ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

APPLICATION FOR CHILD CARE ASSISTANCE

DATE RECEIVED

☐ **INITIAL APPLICATION AND REQUEST** ☐ **REAPPLICATION** To apply for benefits, complete this form. Read each question carefully. Answer the questions honestly and completely. The case manager will assist you with any questions you do not understand.

WHY DO YOU AND YOUR SPOUSE OR OTHER PARENT IN THE HOME NEED CHILD CARE SERVICES? ☐ Employment ☐ School/Training
☐ Medical Reasons ☐ Jobs Program ☐ Job Search *(for Grant Diversion particpants only)* ☐ Other *(Describe)*:

*You may voluntarily indicate your race and ethnic background. Please indicate all that apply.
**☐ Yes ☐ No Are you an enrolled member of an American Indian tribe? If yes, which tribe?

	LIST ALL HOUSEHOLD MEMBERS **APPLICANT INFORMATION**		***RACE** **AI:** American Indian or Alaskan Native; **AS:** Asian; **BL:** Black or African American; **NH:** Native Hawaiian or Other Pacific Islander; **WH:** White	**HISPANIC/LATINO?** *(Circle if yes)*	**SOC. SEC. NO.**	**DATE OF BIRTH** *(MM/DD/YY)*	**MARITAL STATUS**	**OTHER NAMES USED BY YOU (e.g., maiden, alias)**
1	APPLICANT'S FULL LEGAL NAME *(First, M.I, Last)*	**SELF**	☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
2	SPOUSE/OTHER PARENT	**SPOUSE** ☐ Yes ☐ No	☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**				

APPLICANT'S MAILING ADDRESS *(Apt. / Space No., House No., Street, City, State, ZIP)* — PHONE NO. ( )

APPLICANT'S RESIDENTIAL ADDRESS *(If different from above)* — MESSAGE PHONE NO. ( )

	LIST THE NAMES OF EVERYONE ELSE WHO LIVES IN YOUR HOME IN THE SPACES BELOW *(First, M.I, Last)* *(If you have more than 9 people in your home, list their names and relationship to you on a separate sheet of paper.)*	**RELATIONSHIP TO YOU**	***RACE** **AI:** American Indian or Alaskan Native; **AS:** Asian; **BL:** Black or African American; **NH:** Native Hawaiian or Other Pacific Islander; **WH:** White	**HISPANIC/LATINO?** *(Circle if yes)*	**SOC. SEC. NO.**	**DATE OF BIRTH** *(MM/DD/YY)*	**NEEDS CHILD CARE?** *(Circle if yes)*	**NAME OF CHILD'S SCHOOL** *(Indicate if school is year round)*	**GRADE**	**SCHOOL HOURS**
3	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				
4	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				
5	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				
6	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				
7	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				
8	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				
9	NAME		☐**AI ☐ AS ☐ BL ☐ NH ☐ WH	**Y**			**Y**			
	IF THIS PERSON IS YOUR CHILD, PRINT THE NAME OF THIS CHILD'S OTHER PARENT					DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No				

Disponible en español en la oficina local.

☐ Yes ☐ No Is any household member temporarily out of the home?

IF YES, NAME OF THE ABSENT HOUSEHOLD MEMBER	RELATIONSHIP TO YOU/YOUR CHILD	REASON FOR ABSENCE	EXPECTED DATE OF RETURN

ARE YOU CURRENTLY A U.S. CITIZEN? ☐ YES ☐ NO
IF NO, ARE YOU A LEGAL RESIDENT OF THE U.S.? ☐ YES ☐ NO

IF NO, WHAT IS YOUR IMMIGRATION STATUS?

HOW LONG DOES IT TAKE YOU TO TRAVEL FROM YOUR CHILD CARE PROVIDER TO YOUR WORK OR SCHOOL? _____ Minutes
TRANSPORTATION USED? ☐ Own Vehicle ☐ Carpool ☐ Bus ☐ Bicycle ☐ Walk ☐ Other:

WHICH CHILD CARE PROVIDER HAVE YOU CHOSEN? ***(if known)***	**PROVIDER'S ADDRESS** ***(No., Street, City, State, ZIP)***	**PHONE NO.** ( )

☐ Yes ☐ No Do any of your children have special needs? If yes, please indicate which child and a description of any special needs:

☐ Yes ☐ No Do you or your spouse receive housing assistance in the form of cash or vouchers?

