER	If your child is already in care, or you know the name of the program/provider where you plan to enroll your child, please list the provider name and address below. You may list a second choice.			
	Name: _____	PROGRAM #	Name: _____	PROGRAM #
	Address: _____		Address: _____	
Please check the types of care that you would consider if there are no available slots with the provider(s) you listed above or if you do not have a provider in mind: <input type="checkbox"/> Center Based Care <input type="checkbox"/> Head Start <input type="checkbox"/> Informal Care <input type="checkbox"/> Family Day Care				

Section 7 CITIZENSHIP	Is/are the child/children for whom you are applying a U.S. citizen(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If Yes , Parent/Guardian must sign and date to certify that the child/children in receipt of child care assistance/subsidy is/are a U.S. citizen(s). <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border-bottom: 1px solid black; width: 60%;"></div> <div style="text-align: center;">PARENT/CARETAKER/WIFE/HUSBAND</div> <div style="border-bottom: 1px solid black; width: 15%;"></div> <div style="text-align: center;">DATE</div> </div>	
	If No , your eligibility must be determined at the Resource Area (R.A.), please make an appointment at your R.A. and bring the documentation listed in the instructions for this form.	

Section 8 CERTIFICATION	<p>1. I understand that the information contained on this form will be used to determine my or my family's eligibility for services/subsidy and that the information will only be used for the purposes of determining child care eligibility.</p> <p>2. The social security numbers (if provided) will not be released as they are confidential under federal law and can be released/used only for the purposes specified in federal law.</p> <p>3. I agree to inform the agency immediately of any change in my income, living arrangement, household composition or address, where care is provided, who is providing child care, provider fees, hours for which child care is needed, and that New York State Law and Federal Law provides that any applicant may be investigated for fine or jail or both, for a person found guilty of obtaining child care assistance/subsidy by concealing information or providing false information.</p> <p>4. I understand that this application is used only for the expressed purpose of child care subsidy. To obtain other assistance such as Food Stamps, Medicaid, Temporary Assistance, or other services, additional applications will be required.</p> <p>5. I certify under the penalty of law that all the information I have supplied on this form is true and correct.</p>	
	Please provide the signature of the parent/caretaker who is applying for child care assistance or the signature of an authorized representative.	
	<p>X _____ /_____/_____ SIGNATURE PARENT/CARETAKER/WIFE/HUSBAND DATE</p> <p>_____ PRINT NAME</p>	<p>X _____ /_____/_____ SIGNATURE AUTHORIZED REPRESENTATIVE DATE</p> <p>_____ PRINT NAME</p>

Section 9 OFFICE ONLY	Enrollment Application Completed by: _____ /_____/_____ PRINT AND INITIAL DATE	Length of Eligibility: from: _____ /_____/_____ to: _____ /_____/_____ I.S. - Verified by: _____ /_____/_____ PRINT AND INITIAL DATE
	ACS - Eligibility Approved by: _____ /_____/_____ PRINT AND INITIAL DATE	
	Parent Fee: _____ /_____/_____ INITIAL DATE	CODES: ♦RFC: ___ ♦PR: ___ ♦FS: ___