ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

DATE RECEIVED

APPLICATION FOR CHILD CARE ASSISTANCE

INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR CHILD CARE ASSISTANCE

The DES Child Care Administration offers Child Care Assistance programs for low-income families who are working, teen parents in high school or GED classes, homeless/domestic violence shelter residents and families who are unavailable or unable to care for their children due to a physical or emotional condition. You **MUST** provide a completed **Application for Child Care Assistance (CC-001)** in order to make sure your Child Care Specialist is able to determine eligibility.

The check list below is a list of items that may be needed with your Child Care Application. Please provide any of the documents below that match your families' current situation. **You may contact your Local Child Care Office with any questions you may have.**

☐ Proof of U.S. citizenship or legal residency for the applicant.

☐ Copy of your most recent paycheck stub, or current statement signed by your employer verifying the gross wages of your most recent paycheck, frequency of pay and days/hours of employment. Also include verification of tips, bonuses, commissions or allowances and the frequency of payment (weekly, bi-weekly, twice a month, or monthly).

☐ Self-Employment Income and business related receipts (monthly self-employment records or US Individual Income Tax Return with attached schedules, from last year's tax return).

☐ Unearned Income (i.e. direct payments of child support, social security income, veteran's benefits, guardianship, foster, or adoption subsidy, loans or cash gifts).

☐ Verification of school attendance for teen parents (under the age of 20).

☐ Verification of Shelter Residency (You must provide a current statement from the shelter specifying the number of hours per day, days per week, and duration of your current shelter required activity).

☐ Verification of Relationship (birth certificates) or Legal Guardianship Documents (when you are **not** the natural, step or adoptive parent of the child(ren) who need care).

☐ Medical Statement (please speak to your Specialist to get the form needed to fulfill this requirement).

☐ Child Care Provider Selection (if you need assistance with selecting a provider, contact Child Care Resource & Referral 1-800-308-9000 or visit www.azchildcare.org).

Notes:

_____

_____

If you, your representative, or any household member hides or provides false information purposely to receive or continue to receive child care assistance that you are not entitled to, that person will be subject to:

- Criminal Prosecution
- Fines
- Imprisonment
- Other penalties provided for by state and federal laws

If you knowingly break these rules and receive child care assistance you are not entitled to we will disqualify you from receiving services for:

- 6 months for the first violation
- 12 months for the second violation
- Permanently for the third violation

I understand that if I knowingly submit false information or conceal a material fact on the application I may be charged with **FRAUD** pursuant to A.R.S. 13-2311, a class 5 felony. I understand that I will be responsible for all overpayments.

If you need assistance in locating a DES Child Care office in your area:

Please visit https://des.az.gov; or contact the DES Child Care Administration at 602-542-4248.

Child Care Administration

APPLICATION FOR CHILD CARE ASSISTANCE

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Please complete all sections of this application. Missing or inaccurate information can delay eligibility decisions.

☐ **NEW APPLICANT** ☐ **REDETERMINATION**

***RACE:** AI: American Indian/Alaskan Native; AS: Asian; BL: Black or African American; NH: Native Hawaiian or Other Pacific Islander; WH: White

	YOUR LEGAL NAME *(First, M.I, Last)*	RACE *	SOC. SEC. NO.	DATE OF BIRTH (MM/DD/YY)	MARITAL STATUS
1		☐ AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
	LEGAL NAME OF YOUR SPOUSE OR OTHER PARENT LIVING WITH YOU *(First, M.I, Last)*	**RACE ***	**SOC. SEC. NO.**	**DATE OF BIRTH (MM/DD/YY)**	**SPOUSE?**
2		☐ AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			☐ Yes ☐ No

OTHER NAMES USED BY YOU (e.g. maiden, alias):

☐ Yes ☐No Are you an enrolled member of an American Indian tribe? Which tribe? *(Describe)*:

YOUR ADDRESS INFORMATION

APPLICANT'S RESIDENTIAL ADDRESS *(House No., Street, Apt. / Space #, City, State ZIP)*

APPLICANT'S MAILING ADDRESS *(If different from residential address)*

PHONE NUMBER ( )	MESSAGE PHONE NUMBER (*alternate phone number)* ( )	EMAIL ADDRESS

YOUR CITIZENSHIP/LEGAL RESIDENCY STATUS

☐ Yes ☐ No Are you a U.S. Citizen?