☐ Yes ☐ No Do you or your spouse pay child support for children who do not live with you? If yes, complete below:

WHO IS PAYING THE SUPPORT	FOR WHOM PAID *(Name of child)*	MONTHLY AMOUNT PAID

UNEARNED INCOME *(You must answer either yes or no; ✓YES if you or any household member has received or will receive any other source of income, ✓NO if not applicable)*

YES	NO	SOURCE	AMOUNT RECEIVED	HOW OFTEN RECEIVED	NAME OF PERSON RECEIVING INCOME
		Cash Assistance	$		
		Social Security/SSI, SSA	$		
		Child Support ATLAS # / Court Order #	$		
		Any Other Income Source, such as: Gifts, Loans, U.I., GI Bill, Rental income, Interest, VA or any Income from Absent Parent(s), Friends or Relatives *(indicate type)*:	$		

YOUR ACTIVITY INFORMATION – *(Do you have more than one job? ☐ Yes ☐ No)*

EMPLOYER'S NAME	WORK PHONE NO. ( )	DATE PRESENT JOB BEGAN

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*	DATE OF 1st PAYCHECK	DATE OF 1st FULL PAYCHECK

HOURS WORKED PER WEEK	HOURLY WAGE	AMOUNT OF PAYCHECK BEFORE DEDUCTIONS	HOW OFTEN RECEIVED *(✓one)*
	$	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

ADDITIONAL INCOME *(✓all that apply)* ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay

TOTAL EARNED $

HOW OFTEN RECEIVED *(✓one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

WORK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
FROM:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.
TO:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.

SECOND EMPLOYER'S NAME *(If you have a second job)*	WORK PHONE NO. ( )	DATE PRESENT JOB BEGAN

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*	DATE OF 1st PAYCHECK	DATE OF 1st FULL PAYCHECK

HOURS WORKED PER WEEK	HOURLY WAGE	AMOUNT OF PAYCHECK BEFORE DEDUCTIONS	HOW OFTEN RECEIVED *(✓one)*
	$	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

ADDITIONAL INCOME *(✓all that apply)* ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay

TOTAL EARNED $

HOW OFTEN RECEIVED *(✓one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

WORK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
FROM:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.
TO:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.

PREVIOUS EMPLOYER'S NAME	PREVIOUS EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

WORK PHONE NO. ( )	DATE TERMINATED	REASON FOR THE TERMINATION

SCHOOL *(Are you attending high school, college, or a training program? ☐ Yes ☐ No)*

SCHOOL'S NAME	TYPE OF TRAINING OR MAJOR	TERM/SEMESTER BEGIN DATE	TERM/SEMESTER END DATE	**ATTACH YOUR CLASS SCHEDULE TO APPLICATION**

SCHOOL'S ADDRESS *(No. Street, City, State, ZIP)*	PHONE NO. ( )

ACTIVITY INFORMATION OF SPOUSE OR OTHER PARENT OF CHILD(REN) WHO LIVES WITH YOU

(Does this person have more than one job? ☐ Yes ☐ No)

EMPLOYER'S NAME	WORK PHONE NO.	DATE PRESENT JOB BEGAN
	( )	

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*	DATE OF 1st PAYCHECK	DATE OF 1st FULL PAYCHECK

HOURS WORKED PER WEEK	HOURLY WAGE	AMOUNT OF PAYCHECK BEFORE DEDUCTIONS	HOW OFTEN RECEIVED *(✓one)*
	$	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

ADDITIONAL INCOME *(✓all that apply)* ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay	TOTAL EARNED	HOW OFTEN RECEIVED *(✓one)*
	$	☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

WORK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
FROM:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.
TO:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.

