### Information regarding texts and emails

The Department of Children, Youth, and Families invites you to get electronic communications about your benefits and resources available to you. By selecting yes, you consent to get electronic communications and agree to DCYF terms and conditions and privacy policy. Message and data rates may apply. Message frequency varies. Terms and conditions at https://mn.gov/dhs/general-public/policies/text-messaging/economic-assistance/. Privacy policy at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG.

Is it OK to communicate with you via text? ◯ No ◯ Yes – which number should receive texts? _____

Is it OK to communicate with you via email? ◯ No ◯ Yes – email address: _____

## 2. Family members

**Tell us about all the other people living in your home.**

Include all household members, both adults and children. Include family members who do not live with you, but are expected to return to your home.

**Adults:**

- Include your spouse, the parents of children in your family who live with you, and all other adults living with you whether or not they are family members.
- Include proof of identity for each adult in your family, such as a copy of a driver's license, state identification card, passport, school identification card, or birth certificate.

**Children:**

- List all children under the age of 18 who live with you. List children in order from oldest to youngest.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support.
- Include proof of each child's relationship to you, such as a birth certificate, adoption record, legal guardianship statement or baptismal record.
- Include proof of each child's age, such as one of the items listed above or a school or immunization record.
- Include proof of citizenship or immigration status for each child in need of child care assistance, such as a birth certificate, an adoption record or a USCIS (United States Citizenship and Immigration Services) card.

**Note:** Proof of citizenship or immigration status will not be used for immigration purposes.

***RACE codes** *(list all that apply)*
A = Asian B = Black or African American N = American Indian or Alaska Native P = Pacific Islander or Native Hawaiian W = White

| **PERSON 2** | | | | |
|---|---|---|---|---|
| LAST NAME | | FIRST NAME | | MIDDLE NAME |
| DATE OF BIRTH | GENDER ◯ Prefer not to say ◯ Male ◯ Female | SOCIAL SECURITY NUMBER | ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No | RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W |
| RELATIONSHIP TO YOU | | CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No | | |
| Do you need an interpreter? ◯ Yes ◯ No | What is your preferred spoken language? | | What is your preferred written language? | |

**PERSON 3**

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

| DATE OF BIRTH | GENDER ◯ Prefer not to say ◯ Male ◯ Female | SOCIAL SECURITY NUMBER | ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No | RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W |
|---|---|---|---|---|
| | | | | |

| RELATIONSHIP TO YOU | CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No |
|---|---|
| | |

| Do you need an interpreter? ◯ Yes ◯ No | What is your preferred spoken language? | What is your preferred written language? |
|---|---|---|
| | | |

**PERSON 4**

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

| DATE OF BIRTH | GENDER ◯ Prefer not to say ◯ Male ◯ Female | SOCIAL SECURITY NUMBER | ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No | RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W |
|---|---|---|---|---|
| | | | | |

| RELATIONSHIP TO YOU | CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No |
|---|---|
| | |

| Do you need an interpreter? ◯ Yes ◯ No | What is your preferred spoken language? | What is your preferred written language? |
|---|---|---|
| | | |

**PERSON 5**

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

| DATE OF BIRTH | GENDER ◯ Prefer not to say ◯ Male ◯ Female | SOCIAL SECURITY NUMBER | ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No | RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W |
|---|---|---|---|---|
| | | | | |

| RELATIONSHIP TO YOU | CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No |
|---|---|
| | |

| Do you need an interpreter? ◯ Yes ◯ No | What is your preferred spoken language? | What is your preferred written language? |
|---|---|---|
| | | |

**PERSON 6**

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

| DATE OF BIRTH | GENDER ◯ Prefer not to say ◯ Male ◯ Female | SOCIAL SECURITY NUMBER | ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No | RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W |
|---|---|---|---|---|
| | | | | |

| RELATIONSHIP TO YOU | CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No |
|---|---|
| | |

| Do you need an interpreter? ◯ Yes ◯ No | What is your preferred spoken language? | What is your preferred written language? |
|---|---|---|
| | | |

**For additional household members, use the blank page at the end of the application.**

# 3. Child Support and custody arrangement

**List all children in your family who have a parent who does not live in your home.** If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements.

