ARKANSAS DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR CHILD CARE ASSISTANCE

You must complete ALL sections and sign OR the application will be returned to you. Fill in today's date:

NEED

Why do you need child care assistance? ☐ Work ☐ School ☐ Training ☐ Protective/Preventive Services ☐ Foster Care

Will you lose a job or have to drop out of school within 7 days because you cannot pay for child care? ☐ YES ☐ NO

Will you have to refuse a job or admittance to school within 7 days because you cannot pay for child care? ☐ YES ☐ NO

If answered 'yes' to either question, explain:

CASEHEAD INFORMATION

Must be 18 years of age or an emancipated minor and have full-time custody of the child requiring child care services.

Social Security #	First Name MI Last Name	Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Gender: ☐ Male ☐ Female	Race (see codes):

Mailing Address	City/State	Zip	U.S. Citizen or Permanent Resident? ☐ Yes ☐ No	Home Phone (include area code)

Street Address	City/State	County	Zip	Other Phone (include area code)

Highest Grade Completed	# Parents in Home	Primary Language	Have you ever received TEA or ESS Child Care ? ☐ Yes ☐ No Do you receive food stamps? ☐ Yes ☐ No How much? $ Do you receive housing assistance? ☐ Yes ☐ No How much? $

HOUSEHOLD INFORMATION

Include information for all persons living in household. *Do not include yourself.* Attach additional sheets if necessary.

Social Security #	First Name MI Last Name	Date of Birth	Gender	Race (see below)	Citizen/Legal Resident?	Rela ionship to Casehead	Child Care Needed?	List any Special Needs
			☐ Male ☐ Female		☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Male ☐ Female		☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Male ☐ Female		☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Male ☐ Female		☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Male ☐ Female		☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Male ☐ Female		☐ Yes ☐ No		☐ Yes ☐ No	

Use these codes to describe your race(s): A = Asian B = Black/African American H = Native Hawaiian/Pacific Islander I = American Indian or Alaskan Native S = Hispanic/Latino W = White

CHILD CARE INFORMATION

Complete information below for ALL children who require child care.

Child's Name	Age	Name of Child Care Provder Selected:	Is child now attending?	Is provider a relative?	If yes, list relationship:	Status of Child Support for Child	List days and hours of care you need for this child.
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Receive ☐ Applied for ☐ Neither ☐ N/A	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Receive ☐ Applied for ☐ Neither ☐ N/A	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Receive ☐ Applied for ☐ Neither ☐ N/A	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Receive ☐ Applied for ☐ Neither ☐ N/A	

EMPLOYMENT/SCHOOL

Adults in the household must be employed 30 hours per week, be enrolled in school full-time or qualify as working student.

Name	Career Pathways?	List work/school schedule below (include travel time):							If in school, list major or course of study:
		Mon	Tue	Wed	Thu	Fri	Sat	Sun	
Employer/School:	☐ Yes								
	☐ No	School Information: ☐ Semester ☐ Quarter			Start Date:		Hours Enrolled:		

Name	Career Pathways?	List work/school schedule below (include travel time):							If in school, list major or course of study:
		Mon	Tue	Wed	Thu	Fri	Sat	Sun	
Employer/School:	☐ Yes								
	☐ No	School Information: ☐ Semester ☐ Quarter			Start Date:		Hours Enrolled:		

Name	Career Pathways?	List work/school schedule below (include travel time):							If in school, list major or course of study:
		Mon	Tue	Wed	Thu	Fri	Sat	Sun	
Employer/School:	☐ Yes								
	☐ No	School Information: ☐ Semester ☐ Quarter			Start Date:		Hours Enrolled:		

HOUSEHOLD INCOME Proof of all income must be provided.

Name of Adult	Wages		Child Support		SSI		SSA		TEA/Work Pays		Other	
	Amt	How Often Rec'd	Amt	How Often Rec'd	Amt	How Often Rec'd	Amt	How Often Rec'd	Amt	How Often Rec'd	Amt	How Often Rec'd

RIGHTS AND RESPONSIBILITIES Read carefully and sign at the bottom.

