

Department of Human Resources/Child Care Administration
Purchase of Child Care Program
APPLICATION/REDETERMINATION FOR CHILD CARE

Return To:

| | | | | | | | | | | |
|---|--|------------|-----------------|--|------------------------------------|----------------|------------------------------------|--|----------|--|
| I. Applicant Name: | | | | | Social Security Number (optional): | | | | | |
| Address: Street | | Apt Number | | | City | | State | | Zip Code | |
| Mailing address, if different: | | | | | | | | | | |
| Telephone Number: | | | Marital Status: | | | Date of Birth: | | | Race: | |
| II. Spouse (Other Parent) or Relative Caretaker's Name: | | | | | | | Social Security Number (optional): | | | |
| Telephone Number: | | | Marital Status: | | | Date of Birth: | | | Race: | |

| | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|
| III. 1) Do you receive Temporary Cash Assistance (TCA)? a. <input type="checkbox"/> Yes. When did you start getting TCA? b. <input type="checkbox"/> Not any more. When did you stop getting TCA? c. <input type="checkbox"/> No. I applied in the last 30 days. | | | | | | | 1) <input type="checkbox"/> Never 1a) _____ 1b) _____ | | | |
| 2) Does a minor parent reside in the home? 3) Are you a relative caretaker (not the mother or father)? a. If yes, how are you related to the child(ren)? b. Do you receive TCA for the child(ren)? c. Number of related children in your custody? | | | | | | | 2) <input type="checkbox"/> Yes <input type="checkbox"/> No 3) <input type="checkbox"/> Yes <input type="checkbox"/> No 3a) _____ 3b) <input type="checkbox"/> Yes <input type="checkbox"/> No 3c) _____ | | | |
| 4) Does your child attend a Head Start program? | | | | | | | 4) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| IV. Activity Information | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|
| Your Activity | | | | | | Spouse/Other Parent /Activity if in the Household | | | | |
| Name of school or employer: _____ | | | | | | Name of school or employer: _____ | | | | |
| Address of school or employer: _____ | | | | | | Address of school or employer: _____ | | | | |
| Telephone number: _____ | | | | | | Telephone number: _____ | | | | |
| Days and hours of your activity: _____ | | | | | | Days and hours of your activity: _____ | | | | |
| Start and end dates of activity: _____ | | | | | | Start and end dates of activity: _____ | | | | |

V. Child Information (List all child(ren) in household under 13 years old)
 Complete this section for each child for whom child care is needed. Use the codes below to complete the Citizenship, Race and Ethnicity columns. Enter each code that applies, using at least one code for each child. Enter either "Yes" or "No" in the Disabled column to indicate if the child has a disability.
Citizenship/Immigration Code: 1=United States Citizen, 2=Permanent Resident, 3=Asylee, 4=Alien granted conditional entry, 5=Parolee 1 year or more, 6=Alien whose deportation is withheld, 7=Refugee, 8=Battered alien spouse, child, or parent of child(ren)
Social Security Number: Optional-not required for any household members
Ethnicity Codes: 1=Yes/Hispanic or Latino, 2=No/Hispanic/Latino
Race Codes: 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

| Last | Name First | Citizen-ship/Immigration Status | SSN | DOB | Ethnicity | Sex | Race | Dis-abled | Days & Hours of Care | Type of Care (Registered Home, Licensed Center or Informal) |
|---------------|------------|---------------------------------|-------------|--------|-----------|-----|------|-----------|----------------------|---|
| Example: Doe, | Jane | 2 | 111-22-3333 | 4/4/04 | 1 | | 5 | Yes | M-F 8 | Informal |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

| VI. Other Household Members | | | | | | | |
|-----------------------------|---------------|---------------------------|------------------|------|-----|---------------------|-------------------------------|
| Last | Name First | Social Security Number | Date of Birth | Race | Sex | Relationship to you | Name of school or employer |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

