Clear Form

Minnesota Department of **Human Services**

Minnesota Child Care Assistance Program Application

This is the Minnesota Child Care Assistance Program (CCAP) Application. You may be eligible to get help for your child care expenses so you can work, look for work, or attend school.

To qualify, your family must:

- Be income eligible;
- Meet employment and training requirements:
  - work at least an average of 20 hours per week (10 hours per week if a full-time student) at minimum wage, *or*
  - participate in job search, attend school or training classes, *or*
  - comply with the activities of an approved Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP) employment plan;
- Cooperate with child support enforcement for all children in the family who have an absent parent; and
- Use a legal child care provider. (Legal providers include licensed and unlicensed providers, 18 years of age or older, who are registered with a county to provide care.)

Read these instructions before you fill out the application.

We have included the Child Care Assistance Program booklet Do you need help paying for child care? (DHS-3551) to give you information about the Child Care Assistance Program and choosing a child care provider.

Please follow these instructions as you complete your application.

- Print your answers using black ink.
- Read all instructions carefully and answer all questions completely.
- If you need more room, use space provided on page 12 or attach additional sheets of paper.
- **Provide proof of all requested information.** This includes proof of:
  - Identity and residence for each adult in your family
  - Age and relationship to you for each child in your family
  - Citizenship or immigration status for each child in your family who need child care
  - School schedule and program completion date for each adult in your family
  - All earned and unearned income and work schedules
  - Allowable deductions such as insurance premiums, child/spousal support paid, educational expenses
- The county must ask for your Social Security number. You are not required to provide this to be eligible for assistance.
- Carefully read the "Penalty Warning", "Your responsibilities" and "Your rights" sections of this form.
- Sign and date the application.
- Mail, fax or bring the completed application and all other needed items to the address listed below.
- **If you have questions about completing this application or have problems getting the information you need, please call the number listed on the front of the application.**

A child care worker will write or call you if we need more information.

Once we receive all information you will receive a written notice about your eligibility.

Mail application to: ⇨

If you want help, please call this telephone number

Affix County Label Here

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មានេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (10-09)

ADA5 (3-12)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency’s ADA coordinator.

Minnesota Department of **Human Services**

DHS-3550-ENG 8-12

Minnesota Child Care Assistance Program Application

Child care assistance staff only:	
CASE NUMBER	COUNTY DATE STAMP
CCAP WORKER NAME	
MFIP WORKER NAME	
MFIP BEGIN DATE	MFIP END DATE
EMPLOYMENT SERVICES AGENCY	
EMPLOYMENT SERVICES WORKER	

1. Applicant

Tell us about you and where you live.

- Include *proof of your identity,* such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate.
- Include *proof of your residence,* such as one of the items listed above or a copy of a recent utility bill, rental lease, or mortgage document.

PERSON 1 LAST NAME	FIRST NAME	MIDDLE NAME	
OTHER NAMES YOU MIGHT BE KNOWN AS	GENDER ☐ Female ☐ Male	BIRTH DATE	SOCIAL SECURITY NUMBER
ADDRESS			
CITY	STATE	COUNTY	ZIP CODE
MAILING ADDRESS *(if different)*			
CITY		STATE	ZIP CODE
HOME PHONE	WORK PHONE	OTHER PHONE	

What is your preferred language spoken?	What is your preferred written language?	Do you need an interpreter? ☐ Yes ☐ No

MARITAL STATUS:
☐ Married ☐ Divorced ☐ Separated ☐ Single

ETHNICITY *(optional)*	RACE *(optional)*
Hispanic? ☐ Yes ☐ No	☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Pacific Islander or Native Hawaiian ☐ White

Have you ever received or requested Child Care Assistance? ☐ Yes ☐ No

If yes, when? _____	Where? (MN City) _____	(MN County)_____

Do you receive food support (other than MFIP)? ☐ Yes ☐ No

Do you get a housing or Section 8 subsidy? ☐ Yes ☐ No

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 that are not 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 who live with you 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 an INS 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	BIRTH DATE

GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
☐ Female ☐ Male		Hispanic? ☐ Yes ☐ No	☐ 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?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

PERSON 3 LAST NAME	FIRST NAME	MIDDLE NAME	BIRTH DATE

GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
☐ Female ☐ Male		Hispanic? ☐ Yes ☐ No	☐ 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?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

