



CHILD CARE APPLICATION

**Important Notice: Child Care benefits cannot begin before you apply.
Submit your application immediately.**

Applicant Name and Address:

Return your completed application to:
Illinois Action for Children
4554 North Broadway, Suite 320
Chicago IL 60640
Phone: (773) 687-4000
Fax: (773) 481.6610

A REMINDER! Before mailing:

- Did you and your provider sign pages 6 & 7?
- Did you attach copies of your 2 most recent and consecutive pay stubs? (If you just started work and do not have pay stubs, attach a letter from your employer.)

PLEASE PRINT IN INK. Please read the attached instructions before completing this form.
(Este formulario está disponible en español.)

SECTION I - APPLICANT INFORMATION

Parent/Guardian First Name						M.I.		Last Name			
Social Security Number (Optional)				TANF Case Number, if applicable				County			
Home Address				Apt #	City			State		Zip Code	
Mailing address, if different than above.				City				State		Zip Code	
Home Phone Number				Another number where you can be reached				Best time to call			
				Email Address							
Parent/Guardian Date of Birth				Circle one:				MALE or FEMALE			
Month:		Day:		Year:							
Do the children have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO						Does the parent/guardian have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO					

FOR OFFICE USE:
REASON FOR
CHILD CARE

- _____ 1) Work/On-the-job Training for TANF and Non-TANF
- _____ 2) TANF Education/Training Activity or Teen Parent in High School/GED
- _____ 3) TANF Work & Education/Training Activity or Teen Parent Work & High School/GED
- _____ 4) Non-TANF Education & Training

APPLICANT'S NAME:

WORK INFORMATION

If you are working more than one job, you **MUST photocopy** this page and complete a separate work information and work schedule section for each job you have.

Employer/Company Name	Job Title
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Address	City	State	Zip Code
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Work Phone Number	Ext.	Date you started this job:
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I earn before deductions (complete one) \$ _____ per hour \$ _____ per month \$ _____ per year

I get paid (check one) weekly every two weeks twice per month monthly other (please explain) _____

Number of hours worked each week: _____ Number of days worked each week: _____

How long does it take you to travel from the child care provider to work? _____

WORK SCHEDULE: Please give a typical work schedule (**circle am or pm**)

Does your schedule vary? Please explain: _____ _____ _____		MON	TUES	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Are you currently attending school, training or a TANF-Required Activity?

____ NO (Go to the Top of Page 3) ____ YES (Complete the Section below.)

SCHOOL/TRAINING/TANF-REQUIRED ACTIVITY INFORMATION

TYPE OF EDUCATION/TRAINING CURRENTLY ATTENDING: (Check one)

____ 1) High School or GED ____ 2) Other Below Post-Secondary (For example, ABE or ESL) ____ 3) Occupational/Vocational

____ 4) 2-Year College Degree ____ 5) 4-Year College Degree

Type of Degree Being Earned _____

Do you already have a degree? Yes No If yes, list your degrees _____

School Name/Training Program Currently Attending	Phone Number	Date Started	Ending Date
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Address	City	State	Zip Code
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How long does it take you to travel from the child care provider to school? _____

SCHOOL SCHEDULE: Please complete the following schedule (**circle am or pm**)

Does your schedule vary? Please explain: _____ _____ _____		MON	TUES	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

TANF CLIENTS: You **MUST** provide an Official Class Schedule (if you are in school) and one of the following. Check the one you have attached.

- Responsibility and Service Plan (RSP) (Form 4003) Contracted Provider's Referral (Form 2151A)
- IDHS Contract Report - Notification of Employment (Form 3085) IDHS Referral (Form 2151)

CLIENTS NOT RECEIVING TANF CASH ASSISTANCE: You **MUST** provide an Official Class Schedule and a copy of: (check all that apply)

- Confirmation letter from training program Grade Report Form
- Registration/Class information about internship, student teaching, practicum

SECTION II - OTHER PARENT/STEPPARENT INFORMATION

Is the other parent or stepparent of any of the children living in your home?