**CHILD 1**

| CHILD'S NAME | NAME OF PARENT NOT LIVING IN YOUR HOME | Do you receive child support? ◯ Yes ◯ No |
|---|---|---|
| | | |

**Shared Custody/Visitation Schedule** – List time child spends with parent who is not in the home.

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**CHILD 2**

| CHILD'S NAME | NAME OF PARENT NOT LIVING IN YOUR HOME | Do you receive child support? ◯ Yes ◯ No |
|---|---|---|
| | | |

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**CHILD 3**

| CHILD'S NAME | NAME OF PARENT NOT LIVING IN YOUR HOME | Do you receive child support? ◯ Yes ◯ No |
|---|---|---|
| | | |

**Shared Custody/Visitation Schedule** – List time child spends with parent who is not in the home.

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**CHILD 4**

| CHILD'S NAME | NAME OF PARENT NOT LIVING IN YOUR HOME | Do you receive child support? ◯ Yes ◯ No |
|---|---|---|
| | | |

**Shared Custody/Visitation Schedule** – List time child spends with parent who is not in the home.

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**CHILD 5**

| CHILD'S NAME | NAME OF PARENT NOT LIVING IN YOUR HOME | Do you receive child support? ◯ Yes ◯ No |
|---|---|---|
| | | |

**Shared Custody/Visitation Schedule** – List time child spends with parent who is not in the home.

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

# 4. Student information – children

Complete this section for all children in your family who are **now in school or plan to go to school within the next 12 months**.

- Include start date if not currently in school.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support. Include proof of their school status, such as a fee statement or registration confirmation, the expected completion date of their program, and your financial support.
- For preschool age children: Indicate "Head Start" or "preschool" in the "GRADE" field if child attends one of those programs.
- Include proof of school enrollment status for children with earned income.

**STUDENT 1**

| STUDENT NAME | START DATE | END DATE | SCHOOL NAME | GRADE |
|---|---|---|---|---|
| | | | | |

**Days and times student attends school**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**STUDENT 2**

| STUDENT NAME | START DATE | END DATE | SCHOOL NAME | GRADE |
|---|---|---|---|---|
| | | | | |

**Days and times student attends school**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**STUDENT 3**

| STUDENT NAME | START DATE | END DATE | SCHOOL NAME | GRADE |
|---|---|---|---|---|
| | | | | |

**Days and times student attends school**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**STUDENT 4**

| STUDENT NAME | START DATE | END DATE | SCHOOL NAME | GRADE |
|---|---|---|---|---|
| | | | | |

**Days and times student attends school**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

**STUDENT 5**

| STUDENT NAME | START DATE | END DATE | SCHOOL NAME | GRADE |
|---|---|---|---|---|
| | | | | |

**Days and times student attends school**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

# 5. Income

**List all income received by you and all members of your family.**

- Include income received by family members temporarily absent from your home.
- Report self-employment income in question *5.B. Self-employment income*.
- Include proof of work schedule and all income for the most current 30 days, such as wages, tips, commissions and bonuses.

## A. Earned income (wages)

Is anyone employed? ◯ No ◯ Yes

| **Income #1** | | | |
|---|---|---|---|
| EMPLOYEE'S NAME | EMPLOYER NAME | | EMPLOYER PHONE NUMBER |
| EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
| WORK ADDRESS (if different) | CITY | STATE | ZIP CODE |
| HOURLY PAY RATE | NUMBER OF HOURS PER WEEK | HOW OFTEN PAID? ◯ Daily ◯ Weekly ◯ Every other week ◯ Two times a month ◯ Other _____ | |
| TOTAL AMOUNT PAID BEFORE DEDUCTIONS | WORK START DATE | DATE OF FIRST PAY CHECK | DATE OF LAST PAY CHECK |