PERSON 4 LAST NAME	FIRST NAME	MIDDLE NAME	BIRTH DATE

GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
☐ Female ☐ Male		Hispanic? ☐ Yes ☐ No	☐ 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?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

2. Family members *(Continued)*

PERSON 5 LAST NAME	FIRST NAME	MIDDLE NAME	BIRTH DATE

GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
☐ Female ☐ Male		Hispanic? ☐ Yes ☐ No	☐ 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?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

PERSON 6 LAST NAME	FIRST NAME	MIDDLE NAME	BIRTH DATE

GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
☐ Female ☐ Male		Hispanic? ☐ Yes ☐ No	☐ 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?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

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. Under each day, indicate the time that the child is with you under either a shared custody or a visitation agreement.

Child 1

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	DO YOU RECEIVE CHILD SUPPORT?
		☐ Yes ☐ No

List time child spends with parent who is not in the home.	SHARED CUSTODY/VISITATION SCHEDULE						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Child 2

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	DO YOU RECEIVE CHILD SUPPORT?
		☐ Yes ☐ No

List time child spends with parent who is not in the home.	SHARED CUSTODY/VISITATION SCHEDULE						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Child 3

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	DO YOU RECEIVE CHILD SUPPORT?
		☐ Yes ☐ No

List time child spends with parent who is not in the home.	SHARED CUSTODY/VISITATION SCHEDULE						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

3. Child Support and custody arrangement *(Continued)*

Child 4

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	DO YOU RECEIVE CHILD SUPPORT? ☐ Yes ☐ No

List time child spends with parent who is not in the home.	SHARED CUSTODY/VISITATION SCHEDULE						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Child 5

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	DO YOU RECEIVE CHILD SUPPORT? ☐ Yes ☐ No

List time child spends with parent who is not in the home.	SHARED CUSTODY/VISITATION SCHEDULE						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

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 six months.**

- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support.
- Include proof of the school schedule for every child who needs child care, such as a school calendar with start and end times.
- For preschool age children: Indicate "Head Start" or "preschool" in the "**GRADE**" field if child attends one of those programs.
- For kindergarten students: Indicate if they are in half day or full day kindergarten in the "**GRADE**" field.
- Post-secondary students must include proof of their school schedule, such as a fee statement, transcript, or registration confirmation; and the expected completion date of their program.

Student 1

STUDENT NAME	SCHOOL NAME	GRADE

START DATE IF NOT CURRENTLY ATTENDING?	DAYS AND TIMES STUDENT ATTENDS SCHOOL						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
EXPECTED COMPLETION DATE?							

Student 2

STUDENT NAME	SCHOOL NAME	GRADE

START DATE IF NOT CURRENTLY ATTENDING?	DAYS AND TIMES STUDENT ATTENDS SCHOOL						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
EXPECTED COMPLETION DATE?							

4. Student information - children *(Continued)*

Student 3	STUDENT NAME	SCHOOL NAME	GRADE
START DATE IF NOT CURRENTLY ATTENDING?	**DAYS AND TIMES STUDENT ATTENDS SCHOOL**		
EXPECTED COMPLETION DATE?	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Student 4	STUDENT NAME	SCHOOL NAME	GRADE
START DATE IF NOT CURRENTLY ATTENDING?	**DAYS AND TIMES STUDENT ATTENDS SCHOOL**		
EXPECTED COMPLETION DATE?	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Student 5	STUDENT NAME	SCHOOL NAME	GRADE
START DATE IF NOT CURRENTLY ATTENDING?	**DAYS AND TIMES STUDENT ATTENDS SCHOOL**		
EXPECTED COMPLETION DATE?	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

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.
- Include your employer's Federal Employer Identification Number (FEIN).

A. Earned income (Wages)

# 1	EMPLOYEE	EMPLOYER NAME	EMPLOYER PHONE NUMBER
	EMPLOYER'S ADDRESS	FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	WORK ADDRESS IF DIFFERENT
	HOURLY PAY RATE / NO. HOURS PER WEEK	HOW OFTEN PAID? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Other _____	TOTAL AMOUNT PAID BEFORE DEDUCTIONS*
	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK

# 2	EMPLOYEE	EMPLOYER NAME	EMPLOYER PHONE NUMBER
	EMPLOYER'S ADDRESS	FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	WORK ADDRESS IF DIFFERENT
	HOURLY PAY RATE / NO. HOURS PER WEEK	HOW OFTEN PAID? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Other _____	TOTAL AMOUNT PAID BEFORE DEDUCTIONS*
	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK

5. Income *(Continued)*

B. Self-Employment income

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.