1. You have the right to a decision on your application within seven (7) calendar days after all necessary information is submitted.
2. You cannot be denied child care assistance on the basis of race, color, sex, age, disability, religion, national origin, politica belief or failure to disclose a Social Security Number.
3. You may choose any child care provider that meets the requirements of DHHS and the Child Care Assistance Program.
4. Information you provide will not be released without your written consent, except to parties allowed by law. Your name and Social Security Number may be furnished to employers, government agencies, educational institutions or any other party deemed necessary by DHHS to determine your eligibility.
5. If any adverse action is taken on your application or child care case, you have the right to an Internal Review. You may appeal any review decision by sending a written request to: Arkansas Department of Health and Human Services, Office of Appeals and Hearings, P.O. Box 1437, Slot N-401, Little Rock, AR 72203.
6. You must help establish your eligibility by FULLY completing this application and providing as much information as possible about your circumstances. Providing false information or withholding information may result in criminal prosecution.
7. You must report ALL changes that affect eligibility to your Child Care Eligibility Specialist within ten (10) days of the change. These changes include but are not limited to: Address or Telephone, Household Members, Employment, Child Support, Child Care Needs, Training/Education or Monthly Income Changes of Greater than $100. Failure to report changes may result in your case being closed and a referral to the Fraud Unit. You are responsible for any overpayments resulting from changes in your status.
8. You understand that DHHS will not retroactively pay or reimburse you for child care expenses. The first day that DHHS will pay for child care is the day DHHS determines eligibility requirements have been met and you are approved for services.
9. Within six months of receiving child care benefits, you must submit documentation that you are receiving child support or have applied to pursue child support from the absent parent(s) of children for whom assistance is needed.
10. You agree to cooperate in any DHHS investigation concerning your case. You understand that failure to cooperate will result in termination of assistance.
11. If you wish to change child care providers, you must give a minimum of one (1) week's written notice to your Child Care Specialist. If such notice is not given, you will be responsible for any payments to the new child care provider until the Child Care Specialist officially completes the change.
12. Social Security Numbers shall be used for identification purposes only and are not required for eligibility.

STUDENTS ONLY: Students enrolled in education or training programs must maintain full-time status to retain eligibility. Students are allowed a maximum of five (5) years to complete education. Grade reports are checked each term to verify completion of courses. If you reduce your hours, you MUST report this to your Child Care Eligibility Specialist within ten (10) days, and you will be required to obtain work of up to 30 hours per week to remain eligible for assistance. Grades are checked at the end of every full term in which you receive assistance. You must maintain a "C" average (2.00 GPA) in order to continue receiving assistance. If you drop below a 2.00 average, you will be placed on academic probation for one (1) term. If your grades do not meet this requirement the following semester, you will become ineligible for assistance and your case will be closed unless full-time employment is obtained within 30 days..

CERTIFICATION: I certify that I have read and understand my Rights and Responsibilities. I authorize DHHS to collect information from other sources to determine my eligibility for assistance. I authorize any source DHHS deems necessary to determine eligibility to release information concerning me. I certify under penalty of perjury and fraud that all information I have supplied is true and correct. I understand that giving false information or withholding information may result in criminal prosecution and the repayment of financial assistance made on my behalf.

Signature _____ Print Name _____

Date _____

Arkansas Department of Human Services
Verification of Earnings

TO EMPLOYER:
To determine eligibility and correct benefits for your employee we need the information requested below. **This will enable us to ensure that the public funds are used only for the actual and correct benefits to which a household is entitled.** PLEASE COMPLETE THE ITEMS CIRCLED AS WELL AS THE SIGNATURE SECTION AT THE BOTTOM OF THIS FORM.
If you need this material in a different format such as large print, contact your local DHS county office.