Document type you will provide for eligibility determination: ☐ AZ Driver's License ☐ U.S. Birth Certificate ☐ Legal Resident Card ☐ Other:

YOUR REASONS FOR CHILD CARE SERVICES

☐ Employment ☐ High school GED *(under 20 years old)* ☐ Medical ☐ Jobs Program

☐ Job Search (*for Grant Diversion participant)*

☐ Other
(Describe):_____

YOUR CHILD CARE PROVIDER INFORMATION *(If known)*

WHICH CHILD CARE PROVIDER HAVE YOU CHOSEN?	PROVIDER'S ADDRESS (No., Street, City, State, ZIP)	PHONE NUMBER *(Include Area Code)*

ABSENT HOUSEHOLD MEMBER

☐ Yes ☐ No Are any household members temporarily out of the home? If yes, Who?

REASON FOR ABSENCE

ADDITIONAL INFORMATION

☐ Yes ☐ No Does your family assets exceed $1,000,000.00 (one million)?

	LIST THE NAMES OF EVERYONE ELSE WHO LIVES IN YOUR HOME IN THE SPACES BELOW *(First, M.I, Last)* *(If you have more than 9 people in your home, list their names and relationship to you on a separate sheet of paper.)*	RELATIONSHIP TO YOU (required)	*RACE **AI:** American Indian or Alaskan Native; **AS:** Asian; **BL:** Black or African American; **NH:** Native Hawaiian or Other Pacific Islander; **WH:** White	SOC. SEC. NO.	DATE OF BIRTH *(MM/DD/YY)*	NEEDS CHILD CARE? *(Y for yes or N for no)*	NAME OF CHILD'S SCHOOL	US Citizen? (Y/N)
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
3	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
4	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
5	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
6	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
7	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
8	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							
	NAME (First, Middle, Last)		☐ *AI ☐ AS ☐ BL ☐ NH ☐ WH ☐ Yes ☐ No Hispanic?			Y / N		Y / N
9	If this person is your child, PROVIDE NAME OF CHILD'S OTHER PARENT.				DOES THE OTHER PARENT LIVE WITH YOU? ☐ Yes ☐ No			
	☐ Yes ☐ No Does this child have special needs? You must be able to provide verification using one of the documents listed below: ☐ IEP ☐ IFSP ☐ ISP ☐ 504 Plan ☐ Diagnosis ☐ Other _____							

UNEARNED INCOME (*You must answer either Yes or No. You must provide information if Yes.)*

ü YES or NO	SOURCE	AMOUNT RECEIVED	HOW OFTEN RECEIVED	NAME OF PERSON RECEIVING INCOME
☐ Yes ☐ No	Cash Assistance	$		
☐ Yes ☐ No	Social Security/SSI, SSA	$		
☐ Yes ☐ No	Child Support ATLAS # / Court Order #	$		
☐ Yes ☐ No	Identify other income sources (**circle all that apply**): Gifts, Loans, Unemployment Insurance, Rental Income, Interest, VA, Income from Absent Parent(s), Friends or Relatives, Other *(describe):*_____	$		

CHILD SUPPORT PAID OUT

☐ Yes ☐ No Do you or your spouse pay child support? If yes, complete below:

WHO IS PAYING THE SUPPORT	FOR WHOM PAID *(Name of child)*	MONTHLY AMOUNT PAID
		$

YOUR EMPLOYMENT ACTIVITY INFORMATION

Do you have more than two jobs? ☐ Yes ☐ No ? If "yes," provide additional information on a separate sheet.

