CS-925 (FACE)
REV. 5/07

APPLICATION FOR CHILD CARE SUBSIDY

☐ **NEW**
☐ **RECERTIFICATION**
☐ **TRANSITIONAL CHILD CARE**

nyc ACS
NYC Administration for Children's Services

PLEASE PRINT IN ALL CAPITAL LETTERS

OFFICE USE ONLY	Case #:	Application Date: _____ /_____ /_____

Section 1 APPLICANT

LAST Name *(Please include any aliases or maiden names in parentheses)*:	**FIRST** Name:	**M.I.**:
ADDRESS Residence:	**APT. #:** / **CITY/BOROUGH:** / **STATE:** / **ZIP CODE:**	
ADDRESS Mailing *(if different than above)*:	**APT. #:** / **CITY/BOROUGH:** / **STATE:** / **ZIP CODE:**	

TELEPHONE *(Work)*: ( ) _____	**TELEPHONE** (Home): ( ) _____	**TELEPHONE** *(Cell or Other)*: ( ) _____
Do you receive PA? ☐ **YES** ☐ **NO** PA #: _____	Do you receive Medicaid? ☐ **YES** ☐ **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 *(PLEASE INCLUDE ANY ALIASES OR MAIDEN NAMES IN PARENTHESES)*	**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 *(SEE LEGEND BELOW)*	SOCIAL SECURITY NUMBER *(OPTIONAL)*
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.

OFFICE USE ONLY
Family Size: _____

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.e.: Mon – Fri, 9 a.m. – 5 p.m.)*:		Does Job have a Rotation Shift? ☐ **YES** ☐ **NO** Does Job Require O/T? ☐ **YES** ☐ **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.e.: Mon – Fri, 9 a.m. – 5 p.m.)*:		Does Job have a Rotation Shift? ☐ **YES** ☐ **NO** Does Job Require O/T? ☐ **YES** ☐ **NO**	

Section 4 CHILD/ FAMILY NEEDS

Are you requesting child care primarily so that you can work? ☐ **YES** ☐ **NO**
If not, please read the instruction section titled "Child/Family Needs" and write your reason for care here:
_____

Is the child for whom you are requesting care living with someone other than his/her mother or father? ☐ **YES** ☐ **NO**
Does your child have any conditions that require special help or attention? ☐ **YES** ☐ **NO**
Does your child have health insurance? ☐ **YES** ☐ **NO**

OVER➤

CS-925 (REVERSE)
REV. 5/07

nycACS
NYC Administration for Children's Services

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.)

PLEASE PRINT

Section 5 EARNINGS OTHER INCOME

ITEM	GROSS INCOME	TYPE OF DOCUMENTATION	OFFICE USE MONTHLY CALCULATIONS
APPLICANT: Job earnings before deductions. ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other	$		
SPOUSE/OTHER PARENT: Job earnings before deductions. ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ 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** DOCUMENTATION	CALCULATIONS
Alimony and/or child support. **(Received)** ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other			
Unemployment and/or worker's compensation. ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other			
Net income from self-employment and/or rental income. ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other			
BENEFITS: Social Security, SSI, Disability, Retirement and/or Pensions & Annuities. ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other			
OTHER INCOME/BENEFITS *(Check All That Apply)*: ☐ Cash or monetary assistance through the Temporary Assistance to Needy Families (TANF) program or Public Assistance (PA). ☐ Housing voucher or cash assistance. ☐ Food stamps. ☐ 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 #** Name: _____ **PROGRAM #**

Address: _____ 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: ☐ Center Based Care ☐ Head Start ☐ Informal Care ☐ Family Day Care

Section 7 CITIZEN -SHIP

Is/are the child/children for whom you are applying a U.S. citizen(s)? ☐ **YES** ☐ **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). _____ _____ /_____ /_____
PARENT/CARETAKER/WIFE/HUSBAND *DATE*

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

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.
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.
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.
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.
5. I certify under the penalty of law that all the information I have supplied on this form is true and correct.

Please provide the signature of the parent/caretaker who is applying for child care assistance or the signature of an authorized representative.

X _____ _____ /_____ /_____
SIGNATURE *PARENT/CARETAKER/WIFE/HUSBAND* *DATE*

_____
PRINT NAME

X _____ _____ /_____ /_____
SIGNATURE *AUTHORIZED REPRESENTATIVE* *DATE*

_____
PRINT NAME

Section 9 OFFICE ONLY

Enrollment **Application** Completed by: _____ _____ /_____ /_____
PRINT AND INITIAL *DATE*

ACS – **Eligibility** Approved by: _____ _____ /_____ /_____
PRINT AND INITIAL *DATE*

Parent Fee: _____ _____ /_____ /_____
INITIAL *DATE*

Length of Eligibility: from: _____ /_____ /_____
to: _____ /_____ /_____

I.S. – Verified by: _____ _____ /_____ /_____
PRINT AND INITIAL *DATE*

CODES: ◆RFC: _____◆PR: _____◆FS: _____