

CHILD CARE APPLICATION

Are you participating in the Ohio Works First program and you or a member of your family needs child care while working or attending school/training?
Is your family's income low and you or a member of your family needs child care while working or attending school/ training?

You may be able to have part of your child care costs paid by the county department of job & family services. You will have to pay a part of the cost of the child care. How much you have to pay will be based on your family's gross income and size.

Have you received child care benefits in another Ohio county? If yes, _____ county. Date when last received: _____

If you need help with the cost of child care, please fill in the blanks. If additional space is needed use separate a sheet of paper.

Your Name (Last, First, M.I.) :	Maiden Name/ Previous Married Name	Sex	Race: (Please circle the first letter of group) (A)sian (B)lack/African American (H)ispanic/Latino (I)ndian, American/Alaskan (P)acific/Hawaiian Islander (W)hite		
Address Where You Live (Street and Number or P.O. Box)		City	State	Zip Code	County
Phone Number ()	Social Security Number	Date of Birth	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Not married		Do you pay child support? No _____ Yes _____ If yes, how much per month _____
Are you currently participating in the Ohio Works First program? YES <input type="checkbox"/> NO <input type="checkbox"/>			What is your OWF case number?		
If you are no longer eligible for the OWF program, enter the last month you were eligible for the program within the past 12 months.			List the names of absent parent(s)		
How many family members live in your household?			How many children do you have who need child care?		

Is there an adult (18 years or older) who lives with you who could care for your child(ren) while you work, go to school or training? YES NO

If yes, give the name of that person here: _____

How is this person related to you (for example: mother, sister, husband, friend)? _____

FAMILY MEMBERS AND INCOME

List here all family members, by blood, marriage, adoption or law, **WHO LIVE WITH YOU**, and include yourself. Be sure to list the children who do not need child care. For each person who works or has any source of income, fill in the amount and tell how often you or your family members get this income. Use a separate line for each source of income. Some common sources of income may include: wages, tips, retirement benefits, unemployment compensation, interest, dividends, alimony, child support, OWF benefits, and receipts from self employment.

NAME OF FAMILY MEMBER	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	INCOME SOURCE	HOW OFTEN PAID	GROSS AMOUNT MONTHLY
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$

PLACE WHERE YOU WORK, GO TO SCHOOL OR TRAINING:

Please list your name and name of family member and the place where you and family member work or go to school or training. List the phone number where you can be called or the name of the person who can give you a phone message.

Your name	Name of place of work, school or training
Address (street and number) of place of work, school or training	City, state, and zip code of place of work, school or training
Phone number of place of work, school or training	Person who can give you a message
Name of family member	Name of place of work, school or training
Address (street and number) of place of work, school or training	City, state, and zip code of place of work, school or training
Phone number of place of work, school or training	Person who can give you a message

***EVERY PERSON WHO WORKS OR HAS INCOME WILL HAVE TO MAIL OR BRING IN A PAYSTUB OR STATEMENT SHOWING THE AMOUNT OF FAMILY INCOME. THIS WILL BE PART OF YOUR APPLICATION FOR CHILD CARE.**

EMPLOYMENT SCHOOL OR TRAINING SCHEDULE AND INCOME SUMMARY:

Your name							
Circle days of week you are employed, in school or training. Put the time each day you are employed, in school or training.							
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
From: _____	_____	_____	_____	_____	_____	_____	
To: _____	_____	_____	_____	_____	_____	_____	
Shift <u>1 2 3 Variable</u>							
Hourly rate \$ _____							
Gross amount of last four pays:				\$	\$	\$	\$
Variable schedule? YES <input type="checkbox"/> NO <input type="checkbox"/> Variable Hrs: _____ Date of pays: _____							
Name of family member employed, in school or training							
Circle days of week your are employed, in school or training. Put the time each day you are employed, in school or training.							
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
From: _____	_____	_____	_____	_____	_____	_____	
To: _____	_____	_____	_____	_____	_____	_____	
Shift <u>1 2 3 Variable</u>							
Hourly rate \$ _____							
Gross amount of last four pays:				\$	\$	\$	\$
Variable schedule? YES <input type="checkbox"/> NO <input type="checkbox"/> Variable Hrs: _____ Date of pays: _____							
Name of child care center, home provider or in-home aide you will be using, if known.							
Address						Telephone number	

CHILD CARE NEED: List all your children who live with you who need care while you work, go to school or training. Fill out a box for each child who needs care. Attach additional sheet, if necessary.