Include proof of:

- all self-employment income and expenses, such as federal tax returns or business ledgers.
- work schedule, such as a calendar with work hours.

# 1	EMPLOYEE"S NAME		TYPE OF BUSINESS	
	START DATE	NO. HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE DEDUCTIONS	MONTHLY EXPENSES

# 2	EMPLOYEE'S NAME		TYPE OF BUSINESS	
	START DATE	NO. HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE DEDUCTIONS	MONTHLY EXPENSES

Do you expect any changes in work hours, income or expenses for any of the self-employment activities described above? ☐ Yes ☐ No If yes, please describe in detail:

_____

_____

_____

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)	☐	☐			
Relative custody assistance	☐	☐			
Child support/Spousal support	☐	☐			
Worker's Compensation	☐	☐			
Unemployment Insurance	☐	☐			
Insurance benefits	☐	☐			
RSDI (Retirement, survivors, disability insurance)	☐	☐			
Veteran benefits (VA)	☐	☐			
Student grants or scholarships	☐	☐			
Post-secondary child care grant award	☐	☐			

5. Income *(Continued)*

Type	Yes	No	Name of person receiving income	How often received	Amount
Student loans	☐	☐			
Stipends	☐	☐			
Interest/dividends	☐	☐			
Tribal payments	☐	☐			
Direct reimbursement received from your county for cost-effective health care	☐	☐			
Other child care assistance	☐	☐			
Other (lottery or gambling winnings, inheritance, insurance disbursements)	☐	☐			
Type:					
Type:					
Type:					
Type;					

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 monthly co-payment.
- Include proof of deductions, such as check stubs, benefit statements, premium statements or award letters.

Expense	Amount	How often do you pay?
Medical insurance premiums		
Dental insurance premiums		
Vision insurance premiums		
Child support paid for a child not living in the home		
Court ordered spousal support		
Tuition, fees, books and educational supplies*		

**Only include these if student receives scholarships, grants, student loans or work-study income.*

Agency notes:

7. 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 with child care costs to be able to attend school or training classes.

- Include family members participating in GED or ESL classes.
- Include proof of school schedules that shows 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 IF NOT ALREADY ATTENDING?	DAYS AND TIMES THIS ADULT ATTENDS SCHOOL TRAINING						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Adult 2

ADULT'S NAME	NAME OF SCHOOL OR TRAINING SITE	SCHOOL PROGRAM ATTENDING

START DATE IF NOT ALREADY ATTENDING?	DAYS AND TIMES THIS ADULT ATTENDS SCHOOL TRAINING						
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

B. List all *adult* family members who need help with child care costs 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

Adult 2

ADULT'S NAME	EMPLOYER'S NAME

DAYS AND TIMES THIS ADULT WORKS						
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

C. List all *adult* family members who need help with child care costs to be able to look for work.

ADULT'S NAME	ADULT'S NAME
ADULT'S NAME	ADULT'S NAME

D. List all *adult* family members who need help with child care costs to be able to attend MFIP orientations or other MFIP/DWP activities in an approved employment plan.

ADULT'S NAME	JOB COUNSELOR ASSIGNED	JOB COUNSELOR'S NAME	COUNSELOR'S TELEPHONE NUMBER
	☐ Yes ☐ No		
ADULT'S NAME	JOB COUNSELOR ASSIGNED	JOB COUNSELOR'S NAME	COUNSELOR'S TELEPHONE NUMBER
	☐ Yes ☐ No		

8. 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 for your child.
- Call the number on the front of the application if your child has special needs and requires specialized care.

