Application For Child Care Assistance Vouchers

Families eligible to participate in the Community Development Block Grant COVID-19 Impact Assistance are of low to moderate income. Such assistance removes barriers created by COVID-19 to work and employment training so that individuals are able to fully participate in the labor market.

South Coast Business

PLEASE NOTE: All sections of this form must be filled out to be considered complete unless the section is identified as optional. If you do not complete all required sections of this form, you may not be considered for Child Care Assistance.

PLEASE PRINT IN ALL CAPITAL LETTERS

☐ New ☐ Change/Recertification

OFFICE USE ONLY Client #: Application Date:

Section 1 APPLICANT

Last Name *(Please include any aliases or maiden names in parentheses)*: _____ First Name: _____ M.I.: ___ Marital Status: _____

Home Address: _____ Apt. #: _____ City/Borough: _____ State: _____ ZIP Code: _____

Is this a temporary address? ☐ Yes ☐ No If yes, does family currently reside in *(check one)*: ☐ Homeless Shelter ☐ Doubled-up with another family ☐ Hotel/Motel ☐ Car, Bus, Train ☐ Park, Campsite ☐ Other

Telephone (Work): _____ Telephone (Home): _____ Telephone (Cell or Other): _____ Email: _____

Do you receive Cash Assistance? ☐ Yes ☐ No CA#: _____ What is your primary language? ☐ English ☐ Spanish ☐ Other _____

What is your preferred language? ☐ English ☐ Spanish ☐ Other _____

Please list all children in your household needing child care. **(Only children needing care)**

Section 2A CHILD(REN) NEEDING CARE

	Last Name	First Name	M.I.	Relationship	Date of Birth MM/DD/YY	Sex	Both of Child's Parents Reside in the Home?	Ethnicity Hispanic or Latino**	Race** *(See legend below)*	Social Security Number *(Optional)*	Child with a Disability?	Is child U.S. Citizen/ U.S. National/ or person with satisfactory immigration status?
1.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
2.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
3.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
4.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
5.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
6.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
7.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No
8.						☐M ☐F	☐Yes ☐No	☐Yes ☐No			☐Yes ☐No	☐Yes ☐No

**Providing ethnicity and race information is voluntary and will not affect your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.

Racial Affiliation Codes:

AI Native American or Alaskan Native
AS Asian
BL Black or African American
HP Native Hawaiian or Pacific Islander
WH White

Please list all **other** members in your entire household (not listed in Section 2A) including children under age 18 who do **not** need child care. List yourself first, followed by everyone who lives with you.

Section 2B FAMILY MEMBERS

Last Name *(Include any aliases or maiden names in parentheses)*	First Name	M.I.	Relationship	Date of Birth MM/DD/YY	Sex	Ethnicity Hispanic or Latino**	Race** *(See legend to the right)*	Social Security Number *(Optional)*
1.			Self		☐M ☐F	☐Yes ☐No		
2.					☐M ☐F	☐Yes ☐No		
3.					☐M ☐F	☐Yes ☐No		
4.					☐M ☐F	☐Yes ☐No		
5.					☐M ☐F	☐Yes ☐No		
6.					☐M ☐F	☐Yes ☐No		
7.					☐M ☐F	☐Yes ☐No		
8.					☐M ☐F	☐Yes ☐No		

For additional family members, please attach a separate sheet. Include information for any spouse, parent or caretaker of the children applying for care who lives in the home.

Racial Affiliation Codes:

AI Native American or Alaskan Native
AS Asian
BL Black or African American
HP Native Hawaiian or Pacific Islander
WH White

OFFICE USE ONLY Family Size:

Section 3 CHILD/FAMILY NEEDS

How were you negatively impacted by COVID-19?

☐ No Impact
☐ Employment Status
☐ Work Schedule
☐ Income
☐ Availability of childcare
☐ Other Describe:

Is a parent currently active duty (full-time) in the US Military?

☐ No ☐ Yes

Is a parent currently a member of a National Guard or Military Reserve Unit?

