

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 (CCA-0001A)** in order to make sure your Child Care Specialist is able to determine eligibility.

Social Security Numbers are used by the Department to verify eligibility requirements and obtain necessary information regarding employment status, TANF Cash Assistance case status, Child Support, Unemployment Insurance, and Social Security income. While the provision of Social Security Numbers is voluntary, failure to provide Social Security Numbers may delay the eligibility determination process.

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 Identity for the applicant.

Proof of U.S. Citizenship or Qualified Immigrant Status for all children needing child care assistance.

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.

APPLICATION FOR CHILD CARE ASSISTANCE

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

NEW APPLICANT **REDETERMINATION**

My child had Child Care through the AZ Department of Child Safety or Tribal Child Protective Services in the last 30 days.

Have you received subsidized child care assistance in another state? **Yes** **No**

If yes, in what State/County did you receive subsidized child care assistance? _____

***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 <i>(First, M.I., Last)</i>		RACE *	SOCIAL SECURITY NO. <i>(Optional)</i>	DATE OF BIRTH <i>(MM/DD/YY)</i>	MARITAL STATUS
1		AI AS BL NH WH Hispanic? Yes No			Married Separated Divorced Widowed Never Been Married
LEGAL NAME OF YOUR SPOUSE OR OTHER PARENT LIVING WITH YOU <i>(First, M.I., Last)</i>		RACE *	SOCIAL SECURITY NO. <i>(Optional)</i>	DATE OF BIRTH <i>(MM/DD/YY)</i>	SPOUSE?
2		AI AS BL NH WH Hispanic? Yes No			Yes No

Other names used by you (e.g. maiden, alias) : _____

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

YOUR ADDRESS INFORMATION I am enrolled in the Address Confidentiality Program.

Applicant's Residential Address (House No., Street, Apt./Space No., City, State ZIP Code)

Applicant's Mailing Address (If different from residential address)

Phone No. Message Phone No. (Alternate Phone No.) Email Address

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 & PHONE NO. <i>(No., Street, City, State, ZIP Code)</i>	CHILD(REN)

ABSENT HOUSEHOLD MEMBER INFORMATION

Is your spouse or any household member related to the child needing child care temporarily out of the home? Yes No

If yes, Who? _____

Reason for Absence _____

ADDITIONAL INFORMATION

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

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

LIST THE NAMES OF EVERYONE ELSE WHO LIVES IN YOUR HOME IN THE SPACES BELOW <i>(First, M.I., Last)</i> <i>(If you have more than 9 people in your home, list their names and relationship to you on a separate sheet of paper.)</i>	RELATIONSHIP TO YOU <i>(Required)</i>	RACE *	SOC. SEC. NO. <i>(Optional)</i>	DATE OF BIRTH <i>(MM/DD/YY)</i>	Needs Child Care? <i>(Yes or No)</i>	If this person is the child receiving services, are they a U.S. Citizen or Qualified Immigrant?
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
3 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
4 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
5 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
6 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
7 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
8 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						
NAME		AI AS BL NH WH Hispanic? Yes No			Yes No	U.S. Citizen Qualified Immigrant
9 If this person is your child, Provide Name of Child's other Parent.			Does the other parent live with you?			
_____ Yes No						
Does this child have special needs? Yes No			<i>You must be able to provide verification using one of the documents listed below:</i>			
IEP IFSP ISP 504 Plan Diagnosis Other:						

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

RECEIVED?	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 No.	\$		
Yes No	Identify other income sources (check 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

Do you or your spouse pay child support? Yes No *If yes, complete below:*
 Who is Paying the Support For Whom Paid (Name of child) Monthly Amount Paid
 _____ _____ \$ _____

YOUR EMPLOYMENT ACTIVITY INFORMATION

List all jobs. If you have more than two jobs provide additional information on a separate sheet.

Employer's Name Work Phone No. Start Date
 _____ _____ _____

Employer's Address (No., Street, City, State, ZIP Code)

Are you on leave from this job? Average Hours Worked Per Week Hourly Wage or
If so, enter your leave start and end dates. (or range of hours if schedule varies) Monthly Salary
 Leave Start Date: _____ Leave End Date: _____ \$ _____
 How Often Paid (Check one): Weekly Every two weeks Monthly Twice a month-Pay Dates: _____
 Additional Income (Check all that apply): Total Amount of How Often Additional Income Received (Check one):
 Bonuses Tips Additional Income Daily Weekly Monthly Yearly
 Commissions Overtime pay \$ _____ Every two weeks Twice a month-Pay Dates: _____

Second Employer's Name (If you have a second job) Work Phone No. Date Present Job Began
 _____ _____ _____

Second Employer's Address (No., Street, City, State, ZIP Code)

Are you on leave from this job? Average Hours Worked Per Week Hourly Wage or
If so, enter your leave start and end dates. (or range of hours if schedule varies) Monthly Salary
 Leave Start Date: _____ Leave End Date: _____ \$ _____
 How Often Paid (Check one): Weekly Every two weeks Monthly Twice a month-Pay Dates: _____
 Additional Income (Check all that apply): Total Amount of How Often Additional Income Received (Check one):
 Bonuses Tips Additional Income Daily Weekly Monthly Yearly
 Commissions Overtime pay \$ _____ 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 No. Start Date
 _____ _____ _____

Employer's Address (No., Street, City, State, ZIP Code)

Are you on leave from this job? Average Hours Worked Per Week Hourly Wage or
If so, enter your leave start and end dates. (or range of hours if schedule varies) Monthly Salary
 Leave Start Date: _____ Leave End Date: _____ \$ _____
 How Often Paid (Check one): Weekly Every two weeks Monthly Twice a month-Pay Dates: _____
 Additional Income (Check all that apply): Total Amount of How Often Additional Income Received (Check one):
 Bonuses Tips Additional Income Daily Weekly Monthly Yearly
 Commissions Overtime pay \$ _____ Every two weeks Twice a month-Pay Dates: _____