| **Income #2** | | | |
|---|---|---|---|
| EMPLOYEE'S NAME | EMPLOYER NAME | | EMPLOYER PHONE NUMBER |
| EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
| WORK ADDRESS (if different) | CITY | STATE | ZIP CODE |
| HOURLY PAY RATE | NUMBER OF HOURS PER WEEK | HOW OFTEN PAID? ◯ Daily ◯ Weekly ◯ Every other week ◯ Two times a month ◯ Other _____ | |
| TOTAL AMOUNT PAID BEFORE DEDUCTIONS | WORK START DATE | DATE OF FIRST PAY CHECK | DATE OF LAST PAY CHECK |

## B. Self-employment income

Is anyone self-employed? ◯ No ◯ Yes

Complete this section if you or someone in your family is **self-employed**. Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property.

There are two options used to calculate self-employment income:

- Using taxable self-employment income as determined from a federal tax return filed with the IRS for the most recent year, with certain expenses not allowed to reduce income. To use this method, you must have filed a tax return for the most recent tax year and must submit it, including schedules.
- Using 50% of current gross self-employment income. To use this method, you must provide documentation of current gross self-employment income that is reflective of expected future income, such as business ledgers or tax returns and applicable schedules.

The amount of self-employment income calculated impacts income eligibility, family copayment, ability to meet employment requirements and the amount of care that can be authorized. For either method, include proof of work schedule, such as a calendar with work hours. Contact the CCAP agency for more information and to discuss your options.

| **Income #1** | | | |
|---|---|---|---|
| ADULT'S NAME | | TYPE OF BUSINESS | |
| START DATE | NUMBER OF HOURS WORKED PER WEEK | MONTHLY INCOME BEFORE EXPENSES | MONTHLY EXPENSES |

| **Income #2** | | | |
|---|---|---|---|
| ADULT'S NAME | | TYPE OF BUSINESS | |
| START DATE | NUMBER OF HOURS WORKED PER WEEK | MONTHLY INCOME BEFORE EXPENSES | MONTHLY EXPENSES |

## C. Unearned income

Complete this section for each type of **unearned income** you or someone in your family receives.

- Include proof of all unearned income, such as a check stub, an award letter, a financial aid form, or a written statement from the source of the income for the most current 30 days.

| Type | Yes | No | Name of person receiving income | How often received | Amount |
|---|---|---|---|---|---|
| Public assistance (MFIP, DWP, GA, Tribal TANF) | ◉ | ○ | | | |
| Child support/Spousal support | ○ | ○ | | | |
| Unemployment Insurance | ○ | ○ | | | |
| Insurance payments (short- or long-term disability, etc.) | ○ | ○ | | | |
| RSDI (Retirement, Survivors, Disability Insurance) | ○ | ○ | | | |
| Supplemental Security Income (SSI) | ○ | ○ | | | |
| Veteran benefits (VA) | ○ | ○ | | | |
| Contract for deed | ○ | ○ | | | |
| Trust income | ○ | ○ | | | |
| Interest/dividends | ○ | ○ | | | |
| Tribal payments | ○ | ○ | | | |
| Cost-effective health care reimbursement | ○ | ○ | | | |
| Worker's Compensation | ○ | ○ | | | |
| Other (lottery or gambling winnings, cash prizes, capital gains, etc.) - list below: | ○ | ○ | | | |
| Retirement Benefits | ○ | ○ | | | |
| | | | | | |
| | | | | | |
| | | | | | |

### D. Do you expect any changes to work hours or income listed in A, B, or C above?

◯ Yes ◯ No

IF YES, DESCRIBE IN DETAIL

## 6. Deductions

Complete this section if you or someone in your family has any of the expenses listed for which you are not reimbursed.

