MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

CHILD CARE APPLICATION/ELIGIBILITY STATEMENT

SUPERCASE NUMBER	DCN

The following information is necessary to determine your eligibility for Child Care assistance. You must answer each question accurately and completely. You may be required to provide proof of your statements. Please complete this form in ink. If you need help with this form, please contact your local FSD office at:

Phone: 417-256-7121 Worker: _____

APPLICANT NAME	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

COMPLETE MAILING ADDRESS INCLUDING ZIP CODE	DO ALL HOUSEHOLD MEMBERS INTEND TO REMAIN IN MISSOURI? ☐ YES ☐ NO

HOUSEHOLD MEMBERS (LIST YOUR NAME FIRST)

ºNAME	DATE OF BIRTH	RACE/ GENDER	MARITAL STATUS	SOCIAL SECURITY NUMBER	RELATIONSHIP	INDICATE PERSON AND CARE NEEDED		
						Y/N	HOURS	DAY/EVE

LIST AMOUNT OF INCOME AND SOURCE OF INCOME FOR ALL HOUSEHOLD MEMBERS. List person and amount received from child support, SSA, SSI, food stamps, Temporary Assistance, housing assistance, state/federal assistance, or any other source of income.

NAME OF PERSON WITH INCOME	AMOUNT OF INCOME	HOW OFTEN RECEIVED	SOURCE OF INCOME

EXPLANATION OF NEED FOR CARE

CHECK ALL THAT APPLY TO YOU. MY CHILD(REN) NEED(S) CARE BECAUSE I:

PARENT	PARENT
☐	☐ AM WORKING
☐	☐ ATTEND SCHOOL
☐	☐ AM IN JOB TRAINING
☐	☐ AM DISABLED
☐	☐ AM BEING EVALUATED FOR TRAINING AND/OR EMPLOYMENT

☐ I/WE HAVE A CHILD WITH A SPECIAL NEED.
(My child receives SSI, is under court ordered supervision, in foster care, receives services through Department of Mental Health, or is functionally challenged according to medical evidence.)

PARENT	SCHOOL/COLLEGE/TRNG	GRADE LEVEL

DEDUCTIONS

IF YOU PAY FOR HEALTH/DENTAL/HOSPITAL INSURANCE, HOW MUCH IS YOUR PREMIUM? _____ HOW OFTEN DO YOU PAY THIS AMOUNT? _____

IF YOU EXPECT ANY CHANGES IN HOUSEHOLD MEMBERS, INCOME OR HEALTH INSURANCE COSTS, PLEASE EXPLAIN

CHILD CARE PROVIDER	ADDRESS	COUNTY	TELEPHONE	RELATIONSHIP TO CHILD	PROVIDER STATUS	
					LIC/CON/REG	DVN

CERTIFICATION SECTION:

- I agree to provide additional information or verification as requested to determine my family's eligibility for Child Care assistance within fifteen days of this application.
- I agree to report changes in income, employment, household members, health insurance premiums, and need for child care. I understand that my child's caregiver must comply with all state and federal laws and requirements in order for Child Care assistance benefits to be paid by FSD.
- I understand that my statements are subject to investigation and verification. I understand that Missouri laws provide for fine and/or imprisonment for persons who receive or attempt to receive public assistance by knowingly giving false statements, or failing to report information required to determine eligibility for public assistance.
- My signature certifies, under penalty of perjury, that all information given is true and complete.

SIGNATURE OR MARK OF APPLICANT	DATE	WITNESS TO MARK

FOR OFFICE USE ONLY - ELIGIBILITY DETERMINATION

1. NEED FOR CHILD CARE

- ☐ EMPLOYMENT
- ☐ JOB TRAINING
- ☐ SCHOOL ATTENDANCE
- ☐ SPECIAL NEEDS CHILD
- ☐ INCAPACITATION
- ☐ JOB SEARCH (WORK FIRST/DIRECT JOB PLACEMENT)
- ☐ EVALUATION FOR TRAINING/EMPLOYABILITY
- ☐ CWEP/AWEP
- ☐ JOB READINESS
- ☐ 21ST CENT. WAGE SUPP.
- ☐ OUTSTATE. WAGE SUPP.
- ☐ PEER SUPPORT (PARENTS FAIR SHARE)
- ☐ OTHER _____

2. HOUSEHOLD ELIGIBILITY

A. Relationship/age verification:
☐ IM-36 ☐ Temporary Assistance Sect. ☐ CC Sect.

B. ☐ Single parent household C. ☐ DCSE Referral made

3. INCOME GUIDELINES

FAMILY UNIT SIZE _____

MONTHLY INCOME: _____ ☐ MET ☐ NOT MET

MEDICAL INSURANCE SLIDING FEE WAIVED ☐

\-

PREMIUM: _____ ☐ SPECIAL NEEDS CHILD
Functional Age _____

=

NET INCOME: _____ (if applicable)

TYPES OF INCOME

- ☐ EMPLOYMENT INCLUDING SELF EMPLOYMENT
- ☐ TEMPORARY ASSISTANCE
- ☐ HOUSING VOUCHER OR CASH ASSISTANCE
- ☐ FOOD STAMPS
- ☐ OTHER FEDERAL/STATE CASH INCOME PROGRAMS (SUCH AS SSI)
- ☐ OTHER INCOME

4. PROVIDER QUALIFICATIONS: PROVIDER DVN:

FACILITY TYPE: ☐ HOME (DH) ☐ GROUP (GH) ☐ CENTER (DC)

- ☐ LICENSED
  - ☐ CONTRACTED
- ☐ EXEMPT FROM LICENSURE
  - ☐ REGISTERED
    - ☐ IM-91 dated _____
      - ☐ DIRECT PAY
      - ☐ REIMBURSEMENT
        - ☐ RELATIVE
        - ☐ NON-RELATIVE
    - ☐ IM-92 dated _____
    - ☐ IM-93 dated _____
    - ☐ SHP-159 dated _____
  - ☐ REGISTERED/REGULATED
    - ☐ IM-91 dated _____
      - ☐ DIRECT PAY
      - ☐ REIMBURSEMENT
    - ☐ DOH COMPLIANT
    - ☐ IM-93 dated _____

5. EMPLOYMENT PLAN: _____

_____

VERIFICATION

☐ APPROVED ☐ WAITING LIST ☐ REJECTED

DATE OF REQUEST

ELIGIBILITY DATES ▶

BEGIN

END

COUNTY	WORKER NO.	LOAD NO.	CASEWORKER/CASE MANAGER SIGNATURE	DATE OF DETERMINATION	TYPE OF REQUEST APPROVED: ☐ BG ☐ SF ☐ FS ☐ OTHER

MO 886-2845 (3-04)