This application must be submitted to our office for a child care case to be opened. Please call our office at 304-523-9540 for additional information.

West Virginia Department of Health and Human Resources

Application for Child Care Services

I. INSTRUCTIONS

Please complete this form in order to apply for child care services. **Be sure to sign and date the form and attach any information which is requested.** If your application is not signed and dated, it cannot be processed. New applicants must contact the office listed below to schedule an appointment to complete the application process. Please return form to:

Agency _____ Phone _____

Address _____ Worker _____

II. IDENTIFYING INFORMATION - Head of Household/Applicant

Name:		Maiden Name or any other previous names:			
Social Security # (*Optional)		Birth Date:		Sex:	☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Live-In ☐ Other: _____				Are you a US Citizen?	☐ Yes ☐ No
				Are you a DHHR Kinship Relative Caretaker?	☐ Yes ☐ No
				Are you a Foster Parent?	☐ Yes ☐ No
Mailing Address:				Are you currently homeless?	☐ Yes ☐ No
City:		State:	Zip Code:	County :	
Phone Number:		Business Phone or Message number:			

Ethnicity (must choose one)	Race (check all that apply)
☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White
Email Address:	

*Under the Privacy Act, §7(a), states are prohibited from denying an individual any right, benefit, or privilege provided by law because of the individual's refusal to disclose his or her Social Security Number unless disclosure is required by federal statute.

Proof of Identity and West Virginia Residency: In order to receive child care assistance, you must be a resident of the state of West Virginia. Proof of identity and residency is required, and shall be established by showing a valid photo ID and proof of residency. If you do not have proof of identity, you will be given 13 days to provide it to your worker or your application will be denied.

III. OTHER FAMILY MEMBERS

1.

Name:		Maiden Name or any other previous names:			
Social Security # (*Optional)		Birth Date:		Sex:	☐ Male ☐ Female
Relationship to Head of Household:		Is this person a US Citizen?			☐ Yes ☐ No
Mailing Address:					
City:		State:		Zip Code:	County:
Phone Number:		Business Phone or Message Number:			
Is this a child who needs child care? ☐ Yes ☐ No					
Is this a child with special health care needs? ☐ Yes ☐ No If yes, please describe:					

Ethnicity (must choose one)	**Race (check all that apply)**
☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White

2.

Name:		Maiden Name or any other previous names:			
Social Security # (*Optional)		Birth Date:		Sex:	☐ Male ☐ Female
Relationship to Head of Household:		Is this person a US Citizen?			☐ Yes ☐ No
Mailing Address:					
City:		State:		Zip Code:	County:
Phone Number:		Business Phone or Message Number:			
Is this a child who needs child care? ☐ Yes ☐ No					
Is this a child with special health care needs? ☐ Yes ☐ No If yes, please describe:					

Ethnicity (must choose one)	**Race (check all that apply)**
☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White

3.

Name:		Maiden Name or any other previous names:			
Social Security # (*Optional)		Birth Date:		Sex:	☐ Male ☐ Female
Relationship to Head of Household:		Is this person a US Citizen?			☐ Yes ☐ No
Mailing Address:					
City:		State:		Zip Code:	County:
Phone Number:		Business Phone or Message Number:			
Is this a child who needs child care? ☐ Yes ☐ No					
Is this a child with special health care needs? ☐ Yes ☐ No If Yes, please describe:					

Ethnicity (must choose one)	**Race (check all that apply)**
☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White

4.

Name:		Maiden Name or any other previous names:			
Social Security # (*Optional)		Birth Date:		Sex:	☐ Male ☐ Female
Relationship to Head of Household:		Is this person a US Citizen?			☐ Yes ☐ No
Mailing Address:					
City:		State:		Zip Code:	County:
Phone Number:		Business Phone or Message Number:			
Is this a child who needs child care? ☐ Yes ☐ No					
Is this a child with special health care needs? ☐ Yes ☐ No If Yes, please describe:					

Ethnicity (must choose one)	**Race (check all that apply)**
☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White

IV. REASON FOR NEEDING CHILD CARE

The following information shows why you need child care.

1. List adult's name.
2. Is this person a WV WORKS participant? Put Y or N.
3. Why does this person need care? Enter working, school or training, Court Ordered Child Care or CPS Plan.
4. Enter name of employer or school.
5. Enter date this person started working or attending school.
6. Enter the adult's phone number at work or school.
7. Enter the days and hours this person works or attends school.

1. Name of Adult	2. WV WORKS Participant? Y or N	3. Reason for Care	4. Employer Name or School Name	5. Starting Date	6. Phone Number	7. Schedule (Days & Hours)	8. Does Client work minimum no. of required hours?

Required Verifications:

1. **School** – You must verify school attendance with a letter from the school, copy of your school schedule, and a copy of your most recent grades.
2. **Work** – you must provide one month's worth of pay stubs for each person who works. If you are newly employed and have not received one month's worth of pay stubs, you must have your employer complete the New Employment Verification Form (ECE-CC-1B)
3. **CPS Safety or Treatment Plan** – a copy of the plan must be received which lists days and hours care is requested and any special requirements such as a waiver of fee payment.