EMPLOYER'S NAME	WORK PHONE NUMBER ( )	START DATE

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

DATE OF 1ST PAYCHECK	AVG. HOURS WORKED PER WEEK *(or range of hours if schedule varies)*

HOURLY WAGE OR MONTHLY SALARY	HOW OFTEN PAID *(Check one)*	
$	☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month – Pay Dates:_____	
ADDITIONAL INCOME *(ü all that apply)* ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay	TOTAL AMOUNT OF ADDITIONAL INCOME $	HOW OFTEN ADDITIONAL INCOME RECEIVED *(ü one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Every two weeks ☐ Twice a month – Pay Dates:_____

SECOND EMPLOYER'S NAME *(If you have a second job)*	WORK PHONE NUMBER ( )	DATE PRESENT JOB BEGAN

SECOND EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

DATE OF 1ST PAYCHECK	AVG. HOURS WORKED PER WEEK (or range of hours if schedule varies)

HOURLY WAGE OR MONTHLY SALARY	HOW OFTEN PAID *(CHECK ONE)*	
$	☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month – Pay Dates:_____	
ADDITIONAL INCOME *(ü all that apply)* ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay	TOTAL AMOUNT OF ADDITIONAL INCOME $	HOW OFTEN ADDITIONAL INCOME RECEIVED (ü one) ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Every two weeks ☐ Twice a month – Pay Dates:_____

EMPLOYMENT ACTIVITY INFORMATION OF SPOUSE OR OTHER PARENT OF CHILD(REN) WHO LIVES WITH YOU

Does this person have more than two jobs? ☐ Yes ☐ No If "yes," provide additional information on a separate sheet.

EMPLOYER'S NAME	WORK PHONE NUMBER ( )	START DATE

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

DATE OF 1ST PAYCHECK	AVG. HOURS WORKED PER WEEK *(or range of hours if schedule varies)*

HOURLY WAGE OR MONTHLY SALARY	HOW OFTEN PAID *(CHECK ONE)*	
$	☐ Weekly ☐ Every two week ☐ Monthly ☐ Twice a month – Pay Dates:_____	
ADDITIONAL INCOME (ü all that apply) ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay	TOTAL AMOUNT OF ADDITIONAL INCOME $	HOW OFTEN ADDITIONAL INCOME RECEIVED (ü one) ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Every two weeks ☐ Twice a month – Pay Dates:_____

SECOND EMPLOYER'S NAME *(If you have a second job)*	WORK PHONE NUMBER ( )	DATE PRESENT JOB BEGAN

SECOND EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

DATE OF 1ST PAYCHECK	AVG. HOURS WORKED PER WEEK *(or range of hours if schedule varies)*

HOURLY WAGE OR MONTHLY SALARY	HOW OFTEN PAID *(CHECK ONE)*	
$	☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month – Pay Dates:_____	
ADDITIONAL INCOME (ü all that apply) ☐ Bonuses ☐ Tips ☐ Commissions ☐ Overtime pay	TOTAL AMOUNT OF ADDITIONAL INCOME $	HOW OFTEN ADDITIONAL INCOME RECEIVED (ü one) ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Every two weeks ☐ Twice a month – Pay Dates:_____

YOUR SELF-EMPLOYMENT ACTIVITY INFORMATION

☐ Yes ☐ No Are you currently self-employed? If Yes, describe your business:

Business Type: ☐ Corporation ☐ Owned by yourself ☐ A Partnership *(Name all partners):*

☐ Yes ☐ No Can you set your own schedule? | ☐ Yes ☐ No Do you have business expenses from Self-Employment?

Who pays you? ☐ Individual Customer ☐ Parent Company ☐ Other (explain):

If newly self-employed, how much gross income (before deducting any business expenses) do you think you will earn each month?
$

SPOUSE OR OTHER PARENT SELF-EMPLOYMENT ACTIVITY INFORMATION

☐ Yes ☐ No Is this person currently self-employed? If Yes, describe their business:

Business Type: ☐ Corporation ☐ Owned by their self ☐ A Partnership *(Name all partners):*

☐ Yes ☐ No Can they set their own schedule? | ☐ Yes ☐ No Do they have business expenses from Self-Employment?