☐ No ☐ Yes

Is the applicant receiving and/or applying for child care assistance through another program? If yes please indicate the agency:

Section 4 EMPLOYMENT (if employment is reason for care)

Applicant's Employer Name: _____ Tel#: _____ Address: _____ City: _____ State: ____ ZIP Code: _____

Employment Start Date: _____ Does job have a rotating shift? ☐Yes ☐No Does job require overtime (OT)? ☐Yes ☐No

If applicant has a second job

Employer Name: _____ Tel#: _____ Address: _____ City: _____ State: ____ ZIP Code: _____

Employment Start Date: _____ Does job have a rotating shift? ☐Yes ☐No Does job require overtime (OT)? ☐Yes ☐No

Second parent, caretaker or stepparent in the household

Employer Name: _____ Tel#: _____ Address: _____ City: _____ State: ____ ZIP Code: _____

Employment Start Date: _____ Does job have a rotating shift? ☐Yes ☐No Does job require overtime (OT)? ☐Yes ☐No

If second parent, caretaker or stepparent in the household has a second job

Employer Name: _____ Tel#: _____ Address: _____ City: _____ State: ____ ZIP Code: _____

Employment Start Date: _____ Does job have a rotating shift? ☐Yes ☐No Does job require overtime (OT)? ☐Yes ☐No

Section 5 WORK/ACTIVITY/TRAVEL TIME SCHEDULE

Typical work/activity schedule (i.e., educational/vocational activity)

Sunday from to	Monday from to	Tuesday from to	Wednesday from to	Thursday from to	Friday from to	Saturday from to

Please complete the schedule below **only** if the parent has a second shift, job or activity

Sunday from to	Monday from to	Tuesday from to	Wednesday from to	Thursday from to	Friday from to	Saturday from to

Typical work/activity schedule for second parent, caretaker or stepparent in the household

Sunday from to	Monday from to	Tuesday from to	Wednesday from to	Thursday from to	Friday from to	Saturday from to

Please complete the schedule below **only** if the second parent, caretaker or stepparent in the household has a second shift, job or activity

Sunday from to	Monday from to	Tuesday from to	Wednesday from to	Thursday from to	Friday from to	Saturday from to

Travel Time

Drop off: Travel time from the child care provider to work/activity?
Check one of the following: ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 1 hour ☐ More than 1 hour. Amount of time if more than 1 hour _____ Public Transportation? ☐ Yes ☐ No

Pick-up: Travel time from work/activity to the child care provider?
Check one of the following: ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 1 hour ☐ More than 1 hour. Amount of time if more than 1 hour _____ Public Transportation? ☐ Yes ☐ No

Spouse/Other Parent

Drop off: Travel time from the child care provider to work/activity?
Check one of the following: ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 1 hour ☐ More than 1 hour. Amount of time if more than 1 hour _____ Public Transportation? ☐ Yes ☐ No

Pick-up: Travel time from work/activity to the child care provider?
Check one of the following: ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 1 hour ☐ More than 1 hour. Amount of time if more than 1 hour _____ Public Transportation? ☐ Yes ☐ No

Section 6 INCOME INFORMATION

Indicate if you or anyone who is applying with you receives money from the following sources. PLEASE PRINT

Sources	Yes	No	Gross Amount	How often? (weekly, biweekly, monthly, etc?)	Who is the recipient?	OFFICE USE ONLY: Type of Documentation	OFFICE USE ONLY: Monthly Calculations
Applicant Wages/Salary, including overtime, commissions, training programs, tips	☐	☐	$		Self		
Second parent, caretaker or stepparent in the household Wages/Salary, incl. overtime, commissions, training programs, tips	☐	☐	$				
Net Self-Employment Income	☐	☐	$				
Child Support Payments (received)	☐	☐	$				
Alimony/Spousal Support (received)	☐	☐	$				
Unemployment Insurance Benefits, Workers' Comp	☐	☐	$				
Social Security Benefits (including SSI)	☐	☐	$				
Disability Benefits	☐	☐	$				
Rental/Boarder/Lodger Income (received)	☐	☐	$				
Dividends/Interest – Stocks, Bonds, Savings	☐	☐	$				
Retirement, Pensions/Annuities	☐	☐	$				
DHS Employment Related Day Care Subsidy	☐	☐	$				
Other (please specify)	☐	☐	$				
Total Income			$ **0.00**				

Section 7 PROVIDER

If you qualify for Child Care Assistance, you have the option to choose: center-based or home-based child care. If you choose a provider that is not licensed or registered, the provider must be enrolled as a Legally-Exempt provider. Provide below the name(s) and address(es) of your child care provider(s).