SECOND EMPLOYER'S NAME *(If this person has a second job)*	WORK PHONE NO.	DATE PRESENT JOB BEGAN
	( )	

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*	DATE OF 1st PAYCHECK	DATE OF 1st FULL PAYCHECK

HOURS WORKED PER WEEK	HOURLY WAGE	AMOUNT OF PAYCHECK BEFORE DEDUCTIONS	HOW OFTEN RECEIVED *(✓one)*
	$	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

ADDITIONAL INCOME *(✓all that apply)* ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay	TOTAL EARNED	HOW OFTEN RECEIVED *(✓one)*
	$	☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

WORK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
FROM:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.
TO:	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M.

PREVIOUS EMPLOYER'S NAME	PREVIOUS EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

WORK PHONE NO.	DATE TERMINATED	REASON FOR THE TERMINATION
( )		

SCHOOL *(Is this person attending high school, college, or a training program? ☐ Yes ☐ No)*

SCHOOL'S NAME	TYPE OF TRAINING OR MAJOR	TERM/SEMESTER BEGIN DATE	TERM/SEMESTER END DATE	ATTACH YOUR CLASS SCHEDULE TO APPLICATION

SCHOOL'S ADDRESS *(No. Street, City, State, ZIP)*	PHONE NO.
	( )

TAX CLAIMANT QUESTIONNAIRE

You must complete this questionnaire to determine if there are any relatives living with you who must be included in your family size (and have their income counted) based on whether they intend to claim you, or your family members (your spouse, your children or the other parent of your children who lives with you, or the children of the other parent) as a dependent when filing their federal or state income tax return.

1. Are you the natural, step or adoptive **parent** of the **child(ren)** needing child care?

☐ NO .....If the answer is **NO**, you are NOT required to complete the remainder of the questionnaire. Complete the ***Self Sufficiency Statement*** on page 4 ***and*** **READ** and **SIGN** the ***Rights and Responsibilities*** on page 5, before submitting this application.

☐ YES.....If the answer is **YES**, **continue** to **Question #2**.

2. Are there any **other adults** (other than you and your spouse) **living** in your home?

☐ NO .....If the answer is **NO**, you are NOT required to complete the remainder of the questionnaire. Complete the ***Self Sufficiency Statement*** on page 4 ***and*** **READ** and **SIGN** the ***Rights and Responsibilities*** on page 5, before submitting this application.

☐ YES.....If the answer is **YES**, **continue** to **Question #3**.

3. Are any of the other adults who are living with you related to any of the following family members (who are also living with you)?

- Yourself;
- Your spouse (or other parent of your children); or
- Your children;
- The children of your spouse (or the other parent)

☐ NO .....If the answer is **NO**, you are NOT required to complete the remainder of this questionnaire. Complete the ***Self Sufficiency Statement*** on page 4 ***and*** **READ** and **SIGN** the ***Rights and Responsibilities*** on page 5, before submitting this application.

☐ YES.....If the answer is **YES**, **continue** to **Question #4 (on reverse)**.

4. Do any of the adult relatives **living with you** intend to claim you, your child(ren), or your spouse (or other parent of your children), or the children of your spouse or other parent from a prior relationship as dependents on their state or federal income tax return (when they file their taxes in the ***next calendar year***)?

☐ NO .....If the answer is **NO**, you are NOT required to complete the remainder of this questionnaire. Complete the ***Self Sufficiency Statement*** below ***and*** **READ** and **SIGN** the ***Rights and Responsibilities*** on page 5 of this application. By answering NO and signing the ***Rights and Responsibilities*** you have declared that no adult relative living in your home intends to claim you or any of your family members as dependents on their state or federal income tax return (when they file their taxes in the next calendar year).**

☐ YES.....If the answer is **YES**, you and the adult relative **MUST complete and sign Section B** of the **Tax Claimant Declaration, CCA-1105A** (available at any DES Child Care Assistance office).**

☐ DON'T KNOW...If you stated that you don't know, then you and your adult relative must determine through discussion, whether they intend to claim you or any of your family members as a dependent on their state or federal income tax return. You and your relative must complete and sign the **Tax Claimant Declaration, CCA-1105A** and return it to your DES Child Care Specialist.**