Who pays them? ☐ Individual Customer ☐ Parent Company ☐ Other *(explain):*

If newly self-employed, how much gross income (before deducting any business expenses) do you think they will earn each month?
$

TEEN PARENT INFORMATION

HIGH SCHOOL / GED PROGRAM NAME	TERM/SEMESTER BEGIN DATE	TERM/SEMESTER END DATE	**ATTACH YOUR CLASS SCHEDULE TO APPLICATION**

SCHOOL'S ADDRESS OR WEBSITE ADDRESS (No. Street, City, State, ZIP)	PHONE NUMBER ( )

SPOUSE OR OTHER PARENTS HIGH SCHOOL OR GED PROGRAM ACTIVITY INFORMATION

Is this person attending high school, or a GED program? ☐ Yes ☐ No

HIGH SCHOOL'S NAME / GED PROGRAM NAME	TERM/SEMESTER BEGIN DATE	TERM/SEMESTER END DATE	**ATTACH THEIR CLASS SCHEDULE TO APPLICATION**

SCHOOL'S ADDRESS OR WEBSITE ADDRESS (No. Street, City, State, ZIP)	PHONE NUMBER ( )

SELF-SUFFICIENCY STATEMENT (must check at least one box)

I have made the following efforts to improve my skills and move toward self-sufficiency in the last 12 months. (*ü* all that apply)

1. ☐ I registered or job searched via DES One Stop Career Centers, DES Job Service, other public or private employment agencies, or independently.
2. ☐ I applied for a better job.
3. ☐ I have been consistently employed.
4. ☐ I was laid-off but found new employment within 60 days.
5. ☐ I left one job for a better job (higher pay, more hours, or better benefits).
6. ☐ I consistently demonstrated a net profit in my self-employment activity.
7. ☐ I attended remedial education for the attainment of a high school diploma or GED.
8. ☐ I attended English for Speakers of Other Languages (ESOL) classes.
9. ☐ I attended a trade/vocational school, college or university and made satisfactory progress in the activity.
10. ☐ I attended work related school or training, or pursued a degree or certificate that will lead to enhanced career opportunities.
11. ☐ I have NOT requested TANF (Temporary Assistance to Needy Families) Cash Assistance for myself.
12. ☐ I made contact with DES Child Support Enforcement about support from an absent parent or paternity establishment.
13. ☐ I continued with my treatment plan under the direction of a physician, psychiatrist, or psychologist.
14. ☐ I followed a domestic violence/homeless shelter case plan.
15. ☐ I completed or am in the process of completing a drug/alcohol rehabilitation or court ordered community service program.
16. ☐ Other _____

YOUR MILITARY STATUS *(You must answer either yes or no)*

☐ Yes ☐ No Are you currently active duty (serving full-time) in the US Military?
☐ Yes ☐ No Are you currently a member of a National Guard Unit?
☐ Yes ☐ No Are you currently a member of a military reserve unit?

YOUR SPOUSE/OTHER PARENT MILITARY STATUS *(Answer yes or no if your spouse or the other parent is residing with you)*

☐ Yes ☐ No Is the spouse/other parent currently active duty (serving full-time) in the US Military?
☐ Yes ☐ No Is the spouse/other parent currently a member of a National Guard Unit?
☐ Yes ☐ No Is the spouse/other parent currently a member of a military reserve unit?

YOUR RESIDENCE STATUS according to McKinney-Vento Homeless Assistance Act *(Please answer all that apply)*

The questions below apply to the children whom you are applying to receive Child Care Assistance for.

☐ Yes ☐ No Are they sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason?
☐ Yes ☐ No Are they living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations?
☐ Yes ☐ No Are they living in emergency or transitional shelters?
☐ Yes ☐ No Are they abandoned in hospitals?
☐ Yes ☐ No Are they awaiting foster care placement?
☐ Yes ☐ No Do they have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings?
☐ Yes ☐ No Are they living in cars?
☐ Yes ☐ No Are they living in parks or other public spaces?
☐ Yes ☐ No Are they living in abandoned buildings?
☐ Yes ☐ No Are they living in substandard housing?
☐ Yes ☐ No Are they living in bus or train stations or similar settings?