Name: _____ Program # *(if applicable)* _____ Name: _____ Program # *(if applicable)* _____ Name: _____ Program # *(if applicable)* _____

Address: _____ Address: _____ Address: _____

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. I understand that by signing this application form, I agree to cooperate fully with any investigation to verify or confirm the information I have given or any other investigation in connection with my request for child care assistance. I will provide additional information if requested.
2. Social Security Numbers, if provided, may be used by federal, state, and local agencies to prevent duplication of services, fraud and for federal reporting.
3. I agree to inform the agency immediately of any change in my needs, income, address, living arrangement, household composition or address where care is provided, who is providing child care, provider fees and/or hours for which child care is needed.
4. I certify that the children indicated as needing child care are United States (U.S.) citizens, U.S. nationals, or persons with satisfactory immigration status. I understand that this information about these children may be submitted to the Immigration and Naturalization Service (INS) for verification of immigration status, if applicable. I further understand that the use or disclosure of this information about these children is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of provisions of the Child Care Assistance Program.
5. I understand that this application is used only for the expressed purpose of child care assistance. However, this application and any information obtained as part of an investigation of this application may be shared with any City, State or Federal agency to which you apply or have applied for any other assistance or benefits.
6. Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Child Care Assistance, or when you are questioned about your eligibility, or if you cause someone else not to tell the truth regarding your application or continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial or continuing eligibility for Child Care Assistance; or if you conceal or fail to disclose facts that would affect the right of someone, for whom you have applied, to obtain or continue to receive Child Care Assistance. If you are the authorized representative applying on behalf of someone else, Child Care Assistance must be used for that person and not yourself. It is unlawful to obtain Child Care Assistance by concealing information or providing false information.

It is the policy and commitment of South Coast Business that it does not discriminate on the basis of race, creed, age, color, sex, religion, national origin, alienage or citizenship status, physical or mental disability, gender, gender identity, sexual orientation, pregnancy, marital or partnership status.

This grant is subject to Robert T. Staffort Act (42 U.S.C.5155) of which a repayment of the assistance would be required if the assistance is determined to be duplicative. Title 18 United States Code Section 1001: (1) makes it a violation of federal law for a person to knowingly and willfully (a) falsify, conceal, or cover up a material fact; (b) make any materially false, fictitious, or fraudulent statement or representation; or (c) make or use any false writing or document knowing it contains a materially false, fictitious, or fraudulent statement or representation, to any branch of the United States Government; and (2) requires a fine, imprisonment for not more than five (5) years, or both, which may be ruled a felony, for any violation of such Section.

Certification: I affirm under the penalties of perjury that all of the information I have given or will give to South Coast Business relating to Child Care Assistance is correct. I have read and understand the notices above. **I further affirm that I am/or have been negatively impacted by the COVID-19 public health emergency.**

Please provide the signatures in ink of both parents/caretakers if two parent/caretaker household.

Signature Parent/Caretaker: _____ Signature Second Parent/Caretaker: _____ Signature Authorized Representative: _____

Print Name: _____ Date: ___/___/___ Print Name: _____ Date: ___/___/___ Print Name: _____ Date: ___/___/___

Section 9 OFFICE ONLY

Authorized Days and Hours of Care:

Sunday from	to	Monday from	to	Tuesday from	to	Wednesday from	to	Thursday from	to	Friday from	to	Saturday from	to

Authorized Days and Hours of Care for Second Shift/Work/Activity Schedule
(Complete only if parent provides second shift/work/activity schedule in Section 5)

Sunday from	to	Monday from	to	Tuesday from	to	Wednesday from	to	Thursday from	to	Friday from	to	Saturday from	to

Eligibility determined and approved by *(print and initial)*: _____ Date: ___/___/___

Length of Eligibility from ___/___/___ to ___/___/___ **Codes:** RFC: _____ PR: _____ FS: _____