_____ **Address** Department of Human Services
Caseworker

_____ _____
Telephone Number TDD#

_____ _____
Employee **Casehead**

_____ _____
SSN of Employee Case Number

1. The above employee began work _____ and earns $_____ per hour. He/she works an average of _____ hours per week. Date first pay to be received _____.
   Anticipated gross amount of 1st pay $_____.
   Employee is paid: ☐ Weekly ☐ Monthly ☐ Other -- Please indicate how often _____
   ☐ Every 2 weeks ☐ Twice Monthly
2. Please show GROSS EARNINGS (before any deductions) PAID TO this employee as indicated. Please list each pay check separately **including vacation pay and bonuses.**

	Pay Period Ending	**Date Received**	**Hours Worked**	**Gross Wages**	**Tips**	**Housing/Utilities** Paid above wages
☐ REC'D in the Month of						
☐ For the past _____ consecutive pay periods						

3. **Earnings:** Are any of the earnings funded by JTPA - On The Job Training Program? ☐ Yes or ☐ No

4. **Termination:** If employee no longer is employed by you, what was the date and reason for leaving this job?
   _____
   Date last check will be received _____ and gross amount _____
5. Additional Information/Expected Changes: (such as layoffs, raises, increased or reduced hours, vacation pay, bonuses, and sick pay).
   _____
6. **Insurance:** If employee has insurance through this job, what is the name and address of the insurance carrier?_____
   Claims processing address if different than insurance carrier _____
   Policy Number _____ Effective date of policy _____
   Type of coverage _____ Policy: ☐ individual or ☐ group
   Policyholder and covered individuals _____
   I do hereby certify that the above information is factual and correct to the best of my knowledge.

_____ _____ _____
Employer/Payroll Clerk Signature Date Telephone

_____ _____
Place of Business Address

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Child Care and Early Childhood Education

DECLARATION OF U.S. CITIZENSHIP OR SATISFACTORY IMMIGRATION STATUS

Name of Casehead_____

Please check all boxes which apply to you and your household and list any names which are requested.

☐ I declare that I am a U.S. Citizen or National.

☐ I declare that the persons listed as household members on my Application for Child Care Assistance are U.S. Citizens or Nationals.

☐ I declare that the following persons are aliens who are either:
- lawfully admitted for permanent residence
- refugees
- asylees
- parolees with status granted for at least one (1) year
- individuals whose deportation is withheld OR
- conditional entrants:

NAME	USCIS* REGISTRATION NUMBER
_____	_____
_____	_____
_____	_____

☐ I declare that the following persons are lawfully admitted aliens who are either:
- U.S. military veterans with an honorable discharge
- active duty servicepersons OR
- spouses or children of one of the above:

NAME	FORM NUMBER
_____	_____
_____	_____

☐ OTHER: Please specify status_____

NAME	USCIS* REGISTRATION NUMBER
_____	_____
_____	_____

I declare under penalty of perjury that the foregoing information is true and correct (28 USC 1746). I understand that providing false information or withholding information for the purpose of obtaining child care assistance may result in criminal prosecution and repayment of any financial assistance made on my behalf.

_____ _____
SIGNATURE OF CASEHEAD DATE

If you need this material in a different format, such as large print, or if you have any questions regarding this form, please contact your Child Care Eligibility Specialist or the DCC-ECE Family Support Unit at 1-800-322-8176.

**-U.S. Citizenship and Immigration Service*

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Child Care and Early Childhood Education

Child Care Arrangement Verification

This is NOT an approval for services.

Name of Casehead/Applicant____

The information below must be completed by the CHILD CARE PROVIDER where children are either currently attending or will be attending.

CHILD CARE PROVIDER: List children of casehead who are enrolled and complete all applicable information for each child. Return form to casehead upon completion.