- These expenses may be deducted from your gross income in determining your co-payment.
- Include proof of deductions, such as check stubs, benefit statements or premium statements.

| Expense | How often do you pay? | Amount |
|---|---|---|
| Medical insurance premiums | | |
| Dental insurance premiums | | |
| Vision insurance premiums | | |
| Child support paid for a child not living in the home | | |
| Court ordered spousal support | | |

## 7. Assets

Assets include cash, bank accounts, vehicles, investments, and real estate (other than your home). Do not include the home you live in, personal belongings, or self-employment assets (if used only for business purposes). How much are your family's assets?

◉ My family's assets are **LESS THAN $1 million** (or equal to $1 million), **OR**

◯ My family's assets are **MORE THAN $1 million** (your worker will contact you for more information)

# 8. Request for child care assistance

**Complete the sections that apply to adult members of your family.**

**A. List all *adult* family members who need help paying for child care to attend school or training classes.**

- Include family members participating in GED or ESL classes.
- Include proof of school schedules that show the days and times classes meet, including school breaks.

| **ADULT 1** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADULT'S NAME | | | NAME OF SCHOOL OR TRAINING SITE | | | | |
| SCHOOL PROGRAM ATTENDING | | | | | | START DATE | |
| **Days and times this adult attends school or training** | | | | | | | |
| | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | **SATURDAY** | **SUNDAY** |
| **START TIME** | | | | | | | |
| **END TIME** | | | | | | | |

| **ADULT 2** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADULT'S NAME | | | NAME OF SCHOOL OR TRAINING SITE | | | | |
| SCHOOL PROGRAM ATTENDING | | | | | | START DATE | |
| **Days and times this adult attends school or training** | | | | | | | |
| | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | **SATURDAY** | **SUNDAY** |
| **START TIME** | | | | | | | |
| **END TIME** | | | | | | | |

**B. List all *adult* family members who need help paying for child care to be able to work.**

- Include proof of all work schedules, such as a time card or a letter from employer.
  *If the work schedule varies, please provide this information for the past two months.*

| **ADULT 1** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADULT'S NAME | | | EMPLOYER'S NAME | | | | |
| **Days and times this adult works** | | | | | | | |
| | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | **SATURDAY** | **SUNDAY** |
| **START TIME** | | | | | | | |
| **END TIME** | | | | | | | |

| **ADULT 2** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADULT'S NAME | | | EMPLOYER'S NAME | | | | |
| **Days and times this adult works** | | | | | | | |
| | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | **SATURDAY** | **SUNDAY** |
| **START TIME** | | | | | | | |
| **END TIME** | | | | | | | |

### C. List all *adult* family members who need help paying for child care to look for work.

| ADULT'S NAME | NUMBER OF HOURS PER WEEK REQUESTED (up to 20) |
|---|---|
| ADULT'S NAME | NUMBER OF HOURS PER WEEK REQUESTED (up to 20) |

### D. List all *adult* family members who need help paying for child care to attend MFIP orientations or other MFIP/DWP activities in an approved employment plan.

| ADULT'S NAME | JOB COUNSELOR ASSIGNED? | JOB COUNSELOR'S NAME | JOB COUNSELOR'S PHONE NUMBER |
|---|---|---|---|
| ADULT'S NAME | JOB COUNSELOR ASSIGNED? ◯ Yes ◯ No | JOB COUNSELOR'S NAME | JOB COUNSELOR'S PHONE NUMBER |

### E. List all *adult* family members who need help paying for child care to support their mental health needs.

- The child must be receiving MFIP and be under 7.
- Include proof of mental health diagnoses and need for child care as recommended by a mental health professional.

| ADULT'S NAME | NUMBER OF HOURS PER WEEK REQUESTED (up to 20) |
|---|---|
| ADULT'S NAME | NUMBER OF HOURS PER WEEK REQUESTED (up to 20) |

# 9. Child care needs

**List all children who are attending or are in need of child care.**

- Child care assistance is available for children under age 13 and for children with disabilities under age 15.
- Complete the provider questions if you currently use or have chosen a child care provider(s) for your child.
- Contact your county or tribal human services office if your child has special needs and needs specialized care.
- Child care assistance can only pay two providers per child, one primary and one secondary provider.