DO YOU NEED ANY ADDITIONAL ASSISTANCE? *(ü all that apply)*

- ☐ Locating a child care provider
- ☐ Immunization assistance
- ☐ WIC (Women, infants, children) food and nutrition service
- ☐ Adoption assistance
- ☐ Developmental disabilities assistance
- ☐ Hearing and visually impaired assistance
- ☐ Medical assistance
- ☐ Dental assistance
- ☐ Domestic violence assistance
- ☐ Domestic violence/homeless shelter
- ☐ Financial assistance - TANF (Cash Assistance)
- ☐ Food and nutrition assistance
- ☐ Child support assistance
- ☐ Aging services
- ☐ Unemployment assistance
- ☐ Housing assistance
- ☐ Utility assistance
- ☐ Employment assistance
- ☐ Substance abuse assistance
- ☐ Mental health assistance
- ☐ Tax assistance
- ☐ Legal aid assistance
- ☐ Family counseling
- ☐ Other:

TAX CLAIMANT QUESTIONNAIRE

You must complete this questionnaire to determine if there are any relatives living with you who must be included in your family size (and have their income counted) based on whether they intend to claim you, or your family members (your spouse, your children or the other parent of your children who lives with you, or the children of the other parent) as a dependent when filing their federal or state income tax return.

1. Are you the **parent** (natural, step or adoptive) of the **child(ren)** needing child care?

☐ No — If the answer is **NO**, you are NOT required to complete **Question #2**.
READ and **SIGN** the ***Rights and Responsibilities*** on page 7, before submitting this application.

☐ Yes — If the answer is **YES**, **continue** to **Question #2**.

2. Do you have an **adult relative living with you** who intends to claim you, your child(ren), or your spouse [or other parent of your child(ren)], or the child(ren) of your spouse or other parent from a prior relationship as dependents on their state or federal income tax return (when they file their taxes in the ***next calendar year***)?

☐ No — By answering NO and signing the ***Rights and Responsibilities*** on page 7 of this application you have declared that either no adult relative is living with you or that an adult relative living with you does NOT intend to claim you or any of your family members as dependents on their state or federal income tax return (when they file their taxes in the next calendar year).**

☐ Yes — If the answer is **YES**, you and the adult relative **MUST complete and sign Section B** of the **Tax Claimant Declaration,**
CCA-1105A (available at any DES Child Care Assistance office).**

☐ Don't know — If you stated that you don't know, then you and your adult relative must determine through discussion, whether they intend to claim you or any of your family members as a dependent on their state or federal income tax return. You and your relative must complete and sign the **Tax Claimant Declaration, CCA-1105A** and return it to your DES Child Care Specialist.**

**** IMPORTANT:** The Department of Economic Security, Child Care Administration **cannot** advise you or your family whether a relative may claim a member of your family as a dependent for income tax purposes. **If you need help** finding out whether a **relative** who **lives with you** may be able to claim you or any of your family members as **dependents** for **income tax purposes**, the Department of Economic Security recommends that you **seek *help*** through the **U.S. Internal Revenue Service** at **www.irs.gov**, and the **Arizona Department of Revenue** at **www.azdor.gov**, or consult a tax professional.

TAX CLAIMANT'S (RELATIVE'S) INCOME

If you indicated that a **relative intends** to **claim you** or **your family members** as **dependents** on their income tax return, **you must answer either YES or NO for each type of income source.** Check (ü) **YES** if the **Tax Claimant**, and/or their **spouse** have received or will receive **income from any source**. Check (ü) **NO** if no income from that source.