Child's Name	Age	Start Date	Head Start/ABC	Type of Service Requested	Time of Service Requested	Cost Per Day
			☐ Head Start (Full Day) ☐ Head Start (Half Day) ☐ ABC	☐Full Day ☐ Night ☐ Weekend ☐ Half-Time ☐ Part-Time	____am ___am ____am ___pm ____am ___pm	$
			☐ Head Start (Full Day) ☐ Head Start (Half Day) ☐ ABC	☐Full Day ☐ Night ☐ Weekend ☐ Half-Time ☐ Part-Time	____am ___am ____am ___pm ____am ___pm	$
			☐ Head Start (Full Day) ☐ Head Start (Half Day) ☐ ABC	☐Full Day ☐ Night ☐ Weekend ☐ Half-Time ☐ Part-Time	____am ___am ____am ___pm ____am ___pm	$
			☐ Head Start (Full Day) ☐ Head Start (Half Day) ☐ ABC	☐Full Day ☐ Night ☐ Weekend ☐ Half-Time ☐ Part-Time	____am ___am ____am ___pm ____am ___pm	$
			☐ Head Start (Full Day) ☐ Head Start (Half Day) ☐ ABC	☐Full Day ☐ Night ☐ Weekend ☐ Half-Time ☐ Part-Time	____am ___am ____am ___pm ____am ___pm	$
			☐ Head Start (Full Day) ☐ Head Start (Half Day) ☐ ABC	☐Full Day ☐ Night ☐ Weekend ☐ Half-Time ☐ Part-Time	____am ___am ____am ___pm ____am ___pm	$

***Types of Service:**

- Full Day: More than 5 hours per day and up to 10 hours
- Half-Time: 3-5 hours per day, inclusively (Hours do not have to be consecutive.)
- Part-Time: Less than 3 hours per day
- Night: Weekday when more than ½ of total care is after 6:00 p.m.
- Weekend: Care on Saturday and/or Sunday

Signature of Facility Director of Designee	Print Name
Name of Child Care Facility	Telephone Number

Mailing Address	City	Zip Code	County

	☐ YES ☐ NO
License No.	Quality Approved?

Check type of facility: ☐ Child Care Center ☐ Licensed Child Care Family Home ☐ Registered Child Care Family Home
☐ Voluntary Registered Home ☐ Other: ____

Casehead: Complete and return this form to your Child Care Eligibility Specialist. If you have any questions, please contact your specialist or the Family Support Unit at 1-800-322-8176 or 501-682-8947.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Child Care and Early Childhood Education
CHILD CARE ASSISTANCE PROGRAM

NON-CUSTODIAL PARENT CHILD SUPPORT STATEMENT

For persons who are divorced or unmarried, within six (6) months of receiving child care benefits, you must document that you are either receiving child support or show proof of an open Child Support case. If you receive child support directly from the non-custodial parent, you may have that parent complete this form and have it notarized. This form must be submitted, along with copies of checks or money orders to verify child support payments. The amount of child support you receive must at least be equal to the minimum amount per child on the Family Support Chart set by the Office of Child Support Enforcement. If you receive child support through the Office of Child Support Enforcement or through a court, this form does not need to be completed. If you are not a single parent of a child in your household, you may disregard this form.

_____ _____ _____
Custodial Parent Name | Social Security Number | County

NON-CUSTODIAL PARENT MUST COMPLETE SECTIONS BELOW:

_____ _____ _____
Name of Absent Parent | Home Telephone | Work Telephone

_____ _____
Address City State Zip | Name of Employer

LIST THE NAME(S) OF YOUR CHILD(REN) YOU PROVIDE SUPPORT FOR:

1._____ 2. _____ 3._____ 4._____

I, _____ give _____ the total sum of
Non-custodial Parent | Custodial Parent

$_____ Check one: ☐ per month ☐ per week ☐ twice a month
☐ every other week ☐ other:_____

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.

I certify that the information I have given is true and factual. I understand that submission of false or misleading information may result in criminal prosecution.

X_____ _____
Signature of Non-Custodial Parent | Date

State of Arkansas, County of _____

Subscribed and sworn to me before a Notary Public in and for the county and state aforesaid, this the _____ day of _____(mo), _____ (year).

AFFIX SEAL HERE

_____
Notary Public

My commission expires on _____, _____(yr).