**** IMPORTANT:** The Department of Economic Security, Child Care Administration **cannot** advise you or your family whether a relative may claim a member of your family as a dependent for income tax purposes. **If you need help** finding out whether a **relative** who **lives with you** may be able to claim you or any of your family members as **dependents** for **income tax purposes**, the Department of Economic Security recommends that you **seek *help*** through the **U.S. Internal Revenue Service** at **www.irs.gov**, and the **Arizona Department of Revenue** at **www.azdor.gov**, or consult a tax professional.

TAX CLAIMANT'S (RELATIVE'S) INCOME

If you indicated that a **relative intends** to **claim you** or **your family members** as **dependents** on their income tax return, **you must answer either YES or NO for each type of income source.** Check (✓) **YES** if the **Tax Claimant**, and/or their **spouse** have received or will receive **income from any source**. Check (✓) **NO** if no income from that source.

YES	NO	Source	Amount Received	How Often Received	Name of Person Receiving Income
		Earned Income/Self-Employment Income	$		
		Cash Assistance	$		
		Social Security / SSI, SSA	$		
		Child Support ATLAS # / Court Order #	$		
		Any Other Income Source, such as: Gifts, Loans, U.I., GI Bill, Rental income, Interest, VA or any Income from Absent Parent(s), Friends or Relatives *(indicate type)*:	$		

IMPORTANT: CHILD CARE ASSISTANCE IS TIME-LIMITED

The Block Grant Work (**BW**), Block Grant Unable/Unavailable (**BU**), & Block Grant Teen Parent (**BT**) Child Care Assistance categories are **time limited to no more than 1380 paid units** or **60 cumulative calendar months per child**, whichever is ***later***. In order to qualify for a ***6 month extension*** of Child Care Assistance (after expiration of your time limit), you will be required to state the efforts you made to improve skills and move toward self-sufficiency (over the most recent 6 month period).

SELF-SUFFICIENCY STATEMENT

I have made the following efforts to improve my skills and move toward self sufficiency in the last 6 months; (✓all that apply.)

1. ☐ I registered or job searched via DES One Stop Career Centers, DES Job Service, other public or private employment agencies, or independently.
2. ☐ I applied for a better job.
3. ☐ I have been consistently employed.
4. ☐ I was laid-off but found new employment within 60 days.
5. ☐ I left one job for a better job (higher pay, more hours, or better benefits).
6. ☐ I consistently demonstrated a net profit in my self-employment activity.
7. ☐ I attended remedial education for the attainment of a high school diploma or GED.
8. ☐ I attended English for Speakers of Other Languages (ESOL) classes.
9. ☐ I attended a trade/vocational school, college or university and made satisfactory progress in the activity.
10. ☐ I attended work related school or training, or pursued a degree or certificate that will lead to enhanced career opportunities.
11. ☐ I have NOT requested TANF (Temporary Assistance to Needy Families) Cash Assistance for myself.
12. ☐ I made contact with DES Child Support Enforcement about support from an absent parent or paternity establishment.
13. ☐ I continued with my treatment plan under the direction of a physician, psychiatrist, or psychologist.
14. ☐ I followed a domestic violence/homeless shelter case plan.
15. ☐ I completed or am in the process of completing a drug/alcohol rehabilitation or court ordered community service program.
16. ☐ Other *(Describe)*:

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RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

1. Section 601 of the U.S. Civil Rights Act of 1964 states, "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."
2. You have the right to apply for child care services.
3. You have the right to a decision on the application within 30 days from the date your application is received.
4. You have the right to appeal for a hearing on the action or inaction on your case.
5. You have the right to any child care service provided in your area and available to persons in your same circumstances.
6. Information which you provide is confidential and shared with agency staff only as it relates to child care.
7. If you are determined ineligible or if your services are stopped and you disagree with the decision, you may appeal the decision in writing within 10 calendar days of the date the decision letter is mailed. IF CHILD CARE SERVICES ARE BEING STOPPED DUE TO NON-PAYMENT OF THE REQUIRED CO-PAYMENTS FROM YOU, AND YOU WISH TO APPEAL, YOU MUST FILE AN APPEAL WITHIN 10 CALENDAR DAYS OF THE NOTICE DATE IN ORDER FOR CHILD CARE SERVICES TO CONTINUE DURING THE APPEAL PERIOD.