**CHILD 1**

CHILD'S NAME

**Days and hours child care is needed with child's primary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| PRIMARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| PRIMARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

**Days and hours child care is needed with child's secondary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| SECONDARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| SECONDARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

## CHILD 2

CHILD'S NAME

**Days and hours child care is needed with child's primary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| PRIMARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| PRIMARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

**Days and hours child care is needed with child's secondary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| SECONDARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| SECONDARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

## CHILD 3

CHILD'S NAME

**Days and hours child care is needed with child's primary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| PRIMARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| PRIMARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

**Days and hours child care is needed with child's secondary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| SECONDARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| SECONDARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

## CHILD 4

CHILD'S NAME

**Days and hours child care is needed with child's primary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| PRIMARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| PRIMARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

**Days and hours child care is needed with child's secondary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| SECONDARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| SECONDARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

## CHILD 5

CHILD'S NAME

**Days and hours child care is needed with child's primary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| PRIMARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| PRIMARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

**Days and hours child care is needed with child's secondary provider**

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| START TIME | | | | | | | |
| END TIME | | | | | | | |

| SECONDARY CHILD CARE PROVIDER'S NAME | PHONE NUMBER | START DATE |
|---|---|---|
| | | |

| SECONDARY CHILD CARE PROVIDER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

## Important! Please read and sign this application.

## Authorization to share information for fraud investigation and audits.

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation, and conducting federal or state audits. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission to share information about me remains in effect for six months after my benefits stop.

## Provider release.

State and federal privacy laws protect my information. If I am eligible for child care assistance, CCAP staff can share information about the hours and amount of child care assistance I get with my child care provider(s). My provider will be notified when my redetermination is due. I understand:

- This information must be shared so that my child care provider knows how much CCAP will pay for the child care provided.
- This information can be shared only if I give my written permission or if the law allows it.
- I can refuse to sign or cancel this release, but if I do, CCAP may not be able to pay my provider for the child care provided.
- I may cancel this authorization with written notice anytime. This written notice will not affect information already released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by CCAP agencies or the State of Minnesota, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it. Minnesota Data Privacy Act (Minn. Stat., Ch. 13).

## Penalty warning.

If you get child care assistance benefits, do not give false information or hide information:

- To get or continue to get child care assistance benefits
- To help someone else to get or to continue to get child care assistance payments.

The state may bar a family with a member who breaks either of these rules from the Child Care Assistance Program. The bar lasts one year for the first fraud, two years for the second fraud, and is permanent for the third fraud. A person who supplies false information in order for them or someone else to receive Child Care Assistance may also be prosecuted criminally.

## If I get child care assistance I understand:

- I must cooperate with child support enforcement and assign my child care support portion to the Minnesota Department of Children, Youth, and Families. I have the right to claim "good cause" for not cooperating with child support enforcement.
- I may be required to pay a co-payment fee.
- If my child care provider charges more than the maximum rate paid in my county, I will pay the additional costs, as well as my co-payment fee.
- I must report changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment and activity status and schedules, family status, significant income changes, address or residence, or anyone moving in or out of my household. Refer to Reporting Responsibilities for CCAP families (DHS-6953) for specific requirements.
- I must give the county agency and my child care provider 15 calendar days' notice before changing my child care provider(s). This notice is not needed in cases when:
  - A provider's Minnesota child care license has been temporarily immediately suspended or
  - There is an imminent risk of harm to the health, safety, or rights of a child in the care of a provider not licensed by Minnesota.
- My eligibility for child care assistance will be redetermined every 12 months.