1. Child's name		Does this child require transportation to and from: Residence? YES <input type="checkbox"/> NO <input type="checkbox"/> School? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of school child attends.	Sex	Race: (Please circle the first letter of group) (A)sian (B)lack/African American (H)ispanic/Latino (I)ndian, American/Alaskan (P)acific/Hawaiian Islander (W)hite	What grade is child in?
List days/hours of attendance.			
Circle days of week child will need care. Put the time each day this child will need care. Sunday Monday Tuesday Wednesday Thursday Friday Saturday			Does this child need special care? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)
From:			
To:			
2. Child's Name		Does this child require transportation to and from: Residence? YES <input type="checkbox"/> NO <input type="checkbox"/> School? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of school child attends.	Sex	Race: (Please circle the first letter of group) (A)sian (B)lack/African American (H)ispanic/Latino (I)ndian, American/Alaskan (P)acific/Hawaiian Islander (W)hite	What grade is child in?
List day/hours of attendance.			
Circle days of week child will need care. Put the time each day this child will need care. Sunday Monday Tuesday Wednesday Thursday Friday Saturday			Does this child need special care? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)
From:			
To:			
3. Child's name		Does this child require transportation to and from: Residence? YES <input type="checkbox"/> NO <input type="checkbox"/> School? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of school child attends.	Sex	Race: (Please circle the first letter of group) (A)sian (B)lack/African American (H)ispanic/Latino (I)ndian, American/Alaskan (P)acific/Hawaiian Islander (W)hite	What grade is child in?
List days/hours of attendance.			
Circle days of week child will need care. Put the time each day this child will need care. Sunday Monday Tuesday Wednesday Thursday Friday Saturday			Does this child need special care? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)
From:			
To:			
4. Child's Name		Does this child require transportation to and from: Residence? YES <input type="checkbox"/> NO <input type="checkbox"/> School? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of school child attends.	Sex	Race: (Please circle the first letter of group) (A)sian (B)lack/African American (H)ispanic/Latino (I)ndian, American/Alaskan (P)acific/Hawaiian Islander (W)hite	What grade is child in?
List days/hours of attendance.			
Circle days of week child will need care. Put the time each day this child will need care. Sunday Monday Tuesday Wednesday Thursday Friday Saturday			Does this child need special care? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)
From:			
To:			

CHILD CARE NEED, continued:

5. Child's name		Does this child require transportation to and from: Residence? YES <input type="checkbox"/> NO <input type="checkbox"/> School? YES <input type="checkbox"/> NO <input type="checkbox"/>						
Name of school child attends.	Sex	Race: (Please circle the first letter of group) (A)sian (B)lack/African American (H)ispanic/Latino (I)ndian, American/Alaskan (P)acific/Hawaiian Islander (W)hite				What grade is child in?		
List days/hours of attendance.								
Circle days of week child will need care. Put the time each day this child will need care.						Does this child need special care? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)		
	Sunday	Monday	Tuesday	Wednesday	Thursday		Friday	Saturday
From:	_____	_____	_____	_____	_____		_____	_____
To:	_____	_____	_____	_____	_____	_____	_____	

YOU HAVE A RIGHT TO A STATE HEARING BEFORE THE OHIO DEPARTMENT OF HUMAN SERVICES IF:

- (1) Your application is denied but you believe you are eligible;
- (2) You are not told in writing within 30 days of the date you hand in your application whether or not you are eligible for child care benefits;
- (3) You do not agree with the type or amount of your benefits;
- (4) You are not told in writing the reason your benefits are to change.