VII. Income Information

Complete those which apply to household members:

| | | | | | | |
|---------------|----|-----|----|-----|----|-----|
| GROSS SALARY | \$ | per | \$ | per | \$ | per |
| TCA | \$ | per | \$ | per | \$ | per |
| CHILD SUPPORT | \$ | per | \$ | per | \$ | per |
| OTHER | \$ | per | \$ | per | \$ | per |

| | | |
|--------------------|-----------------|-----------------|
| TOTAL UNIT INCOME: | HOUSEHOLD SIZE: | DATE COMPLETED: |
|--------------------|-----------------|-----------------|

Do you receive Housing Assistance? Yes No Do you receive Food Stamps? Yes No

Attach proof of all income for: applicant, spouse, other parent in home, parents of minor parent, adult and spouse with physical custody of minor child.

VIII. Child Support Information

- Are you receiving child support for all children in your household who are eligible for child support? Yes No
- Have you applied for child support for all children in your household eligible to receive child support? Yes No
- Do you claim good cause for not pursuing child support for any child in your household eligible for child support? Yes No
If you claim good cause, you are required to give proof of your claim. The POC case manager will send you information and a form to help you with your claim.

Your application gives us information about whether you are eligible for benefits and services. These benefits are provided at public expense and you must give true information. It may be verified with public and private agencies and businesses. You must report any changes to the information provided on this form within 10 days of the change. If you knowingly give false information or willfully fail to report changes you may be subject to disqualification and to the penalties listed below.

Article 27, 230A of the Annotated Code of Maryland states that:

- Any person who fraudulently obtains, attempts to obtain, or aides another person in fraudulently obtaining or attempting to obtain money, property, food stamps, medical care, or other assistance to which he is not entitled, under a social, health, or nutritional program based on need, financed in whole or in part by the State of Maryland, and administered by the state or its political subdivisions is guilty of a misdemeanor. For purpose of this section, fraud shall include:
 - willfully making a false statement or representation; or
 - willfully failing to disclose a material change in household or financial condition; or
 - impersonating another person.
- Upon conviction, after notice and the opportunity to be heard as to the amount of payment and how the payment is to be made, the person shall make full restitution of the money, property, food stamps, medical care or other assistance unlawfully received, or the value thereof, and shall be fined not more than \$1,000 or imprisoned for not more than three years, or both fined and imprisoned.

Consent to release information:
I hereby authorize the Inspector General's Office of the Department of Human Resources to review any records relating to me maintained by a local department of social services, the Child Care Administration, or my employer for purposes of investigating whether I have knowingly given false information or willfully failed to report changes that could affect my eligibility for POC benefits. By signing below I certify that I am the undersigned, and that I am competent to consent to this release of information. A photocopy of this form is as valid as the original.

| | |
|---|------|
| Parent Signature | Date |
| Signature of Other Parent/Spouse in the Household/Parent of Minor Child | Date |
| Case Manager Signature | Date |
| Supervisor Signature | Date |

| IX. Child Care Plan (AGENCY USE ONLY) | | |
|---|--|--|
| <p>1. <input type="checkbox"/> New <input type="checkbox"/> Current <input type="checkbox"/> Previous (if so, date closed)</p> <p>2. Type of Care <input type="checkbox"/> Licensed (Home) <input type="checkbox"/> Licensed (Center) <input type="checkbox"/> Informal, Who: _____ & Relationship: _____</p> | <p>3. <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible</p> <p><i>If eligible, was the customer placed on a waiting list:</i> Yes No What is the number in the Eligibility Unit: _____ Where is child care? _____</p> <p>4. Child Support: Yes No <input type="checkbox"/> Referral <input type="checkbox"/> Non-Cooperation <input type="checkbox"/> Good Cause Claim</p> | <p>5. CIS Inquiry Date: _____ CIS Case #: _____</p> <p>6. Gross Annual Household Income: _____</p> <p>7. Date Entered on CCAMIS: _____ CCAMIS Case #: _____</p> <p>8. Priority Code: _____</p> |