YES	NO	Source	Amount Received	How Often Received	Name of Person Receiving Income
		Earned Income/Self-Employment Income	$		
		Cash Assistance	$		
		Social Security / SSI, SSA	$		
		Child Support ATLAS # / Court Order #	$		
		Any Other Income Source, such as: Gifts, Loans, Unemployment Insurance, Rental income, Interest, VA or any Income from Absent Parent(s), Friends or Relatives *(indicate type)*:	$		

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

1. Section 601 of the U.S. Civil Rights Act of 1964 states, "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."
2. You have the right to apply for child care services.
3. You have the right to a decision on the application within 30 days from the date your application is received.
4. You have the right to appeal for a hearing on the action or inaction on your case.
5. You have the right to any child care service provided in your area and available to persons in your same circumstances.
6. Information which you provide is confidential and shared with agency staff only as it relates to child care.
7. If you are determined ineligible or if your services are stopped and you disagree with the decision, you may appeal the decision in writing within 10 calendar days of the date the decision letter is mailed. IF CHILD CARE SERVICES ARE BEING STOPPED DUE TO NON-PAYMENT OF THE REQUIRED CO-PAYMENTS FROM YOU, AND YOU WISH TO APPEAL, YOU MUST FILE AN APPEAL WITHIN 10 CALENDAR DAYS OF THE NOTICE DATE IN ORDER FOR CHILD CARE SERVICES TO CONTINUE DURING THE APPEAL PERIOD.

YOUR RESPONSIBILITIES

1. You must sign this form below.
2. You must be a U.S. citizen or a legal resident of the U.S. in order to receive child care benefits.
3. Your child care services may be stopped if you fail to pay the designated co-payment to your child care provider.
4. You may only use child care for purposes authorized *(i.e., employment or participation in a Jobs activity)*.
5. You must read all information sent to you. Contact your child care specialist if you have any questions regarding information that you receive on your case status or child care arrangements.
6. YOU MUST NOTIFY YOUR CHILD CARE SPECIALIST WITHIN **FIVE (5) WORK DAYS** WHEN OR IF:
   a. You move.
   b. **You** or **any adult** in your household experience a loss of employment.
   c. Someone moves in or out of your home.
   d. Your family's gross monthly income increases above 85% of the State Median Income (SMI).
   e. You change child care providers. Payment cannot be made for child care services if the provider has not been authorized by your child care specialist.
7. You are responsible for any additional charges not covered by DES *(i.e., registration fees, late fees).*
8. You must cooperate with the Arizona Department of Economic Security (DES) in order to initiate and maintain eligibility. IT IS YOUR RESPONSIBILITY TO REPORT ALL CHANGES. Verification of the information may be requested. Failure to comply with departmental requirements may result in a loss of child care services and you may be subject to a Waiting List upon reapplication.
9. When a Waiting List is in effect you must comply with all department requirements and maintain eligibility in order to retain your placement on the Waiting List.
10. You must make efforts to improve your skills and move toward self-sufficiency in accordance with Arizona Revised Statutes (A.R.S.) § 46-803 (K) (1). In order to receive more than 60 cumulative months of Block Grant Child Care per child you may be asked to state how your family has made efforts to improve skills and move toward self-sufficiency in the past 12 months.
11. You must be truthful in your statements to DES or you may be charged with fraud. (A.R.S.) §§ 46-213 and 46-216 provide for a fine and/or imprisonment as punishment for conviction of fraud.
12. You are responsible to repay overpayments incurred as determined by the DES.
13. If you file for an appeal, and elect to have services continued pending the outcome, you will be responsible to repay DES for the cost of services during the appeal process if the hearing decision or Board of Appeals' decision is **NOT** in your favor.

AFFIDAVIT OF TRUTH: I hereby apply for Child Care Assistance and affirm that I have been informed of my rights and responsibilities. I swear under penalty of perjury that statements on this form, information and documents provided by me, or on my behalf to DES are true and correct to the best of my knowledge, that I have not withheld information, and have honestly reported my U.S. citizenship or alien status. I understand that if I knowingly submit false information or conceal a material fact on the application, I may be charged with fraud pursuant to A.R.S. § 13-2311, a class 5 felony. I authorize DES to verify information through current or former employers, or other persons or institutions. I understand that I will be responsible for overpayments.