YOUR RESPONSIBILITIES

1. You must sign this form below.
2. You must be a U.S. citizen or a legal resident of the U.S. in order to receive child care benefits.
3. Your child care services may be stopped if you fail to pay the designated co-payment to your child care provider.
4. You may only use child care for purposes authorized *(i.e., employment or participation in a Jobs activity).*
5. You must read all information sent to you. Contact your child care specialist if you have any questions regarding information that you receive on your case status or child care arrangements.
6. YOU MUST NOTIFY YOUR CHILD CARE SPECIALIST WITHIN TWO (2) WORK DAYS WHEN OR IF:
   a. you move.
   b. **you** or **any adult** in your household experience a change in employment status, work hours, work days, increase or decrease in wages or any type of unearned income, or changes in days/hours of school/training attendance.
   c. you begin receiving Cash Assistance or your Cash Assistance benefit status changes.
   d. someone moves in or out of your home.
   e. a relative residing in your home indicates to you that they have changed their intent to claim you, your child(ren), or your spouse (or other parent of your children), or the children of your spouse/other parent as a dependent on their state or federal income tax return for the current calendar year.
   f. you stop using child care services or if you need to change child care providers. Payment cannot be made for child care services if the provider has not been authorized by your child care specialist.
7. You are responsible for any additional charges not covered by DES *(i.e., registration fees, late fees).*
8. You must cooperate with the Arizona Department of Economic Security (DES) in order to initiate and maintain eligibility. IT IS YOUR RESPONSIBILITY TO REPORT ALL CHANGES. Verification of the information may be requested. Failure to comply with departmental requirements may result in a loss of child care services and you may be subject to a Waiting List upon reapplication.
9. When a Waiting List is in effect you must comply with all department requirements and maintain eligibility in order to retain your placement on the Waiting List.
10. You must make efforts to improve your skills and move toward self-sufficiency in accordance with Arizona Revised Statutes (A.R.S.) § 46-803 (K) (1). In order to receive more than 60 cumulative months of Block Grant Child Care per child you may be asked to state how your family has made efforts to improve skills and move toward self-sufficiency in the past 6 months.
11. You must be truthful in your statements to the DES or you may be charged with fraud. (A.R.S.) §§ 46-213 and 46-216 provide for a fine and/or imprisonment as punishment for conviction of fraud.
12. You are responsible to repay overpayments incurred as determined by the DES.
13. If you file for an appeal, and elect to have services continued pending the outcome, you will be responsible to repay DES for the cost of services during the appeal process if the hearing decision or Board of Appeals' decision is **NOT** in your favor.

I hereby apply for the services requested. Statements made on this form by me or on my behalf are true and correct to the best of my knowledge. I authorize the Arizona Department of Economic Security to verify any information through employers, current or prior, or other persons or institutions. I have been informed of my rights and responsibilities regarding eligibility for services. Any applicant who knowingly submits false information or knowingly conceals a material fact on the application may be charged with fraud pursuant to A.R.S. § 13-2311, a class 5 felony. Clients will be responsible for overpayments.

SIGNATURE OF APPLICANT ➔	PRINT NAME OF APPLICANT	DATE

PLEASE SUBMIT THE ORIGINAL AND KEEP THE COPY FOR YOUR RECORDS **(SEE REVERSE)**

DES CHILD CARE SERVICES INFORMATION

REPORT CHANGES IMMEDIATELY

If you or any household member experience changes in employment or school status, income, Cash Assistance status, an increase or decrease in household size, or any other changes which may effect your eligibility for DES Child Care services, you must report the change within 2 work days to your local DES Child Care office. You may be required to submit one or more of the applicable types of verification listed below.