Child 1

CHILD'S NAME	WHERE IS CARE PROVIDED? ☐ Child's home ☐ Licensed child care center ☐ Licensed family child care home ☐ Legal Non-licensed Provider's home	
HOURS AND DAYS CHILD CARE IS PROVIDED		
MONDAY / TUESDAY / WEDNESDAY / THURSDAY / FRIDAY / SATURDAY / SUNDAY		
CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE
PROVIDER'S ADDRESS		

Is provider related to the child? ☐ Yes ☐ No If yes, relationship: _____

Child 2

CHILD'S NAME	WHERE IS CARE PROVIDED? ☐ Child's home ☐ Licensed child care center ☐ Licensed family child care home ☐ Legal Non-licensed Provider's home	
HOURS AND DAYS CHILD CARE IS PROVIDED		
MONDAY / TUESDAY / WEDNESDAY / THURSDAY / FRIDAY / SATURDAY / SUNDAY		
CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE
PROVIDER'S ADDRESS		

Is provider related to the child? ☐ Yes ☐ No If yes, relationship: _____

Child 3

CHILD'S NAME	WHERE IS CARE PROVIDED? ☐ Child's home ☐ Licensed child care center ☐ Licensed family child care home ☐ Legal Non-licensed Provider's home	
HOURS AND DAYS CHILD CARE IS PROVIDED		
MONDAY / TUESDAY / WEDNESDAY / THURSDAY / FRIDAY / SATURDAY / SUNDAY		
CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE
PROVIDER'S ADDRESS		

Is provider related to the child? ☐ Yes ☐ No If yes, relationship: _____

8. Child care needs *(Continued)*

Child 4

CHILD'S NAME	WHERE IS CARE PROVIDED? ☐ Child's home ☐ Licensed child care center ☐ Licensed family child care home ☐ Legal Non-licensed Provider's home	
HOURS AND DAYS CHILD CARE IS PROVIDED		
MONDAY	TUESDAY	WEDNESDAY
CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE
PROVIDER'S ADDRESS		
Is provider related to the child? ☐ Yes ☐ No If yes, relationship: _____		

THURSDAY	FRIDAY	SATURDAY	SUNDAY

Child 5

CHILD'S NAME	WHERE IS CARE PROVIDED? ☐ Child's home ☐ Licensed child care center ☐ Licensed family child care home ☐ Legal Non-licensed Provider's home	
HOURS AND DAYS CHILD CARE IS PROVIDED		
MONDAY	TUESDAY	WEDNESDAY
CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE
PROVIDER'S ADDRESS		
Is provider related to the child? ☐ Yes ☐ No If yes, relationship: _____		

THURSDAY	FRIDAY	SATURDAY	SUNDAY

Important! Please read and sign this application.

Authorization to share information for fraud investigation. 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. 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). 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 DHS, 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, you must follow these rules. 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 three months for the first fraud, six months for the second fraud, two years for the third fraud and is permanent for the fourth fraud. The maximum penalty is a fine of $100,000 or a jail term of 20 years, or both.

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 Human Services. 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 all changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment, school and training schedules, marital status, income, address or residence, or anyone moving in or out of my household.
- 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 must be redetermined at least every six months.
- I have the right to choose any legal child care provider, including licensed child care centers, licensed family child care providers and legally unlicensed child care providers that meet program requirements.
- If I choose a provider to provide child care in my home, I am considered the employer of the provider and have legal and tax responsibilities.

Perjury and general declarations. I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than $10,000, or both. (Minn. Stat. 256.984, subd. 1)

By signing below:

- I have received a copy of the Notice of Privacy Practices (DHS-3979) and the Client Responsibilities and Rights (DHS-4163). I have read, and understand this information. If I have questions about this information, I will ask a worker to explain them to me.
- I agree to continue to assign my child care support to the state of Minnesota. I understand that I have the right to claim good cause for not cooperating with child support enforcement.
- I agree to the sharing of information as stated in the provider release and fraud investigation authorization information above.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	AGENCY SIGNATURE	DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE	Client given: ☐ R&R ☐ Notice of Privacy Practices (DHS-3979) ☐ ADA brochure (DHS-4133)	

Use this space if you need additional room.

Minnesota Department of Human Services

Client Responsibilities and Rights

NOTE: Cash on an EBT card is provided to help families meet their basic needs. These basic needs include food, shelter, clothing, utilities and transportation. These funds are given until families can support themselves. It is illegal for an EBT user to buy or attempt to buy tobacco products or alcohol with the EBT card. If you do, it is fraud and you will be removed from the program. Do not use an EBT card at a gambling establishment.