V. PROVIDER INFORMATION

1. Use the chart below to list your provider information. Include the following in each block:
   A. Your children's first names.
   B. Name of the provider for each child.
   C. Provider's address – street, city and zip
   D. Provider's phone
   E. If the provider is related to your child – aunt, uncle, grandparent, etc.
   F. Type of care – whether it's a:
      1.) Child care center caring for 13 or more children.
      2.) In home provider who comes to your home. (In-home care is paid only by special approval and on limited basis.)
      3.) Registered family child care home caring for 1- 6 children.
      4.) New family provider.
      5.) Family child care facility caring for 7-12 children.
      6.) Unlicensed after school program operating fewer than 4 hours per day.
      7.) Relative family child care: a grandparent, aunt or uncle who cares only for related children.

1. Child	2. Provider Name	3. Provider Address	4. Provider Phone #	5. If Related, How?	6. Type of Care

2. Do you need your provider to care for children before 6 AM, after 7 PM, on weekends, or for a twelve hour shift?

   ☐ Yes
   ☐ No

VI. PRIMARY LANGUAGE

1. What is the primary language spoken in your home?

   - ☐ English
   - ☐ Spanish
   - ☐ Native Central, South American, and Mexican languages (e.g., Mixteco, Quichean)
   - ☐ Caribbean languages (e.g., Haitian-Creole, Patois)
   - ☐ Middle Eastern and South Asian languages (e.g., Arabic, Hebrew, Hindi, Urdu, Bengali)
   - ☐ East Asian languages (e.g., Chinese, Vietnamese, Tagalog)
   - ☐ Native North American/Alaska Native languages
   - ☐ Pacific Island languages (e.g., Palauan, Fijian)
   - ☐ European and Slavic languages (e.g., German, French, Italian, Croatian, Yiddish, Portuguese, Russian)
   - ☐ African languages (e.g., Swahili, Wolof)
   - ☐ Other (e.g., American Sign Language)
   - ☐ Unspecified (unknown or head of household declined to identify home language)

VII. RESOURCE and REFERRAL

1. Please check below if you were provided any of the following information about child care services.

   - ☐ A list of legally operating child care providers
   - ☐ Written material on types of care and quality of care
   - ☐ Copies of child care regulations
   - ☐ Resource and Referral counseling
   - ☐ Checklist of health and safety concerns
   - ☐ Information on the child care provider complaint policy

2. Did you receive a Child Health Insurance Program Application (CHIP)?

   - ☐ Yes
   - ☐ No
   - ☐ Family has coverage

3. Were you given an opportunity to register to vote?

   - ☐ Yes
   - ☐ No
   - ☐ Already registered to vote

VIII. INCOME VERIFICATION

1. For each person who works, you must attach either:

   A. Copies of that person's most recent pay stubs for at least one month's time, or
   B. A completed “New Employment Verification Form” which shows monthly gross income or hourly wage and average number of hours worked weekly.
   C. If income varies and there have been no changes in hourly wage or salary, three months of pay stubs may be provided.
   D. If a person is self-employed, net income must be reported and verified by business and/or tax records.

2. If you receive child support, you must send in either:

   A. A copy of your divorce or child support decree, or
   B. Verification of child support from the Bureau of Child Support Enforcement.

3. Do your total household assets exceed $1,000,000?

   ☐ Yes
   ☐ No

4. Instructions for completing the chart below:
   A. Please enter the name of the head of the household in the column marked "Your Name."
   B. Please enter the name of other adults or children in your home who receive income.
   C. Go down the column under your name and look at the income types. For example, number one is wages. Enter the amount of your wages and how often you receive it. Go down each row and enter any income you receive from other sources.
   D. If you have a second job, go to the next column and enter your name, then enter your wages from your second job on that line.
   E. If other people in your home have income, enter their names in one of the columns and then go down the chart and enter that income on the row that shows the type of income.

Name of Household Member	**Your Name:**		**Other:**		**Other:**		**Other:**	
Income Type	**List below the gross amount and how often income is received by yourself and other household members.**							
	Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often
Wages (Gross)								
TANF Benefits								
Social Security Benefits								
Veteran's Benefits								
Worker's Compensation								
Disability Benefits								
Unemployment Compensation								
Retirement Benefits								
Farm Self Employment								
Non-Farm Self Employment								
Alimony								
Child Support								
Food Stamps								
Housing Assistance (Not Considered Income)								
Other:								

IX. SIGNATURE

Please read the statements below and sign and date the form.

1. In signing this form, I understand that I am requesting that child care services be provided for my children.

2. I understand that if I receive more benefits than I am entitled to receive, whether through my fault or through an error on the part of the agency, I must repay any extra benefits received.

3. Intentional misuse and/or billing for unapproved services will result in legal action for repayment and prosecution of fraud.

4. The information I have given is true and complete to the best of my knowledge and I agree to allow the agency to contact me or anyone else in order to verify my eligibility for child care.

5. I agree to report any change within 5 working days which would affect my eligibility for child care services.

6. I understand that if I intentionally do not report changes or give false information, I can be prosecuted for fraud or perjury.

7. I understand that I have the right to request a hearing or file a grievance if I am not satisfied with a decision regarding my child care case or if I feel that I have been discriminated against because of race, color, national origin, religion, or sex. I may have an attorney present at a hearing but the attorney's costs will not be paid by the agency.

8. I agree to allow the agency to obtain information from the Social Security Administration if that information is provided and used according to the Social Security Act and the Privacy Act of 1974.

9. I understand that staff of the West Virginia Department of Health and Human Resources, and/or its specified contract agency, are responsible for the provision of child care services, and I give my consent for information about myself and my family to be exchanged as needed between the Department and the contract agency.

_____ _____

Signature Date