VERIFICATION REQUIREMENTS

- If you are working, or are in a work study program, provide:
  - copies of your paycheck stubs for the most recent month, or
  - a current statement signed by your employer verifying monthly gross wages, frequency of pay and days/hours of employment. Also include verification of tips, bonuses, commissions or allowances and the frequency of payment.
- If you are self-employed, provide a copy of your annual tax return, quarterly tax statement or weekly/monthly ledgers verifying gross income, receipts for business income and expenses for the last three months.
- If you are attending school or training, provide a current statement from the school or training program verifying start and end dates of the activity, and days/hours of attendance, and you may be required to verify that you are maintaining satisfactory progress or remain in good standing with the educational institution. Note: In order to receive child care benefits for school or training purposes, you must be employed an average of at least 20 hours per week per calendar month (excluding teen parents in high school/GED and Jobs participants).

VERIFICATION OF OTHER INCOME

- If receiving Unemployment Insurance, Social Security, Veterans' or any other type of benefits, provide a copy of the current award letter.
- Child Support. If you receive child support payments through a court, provide a current printout verifying the most recent payment. If the child support payment is not received through the court, provide the court order or ATLAS number.
- If you pay child support for any children who do not live with you, provide a court order or divorce decree specifying the amount paid each month.
- If you have adult relatives **living with you**, you and your adult relative must determine through discussion, whether they intend to claim you or any of your family members as a dependent on their state or federal income tax return. You and your relative(s) may be required to complete and sign the **Tax Claimant Declaration, CCA-1105A** and return it to your DES Child Care Specialist.
- If any of the adult relatives **living with** you intend to claim you, your child(ren), or your spouse (or other parent of your children), or the children of your spouse or other parent from a prior relationship as a tax dependent, you are required to provide verification of your relative's current income and the current income of your relative's spouse (if married).

CHILD CARE FOR MEDICAL REASONS

You must provide a current statement from your licensed physician, certified psychologist, or certified behavioral health specialist explaining how the medical condition prevents you or the other parent in the home from providing care to your child(ren); the duration and frequency that child care is needed must be specified.

CHILD CARE FOR SHELTER RESIDENT

You must provide a current statement from the shelter specifying the number of hours per day, days per week, and duration of your current activity.

WAITING LIST REQUIREMENTS

- When a Waiting List is in effect, priority for services will be given to families with income at or below 100% of the Federal Poverty Level based on the date the application was received by the Department.
- If you are on the Waiting List, you may remain on the list as long as your family continues to meet income and other eligibility requirements, including continuing to cooperate with the Department to redetermine eligibility as requested. Failure to comply with the case review process, or to provide requested verification may result in the removal of your name from the Waiting List. Once removed from the Waiting List, you will need to reapply for child care services. If you reapply after the review date and you are determined eligible, your name will be added back to the Waiting List effective the date you reapply.

REQUIREMENTS FOR CASH ASSISTANCE FAMILIES IN EDUCATION/TRAINING ACTIVITIES

If you are receiving Cash Assistance benefits, and are receiving child care services for education/training needs, you must comply with the Jobs program *(if contacted by Jobs)* as a requirement for Cash Assistance and child care eligibility. If you are contacted by the Jobs program, you are required to participate in all Jobs activities as assigned. Failure to comply with Jobs requirements may result in a sanction; your Cash Assistance benefits may be reduced, and you may lose child care eligibility.

WHEN YOUR DAILY COPAYMENT IS MORE THAN THE DES PAYMENT RATE

IMPORTANT: If the daily copayment assigned to you *(based on your family size and income) is* more than the daily rate DES pays *(based on the provider you have selected and the age of your child), your* provider will not receive payment from DES. If you are at fee levels L5 or L6 check with your provider to see how this will affect you.

ASSISTANCE IN LOCATING A CHILD CARE PROVIDER

The Child Care Resource and Referral service (CCR&R) can assist you in finding a child care provider that meets your needs. This free service is available to all families. Please call 1-800-308-9000 for information about locating a child care provider.