SIGNATURE OF APPLICANT	PRINT NAME OF APPLICANT	DATE
SIGNATURE OF SPOUSE/OTHER PARENT	PRINT NAME OF SPOUSE/OTHER PARENT	DATE

PLEASE SUBMIT THE ORIGINAL AND KEEP THE COPY FOR YOUR RECORDS **(SEE REVERSE)**

DES CHILD CARE SERVICES INFORMATION

REPORT CHANGES IMMEDIATELY

You must report the following changes within 5 work days to your local DES Child Care office: you move, you or any adult in your household experience a loss of employment, someone moves in or out of your household, your family's gross monthly income increases above 85% of the State Median Income (SMI) or you change child care providers. You may be required to submit one or more of the applicable types of verification listed below.

VERIFICATION REQUIREMENTS

- If you are working, or are in a work study program, provide:
  - Copy of your most recent paycheck stub, or
  - A current statement signed by your employer verifying the gross wages of your most recent paycheck, frequency of pay and days/hours of employment. Also include verification of tips, bonuses, commissions or allowances and the frequency of payment.
- If you are self-employed, provide a copy of your annual tax return, or weekly/monthly ledgers verifying gross income, receipts for business income and expenses for the last six months.
- If you are a teen parent (under the age of 20) attending high school, G.E.D. or E.S.O.L. classes, or remedial education activities in pursuit of a high school diploma, provide a current statement from the school or training program verifying start and end dates of the activity, and days/hours of attendance.

VERIFICATION OF OTHER INCOME

- If receiving Unemployment Insurance, Social Security, Veterans' or any other type of benefits, provide a copy of the current award letter.
- Child Support. If you receive child support payments through a court, provide a current printout verifying the last three months of payments. If the child support payment is not received through the court, provide the court order or ATLAS number.
- If you pay child support for any children who do not live with you, provide a court order or divorce decree specifying the amount paid each month and a current paystub showing the child support paid or a printout from the court or child support enforcement agency.
- If you have adult relatives **living with you**, you and your adult relative must determine through discussion, whether they intend to claim you or any of your family members as a dependent on their state or federal income tax return. You and your relative(s) may be required to complete and sign the **Tax Claimant Declaration, CCA-1105A** and return it to your DES Child Care Specialist.
- If any of the adult relatives **living with** you intend to claim you, your child(ren), or your spouse (or other parent of your children), or the children of your spouse or other parent from a prior relationship as a tax dependent, you are required to provide verification of your relative's current income and the current income of your relative's spouse (if married).

CHILD CARE FOR MEDICAL REASONS

You must provide a current statement from your licensed physician, certified physician assistant, certified nurse practitioner, certified psychologist, or certified behavioral health specialist explaining how the medical condition prevents you or the other parent in the home from providing care to your child(ren); the duration and frequency that child care is needed must be specified.

CHILD CARE FOR SHELTER RESIDENT

You must provide a current statement from the shelter specifying the number of hours per day, days per week, and duration of your current activity.

WAITING LIST REQUIREMENTS

- When a Waiting List is in effect, priority for services will be given to families with income at or below 100% of the Federal Poverty Level based on the date the application was received by the Department.
- If you are on the Waiting List, you may remain on the list as long as your family continues to meet income and other eligibility requirements, including continuing to cooperate with the Department to re-determine eligibility as requested. Failure to comply with the case review process, or to provide requested verification may result in the removal of your name from the Waiting List. Once removed from the Waiting List, you will need to reapply for child care services. If you reapply after the review date and you are determined eligible, your name will be added back to the Waiting List effective the date you reapply.

REQUIREMENTS FOR CASH ASSISTANCE FAMILIES IN EDUCATION/TRAINING ACTIVITIES

If you are receiving Cash Assistance benefits, and are receiving child care services for education/training needs, you must comply with the Jobs program *(if contacted by Jobs)* as a requirement for Cash Assistance and child care eligibility. If you are contacted by the Jobs program, you are required to participate in all Jobs activities as assigned. Failure to comply with Jobs requirements may result in a sanction; your Cash Assistance benefits may be reduced, and you may lose child care eligibility.

ASSISTANCE IN LOCATING A CHILD CARE PROVIDER

The Child Care Resource and Referral service (CCR&R) can assist you in finding a child care provider that meets your needs. This free service is available to all families. Please call 1-800-308-9000 for information about locating a child care provider.