YOU HAVE A RIGHT TO AN INFORMAL CONFERENCE WITH YOUR COUNTY DEPARTMENT OF JOB & FAMILY SERVICES. If a mistake has been made, it can be corrected. If you are not satisfied with the result of your county conference, you can still have a state hearing. You will be given "Explanation of State Hearing Procedures" (JFS 04059) and "You Have a Right to a State Hearing" (JFS 08007) with this application. Read it carefully to understand your hearing rights and the hearing process.

YOU MUST REPORT TO THE COUNTY DEPARTMENT OF JOB & FAMILY SERVICES any change, including change in marital or income status, in your work, training or school attendance, relocation to another county, or any other change that would result in a change in your child care benefits or arrangements. Such changes shall be reported within ten working days of the date the change occurred. You are responsible for giving complete and correct information about yourself and members of your family.

IF YOU DO NOT USE CHILD CARE SERVICES FOR 31 CONSECUTIVE CALENDAR DAYS YOU WILL LOSE YOUR CHILD CARE BENEFITS. YOU WILL LOSE YOUR CHILD CARE BENEFITS IF THE COST OF CARE IS LESS THAN YOUR MONTHLY FEE, OR YOU FAIL TO REPAY A CHILD CARE OVERPAYMENT CAUSE BY YOUR INTENTIONAL WITHHOLDING OR FALSIFICATION OF INFORMATION OR MISUSE OF CHILD CARE SERVICES.

I UNDERSTAND MY CHILD CARE BENEFITS SHALL BE TERMINATED IF I FAIL TO COOPERATE IN PAYING THE REQUIRED MONTHLY CHILD CARE FEE.

PLEASE READ AND SIGN BELOW IF YOU AGREE. I received a copy of and I have read my rights and responsibilities and I understand them. I agree to fulfill my responsibilities as described. I give my consent to the agency to make whatever contacts are necessary to determine my eligibility for assistance and to verify information I have given in this application. I agree to provide proof if such proof is requested. I have received a complete explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my responsibility for reporting changes to the county department of job & family services and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification or misuse of child care services.

I understand that this application will be considered without regard to race, color, ancestry, sex, handicap, religion or national origin. I affirm that to the best of my knowledge and belief the answers on this application are complete and correct. I understand the law provides penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance for which he or she is not eligible. I state under penalty of perjury that all information is true and complete to the best of my knowledge.

Person who filled out this form	Date
Person who helped you fill out this form	Date

**CHILD CARE BENEFITS DISPOSITION
Agency Use Only**

Recipient Name _____
Recipient Case # _____
Date Received: _____
Initial Application: _____
Redetermination: _____
<input type="checkbox"/> Approval
<input type="checkbox"/> Denial
Approval/Denial Date _____
Date Notice Sent _____
Reason for Denial _____

Client given JFS 04059 and 08007 on date: _____

ACTION TAKEN ON APPLICATION:

- 312/326 Ohio Works First (OWF) Child Care
- 313/327 Transitional Child Care: Eligibility established beginning _____ and ending _____
- 314 LEAP Child Care
- 320 FSET Child Care
- 321/329 Income Eligible Employment Child Care
- 322/329 Income Eligible Education and Training Child Care
- 323 Protective Child Care
- 324 Special Needs Child Care
- 325 Homeless Child Care
- 342 Uninterrupted Head Start Child Care

FEES:

The family is required to pay \$ _____ per child-in-care per month up to a maximum of three children in care or the cost of care per child, whichever is lower.

CHILD PLACEMENT

Authorized Placement Date

TYPE OF PLACEMENT

<input type="checkbox"/> Center	Name and Address of Provider
<input type="checkbox"/> Type A Home	Name and Address of Provider
<input type="checkbox"/> Type B Home	Name and Address of Provider
<input type="checkbox"/> In-Home Aide	Name and Address

Signature of Child Care Worker	Date
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