Second Employer's Name (If you have a second job) Work Phone No. Date Present Job Began
 _____ _____ _____

Second Employer's Address (No., Street, City, State, ZIP Code)

Are you on leave from this job? Average Hours Worked Per Week Hourly Wage or
If so, enter your leave start and end dates. (or range of hours if schedule varies) Monthly Salary
 Leave Start Date: _____ Leave End Date: _____ \$ _____
 How Often Paid (Check one): Weekly Every two weeks Monthly Twice a month-Pay Dates: _____
 Additional Income (Check all that apply): Total Amount of How Often Additional Income Received (Check one):
 Bonuses Tips Additional Income Daily Weekly Monthly Yearly
 Commissions Overtime pay \$ _____ Every two weeks Twice a month-Pay Dates: _____

YOUR SELF-EMPLOYMENT ACTIVITY INFORMATION

Are you currently self-employed? Yes No Start Date of Self-Employment: _____
 If Yes, describe your business: _____
 Business Type: Corporation Owned by yourself A Partnership (Name all partners): _____
 Can you set your own schedule? Yes No Do you have business expenses from Self-Employment? Yes No
 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

Is this person currently self-employed? Yes No Start Date of Self-Employment: _____
 If Yes, describe their business: _____
 Business Type: Corporation Owned by their self A Partnership (Name all partners): _____
 Can they set their own schedule? Yes No Do they have business expenses from Self-Employment? Yes No
 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 HIGH SCHOOL OR GED PROGRAM ACTIVITY INFORMATION

Complete this section only if you are under 20 years old and need care while you earn your High School diploma or GED.

High School / GED Program Name Term / Semester ATTACH YOUR CLASS SCHEDULE TO APPLICATION
 _____ Begin Date _____ End Date _____
 School's Address or Website Address (No., Street, City, State, ZIP Code) Phone No. _____

TEEN PARENT HIGH SCHOOL OR GED PROGRAM ACTIVITY INFORMATION

Complete this section only if your spouse or the other parent of your child is under 20 years old and needs care while they earn their High School diploma or GED.

Is this person attending high school, or a GED program? Yes No
 High School / GED Program Name Term / Semester ATTACH YOUR CLASS SCHEDULE TO APPLICATION
 _____ Begin Date _____ End Date _____
 School's Address or Website Address (No., Street, City, State, ZIP Code) Phone No. _____

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

YOUR MILITARY STATUS (You must answer either yes or 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

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

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

YOUR HOUSING STATUS

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

Does your child lack a fixed, regular, and adequate night time residence? Yes No

- Any of the situations listed below could apply:
- Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason,
 - Living in motels, hotels, trailer parks, or camping grounds due to no choice of your own
 - Living in emergency or transitional shelters; or
 - A primary nighttime residence is not designed for ordinary use as a regular sleeping accommodation such as cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.

Do you and your child reside in a homeless or domestic violence shelter? Yes No

DO YOU NEED ANY ADDITIONAL INFORMATION? (Check all that apply)

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

- Are you the **parent** (natural, step or adoptive) of the **child(ren)** needing child care?
 - Yes If the answer is **YES**, continue to **Question #2**.
 - No If the answer is **NO**, you are NOT required to complete **Question #2**.
READ and SIGN the Rights and Responsibilities on page 6, before submitting this application.
- 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 6 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 (✓) **YES** if the **Tax Claimant**, and/or their **spouse** have received or will receive **income from any source**. Check (✓) **NO** if no income from that source.

RECEIVED?	SOURCE	AMOUNT RECEIVED	HOW OFTEN RECEIVED	NAME OF PERSON RECEIVING INCOME
Yes No	Earned Income/Self-Employment Income	\$		
Yes No	Cash Assistance	\$		
Yes No	Social Security/SSI, SSA	\$		
Yes No	Child Support ATLAS / Court Order No.	\$		
Yes No	Identify other income sources (check all that apply): Gifts Loans Unemployment Insurance Rental Income Interest VA Income from Absent Parent(s) Friends or Relatives Other (describe):	\$		

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. For purposes of implementing the citizenship eligibility verification requirements mandated by title IV of the Personal Responsibility and Work Opportunity Reconciliation Act, 8 U.S.C. 1601 et seq., only the citizenship and immigration status of the child, who is the primary beneficiary of the child care benefit, is relevant. Therefore, the Department may not condition a child's eligibility for services upon the citizenship or immigration status of their parent or the provision of any information about the citizenship or immigration status of their parent.
3. You have the right to apply for Child Care Services.
4. You have the right to a decision on the application within 30 days from the date your application is received.
5. You have the right to appeal for a hearing on the action or inaction on your case.
6. You have the right to any child care service provided in your area and available to persons in your same circumstances.
7. Information which you provide is confidential and shared with agency staff only as it relates to child care.
8. 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 and complete an interview with a DES Child Care Specialist.
2. Your child care services may be stopped if you fail to pay the designated co-payment to your child care provider.
3. You may only use child care for purposes authorized (*i.e., employment or participation in a Jobs activity*).
4. 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.
5. 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.
6. You are responsible for any additional charges not covered by DES (*i.e., registration fees, late fees*).
7. 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.
8. 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.
9. 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.
10. 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.
11. You are responsible to repay overpayments incurred as determined by the DES.
12. 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, and that I have not withheld information. 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
_____	_____	_____

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 re-apply 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.