___ NO (Go to Family Information on Page 4) ___ YES (Complete the Section below.)

OTHER PARENT/STEPPARENT INFORMATION

Is the other parent or stepparent working? YES NO

Is the other parent or stepparent attending school or a training program? YES NO

If the other parent or stepparent is not working or in a school/training program, please explain why he/she cannot care for the children.

Other Parent/Stepparent First Name	M.I.	Last Name
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Social Security Number (Optional)	Date of Birth Month: Day: Year:	Phone Number
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WORK INFORMATION (If the other parent/stepparent is working more than one job, you MUST **photocopy** this page and complete a separate work information and work schedule section for each job he/she has.)

Employer/Company Name	Job Title
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Address	City	State	Zip Code
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Phone Number	Ext.	Date he/she started this job:
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He/she earns before deductions (complete one) \$ _____ per hour \$ _____ per month \$ _____ per year

He/she gets paid (check one) <input type="checkbox"/> weekly <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly <input type="checkbox"/> other (please explain)	Number of hours worked each week:	Number of days worked each week:
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How long does it take him/her to travel from the child care provider to work? _____

WORK SCHEDULE: Please give a typical work schedule (**circle am or pm**)

Does his/her schedule vary? Please explain: _____ _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

SCHOOL/TRAINING/TANF-REQUIRED ACTIVITY INFORMATION

TYPE OF EDUCATION/TRAINING CURRENTLY ATTENDING: (Check one)	___ 1) High School or GED ___ 4) 2-Year College Degree ___ 2) Other Below Post-Secondary ___ 5) 4-Year College Degree (For example, ABE or ESL) Type of Degree Being Earned _____ ___ 3) Occupational/Vocational Do You Already Have a Degree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your degrees _____
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School Name/Training Program	Phone Number	Date Started	Ending Date
Address	City	State	Zip Code

How long does it take him/her to travel from the child care provider to school? _____

SCHOOL SCHEDULE: Please complete the following shedule (**circle am or pm**)

Does his/her schedule vary? Please explain: _____ _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

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CLIENTS NOT RECEIVING TANF CASH ASSISTANCE: You MUST provide an Official Class Schedule and a copy of: (check all that apply)

- Confirmation letter from training program Grade Report Form
- Registration/Class information about internship, student teaching, practicum

APPLICANT'S NAME: _____

SECTION III - FAMILY INFORMATION

FAMILY SIZE means the applicant (you); the biological, step or adoptive parent of any of the applicant's children who live in your home; and your biological or adoptive children under age 21 living in your home. You may also choose to include other persons in the home who are related to you by blood or law if they rely on you for more than 50% of their support.

What is your family size? _____ How many adults are in your family? _____
 How many children are in your family? _____ How many children are receiving child care? _____

Complete the information below for each child for whom you are seeking child care payments. If needed, attach an additional page.

FIRST NAME	LAST NAME	DATE OF BIRTH	M/F	ETHNIC ORIGIN*	U.S. CITIZEN YES/NO**	SOCIAL SECURITY NUMBER (Optional)	WARD OF THE STATE YES/NO

* For each child's ETHNIC ORIGIN, list all numbers below that apply: (Required for Federal Reporting)
 1 - White 2 - Black or African American 3 - Hispanic or Latino (Persons declaring Hispanic ethnicity should also list their race. If you list "3" for a child, also list their race, for example, "3, 1", "3, 2" or "3, 5").
 4 - Asian 5 - American Indian or Alaskan Native 6 - Native Hawaiian or Pacific Islander

** If "NO" is entered for U.S. CITIZEN, write alien registration number and attach copy of documentation.

List all other family members counted in family size: (If more space is needed please follow same format on a separate sheet of paper)

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER (Optional)

SECTION IV - INCOME INFORMATION

Enter the MONTHLY income in **each box** for all adults age 19 and over counted in the family size. **If the income doesn't apply, write "N/A".**