Your responsibilities

- **You must report changes which may affect your benefits to the county agency within 10 days** after the change has occurred. **Applicants** - Report these changes to your worker when the change happens.
  This includes the following for everyone in your household:
  - **Employment** - Start or stop a job or business; change in hours, earnings or expenses.
  - **Income** - Receipt or change in child support, Social Security, Veteran benefits, Unemployment Insurance, inheritance, insurance benefits and other payments.
  - **Property** - Purchase, sale or transfer of a house, car or other items of value. Get an inheritance or a settlement
  - **Household** - When a person dies or becomes disabled, moves in or out of your home or temporarily leaves; pregnancy; birth of a child.
  - **Address**
  - **Housing costs/rent subsidy**
  - **Utility costs**
  - **Filing a lawsuit**
  - **Absent parent custody or visits**
  - **Drug felony conviction**
  - **Marriage, separation or divorce**
  - **School attendance**
  - **Health insurance coverage and premiums.**

  Note about child care providers: If you change providers, you must tell your child care worker and provider at least 15 days before the change goes into effect.

  If you have any questions or are unsure about any reporting rules, contact your worker. If your worker is not available, leave a message so the worker can get back to you.
- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get assistance.
- **If you give us information you know is untrue or we get information you did not report,** we will investigate you for fraud.
- **The State or Federal Quality Control agency** may randomly choose your case for review. They will review statements you made on forms. They will check to see if we figured your eligibility correctly. The state agency may seek information from other sources. The State or Federal Quality Control agency will tell you about any contact they intend to make. **If you do not cooperate, your benefits may stop.**
- **Cooperation requirements:**
  - If the county approves you for the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP), you must cooperate with employment services, unless you are exempt. You must develop and sign an employment plan or your DWP application will be denied.
  - To receive Family Cash Benefits and/or Child Care Assistance (CCAP), you must cooperate with child support enforcement for all children in your household. You have the right to claim "good cause" for not cooperating with child support enforcement. You must assign your child support to the State of Minnesota for all eligible children. If you do not cooperate or assign your child support, benefits will be denied or terminated.
  - After the county approves your MFIP or DWP, if you get child support directly from the noncustodial parent, you must report it to your worker. You must cooperate with the child support agency in any legal action brought against a third party for payment of medical expenses, unless you claim and are granted good cause.
  - If you are applying for health care for yourself and your children and you do not live with the other parent, you may have to give information about the other parent to child support staff. Child support staff may use this information to pursue medical support for your children. You do not have to give this information if you are only applying for your children or are pregnant.
  - Household members applying for health care may need to accept and keep other health insurance that is available. This includes Medicare. If you do not give us information about your policy, you may not get coverage.

For Cash and SNAP:

- **Each time you use your electronic benefits transfer (EBT) card or sign your check,** you state that you have informed the county agency about any changes in your situation which may affect your benefits.
- **Each time your electronic benefits transfer (EBT)** card is used we assume you have received your cash or SNAP benefits, unless you reported your card lost or stolen to the county agency.

For Child Care:

- **You may be required to pay a co-payment fee.** If you do not pay the fee, your Child Care Assistance will be terminated until fees are paid in full or satisfactory payment agreements have been made with the county and your child care provider. Your Child Care Assistance worker will tell you whether to pay this fee to your child care provider or to the county agency.
- **You may be required to pay additional costs** when your child care provider charges a rate that is more than the maximum rate in your county.
- **You must document** the immigration or citizenship status of the children in your family for whom you are applying for child care assistance.

NOTE: If you sign this application as an Authorized Representative of a person who is requesting or receiving assistance, you are agreeing to assume all of the responsibilities listed above on behalf of that person.

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet explaining these rights.
- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application promptly.**
  - 15 days for medical care for pregnant women
  - 30 days for cash, SNAP and child care
  - 45 days for medical care
  - 60 days for cash and medical care related to disability.
- **You have the right to know the rules of the program you are applying for** and for us to tell you how we figured your benefits.
- **You have the right to choose where and with whom you live** and, within certain limits, to choose your own doctor, hospital, etc.
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care **within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.)

  For SNAP, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

  If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.
- **Access to free legal services.** Contact your worker for information on free legal services.
- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Equal Opportunity and Access
PO Box 64997
St. Paul, MN 55164-0997
651-431-3040 (Voice) / 866-786-3945 (TTY)

Minnesota Department of Human Rights
Freeman Building
625 Robert Street North
St. Paul, MN 55155
800-657-3704 (Voice) / 651-296-1283 (TTY)

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
312-886-2359 (Voice) / 312-353-5693 (TTY)

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U.S. Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410
866-632-9992 (Voice) / 800-877-8339 (Federal Relay Service)
800-845-6136 (Spanish)

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