TYPE OF INCOME	APPLICANT	OTHER FAMILY MEMBERS
1. Gross Employment Income (including tips) from pay stubs before deductions. Enter any self-employment below. Attach copies of 2 most recent and consecutive pay stubs for each person.	\$	\$
2. Self Employment Income	\$	\$
3. Child Support Received	\$	\$
4. TANF Cash Assistance	\$	\$
5. Other Federal Cash Income: For example, Social Security payments for all family members and railroad benefits	\$	\$
6. Other Monthly Income: For example, interest income, royalties, pensions, annuities, alimony, ongoing monthly adoption assistance payments from DCFS, unemployment compensation, veteran's pension, survivor's benefits, permanent disability payments, and living expense portion of educational grants.	\$	\$
SUBTOTAL (add lines 1-6)	\$	\$
MINUS: Child Support paid by Applicant's Family	\$	\$
TOTAL MONTHLY INCOME	\$	\$

Housing Cash Assistance, including Vouchers with a Specific Cash Value: (Required for Federal Reporting only, does not count when totaling Monthly Family Income.)	\$
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FOR OFFICE USE ONLY: Parent Co-Payment

APPLICANT'S NAME:

SECTION V - PROVIDER INFORMATION

To be completed by the Applicant and the Provider TOGETHER (Please Print In Ink)

Do you have more than one child care provider for this application? YES NO
 If YES, list your other Child Care Provider(s): _____
 If YES, you MUST photocopy pages 5 & 6 and complete a separate child care arrangement section for each provider.
 Do any of your other children attend Head Start, Pre-K, or Child Care at another provider not on this application? YES NO
 If YES, list your other Child Care Provider(s): _____

**Parents or stepparents cannot be paid to provide child care for any children in the home.
 Providers must be at least 18 years of age and clear a CANTS check every two years.**

Name of Provider _____ If you are a Day Care Center, Corporate Name _____

Address _____ Apt # _____ City _____ State _____ Zip Code _____

Mailing Address, if different than above: _____ County _____

Phone Number _____ Fax Number _____ Email _____

Date of Birth (Not required for Centers and Licensed Providers) Month: _____ Day: _____ Year: _____

Must Complete One: **Social Security Number** (Individual or Sole Proprietor) _____
FEIN (Corporation, Partnership or Sole Proprietor) _____
Gov't. Unit Code (Public School or Park District) _____

Enter date provider recently began or will begin caring for children: Month: _____ Day: _____ Year: _____

CHILD CARE ARRANGEMENT

List only the children who will be cared for by THIS provider (circle am or pm) If your children go to school, pre-K, or Head Start at another facility during the day, list only the hours that they are in child care with this provider. For school age children, list only the hours they are in child care.

CHILD'S NAME	AGE	TYPICAL SCHEDULE OF HOURS IN CHILD CARE								PROVIDER'S CURRENT DAILY RATE
			MON	TUE	WED	THU	FRI	SAT	SUN	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	

Does this child care schedule vary? YES NO
 If yes, please explain: _____

Do you offer a multi-child/family discount? YES NO
 If yes, please explain: _____

CHILD CARE COLLABORATIONS

Are you an IDHS approved Child Care Collaboration? YES NO
 Check all that apply: Head Start ISBE Pre-K

How long is your program? 9mo 12mo other _____

APPLICANT'S NAME:

LEGAL CARE ARRANGEMENT

Check the appropriate type of provider. If licensed, complete Day Care Licensing Information.

CENTERS AND LICENSED PROVIDERS

- Licensed Day Care Center (760)*
- Day Care Center Exempt from Licensing (761)
- Licensed Day Care Home (762)*
- Licensed Group Day Care Home (763)*

* DAY CARE LICENSING INFORMATION

(DO NOT enter a Foster Care License Number)

License Number _____

License Capacity: Day _____ Night _____

License Expiration _____

Hours of Operation: From _____ To _____

CARE BY A RELATIVE (LICENSE NOT REQUIRED)

- In the Child Care Provider's Home (765)
- In the Child's Home (767)

My relationship to the child(ren) is:

CARE BY A NON-RELATIVE (LICENSE NOT REQUIRED)

- In the Child Care Provider's Home (764)
- In the Child's Home (766)

SECTION VI - PROVIDER CERTIFICATION

After reading each of the following statements, I certify that:

- Parents will have unrestricted access to their children at all times.
- All state and local fire, health and safety codes have been followed.
- All child care providers/staff will have a physical examination no more than two years old and a TB skin test documented and on file in the facility/home within 90 days of the signature date on this form. The TB skin test is to be no earlier than the date the provider/staff began providing child care services.
- All cleaning agents, poisons and other hazardous materials are stored in an area inaccessible to the child(ren).
- There are no firearms or ammunition in the home OR any firearms or ammunition in the home are stored in a locked cabinet or locked storage at all times.
- First aid supplies are readily available.
- There will be no corporal punishment.
- The children will be provided developmentally appropriate play activities.
- The children will be supervised (indoors and outdoors) at all times.
- I have not been responsible for the abuse or neglect of children in the past five (5) years or been responsible for acts of sexual molestation or sexual exploitation of children for the past twenty (20) years. I authorize the Dept. of Children and Family Services to check the Child Abuse and Neglect Tracking System (CANTS) to confirm this information for the Department of Human Services.
- **Have you ever been convicted of anything other than a minor traffic violation?** YES NO
If yes, please explain: _____
- All of the statements listed above are true.
- The information provided about myself is true, correct and complete.
- I understand the information provided will be checked using State databases.
- I understand that the information provided will be disclosed only for administrative purposes and that I may be required to verify the information.
- I understand that I cannot be paid until I complete a W-9 form and I am certified by the Office of the Comptroller.
- I understand that I am responsible for collecting a co-payment from each family.
- I understand that the rates charged to the State of Illinois do not exceed those charged to the general public for similar services and do not exceed the maximum allowed by the State.
- I certify that if I am a center provider, licensed home, or group home, I will maintain, for a minimum of 5 years from the date of payment, daily attendance records to fully document the extent of services provided and agree to make all records and supporting documentation relevant to the services billed herein available to any and all authorized Department representatives and Federal authorities. I understand that failure to maintain adequate records shall establish a presumption in favor of the State for any funds paid by the State for which adequate documentation is not available to support disbursement.
- I understand giving false information or failure to provide correct information can result in pay back of overpayments and/or referral for prosecution for fraud.
- I understand that deliberately providing an incorrect/fictitious Social Security number in order to defraud the State of Illinois will cause me to be prosecuted to the fullest extent of the law.

Child Care Provider Signature: _____ Date: _____

SECTION VII - APPLICANT CERTIFICATION

After reading each of the following statements, I certify that:

- I understand that I am responsible for paying a share of my child care costs (parent co-payment) to my provider and that failure to do so may result in the loss of my child care provider.
- I understand that my eligibility will be redetermined every 6 months or as needed.
- The child(ren) is/are current on all immunizations and verification is on file with the provider.
- A review of each facility/home has been completed and I agree that it is a safe environment.
- I have given written notification to each provider if I want anyone other than myself to pick up the child(ren).
- An emergency phone number and written consent for medical care and for dispensing prescription medication has been given to each provider.
- The name of the family physician is on file with each provider.
- I am responsible for the selection of the child care providers for my child(ren).
- I will report any change in child care arrangements or employment within **5 days**. Failure to report changes in a timely manner may result in pay back of overpayments and/or loss of child care benefits.
- I understand that I must be working or attending an IDHS approved education, training, or other work related activity in order to be eligible to receive child care benefits.
- I understand the information provided will be checked using State databases, and if inconsistencies are discovered, the processing of my application may be delayed or denied.

- All of the statements listed above are true.
- The information provided about my case is true, correct and complete.
- I understand that I am not required to provide my Social Security Number and that if I deliberately provide an incorrect or fictitious Social Security Number I may be prosecuted for fraud.
- The information provided will be disclosed only for administrative purposes and that I may be required to verify the information that I have provided.
- I understand that I have the right to appeal and to have a fair hearing of a grievance.
- I understand that giving false information or failure to provide correct information can result in pay back of overpayments and/or referral for prosecution for fraud.
- My signature is my consent and authorization for information to be released to the Illinois Department of Human Services or its agents that may establish my eligibility or my continued eligibility for the Child Care Program.

Applicant Signature: _____

Date: _____