# INFORMATION, RIGHTS AND RESPONSIBILITIES FOR THE RECIPIENT OF THE CHILD CARE ASSISTANCE PROGRAM

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

SFN 598 (10-2016)

## APPLICATION - PART 1

## PURPOSE OF PROGRAM

Provide help with child care costs for families with low income while they are participating in work, job search or allowable education or training or other allowable activities.

## APPLICATION

- Read application carefully and answer each question completely. The more information you give us the easier it will be to process your application.
- Assistance will begin the first day of the month the application is received in the County Social Service Office if all factors of eligibility are met. Eligibility can be determined for the month prior to the application month, if there is a need for assistance in that month and if all other factors of eligibility are met.

## ELIGIBILITY REQUIREMENTS

- An applicant must verify **ALL** earned, unearned and self-employment income for **ALL** members of the household.
- Each person attending postsecondary education must complete and submit a Postsecondary Education Information (SFN 113) form. Each person attending postsecondary education or training must provide a copy of their class schedule.
- Provide verification of the applicant's identity and verification of the applicant's relationship/association to each child for whom Child Care Assistance Program benefits are being requested.
- Provide verification of age for each child for whom Child Care Assistance Program benefits are being requested.
- If you or another adult member of your household make court-ordered child support or court order spousal support payments, attach verification of the monthly amount.
- To be considered for the program, you must be a resident of the state of North Dakota.
- You must have a qualified child care provider.

## PROVIDER INFORMATION

- Your provider must be at least 18 years of age.
- Your provider must be licensed, self-declaration, tribal registered, or an approved relative. The approved relative must be specifically approved for your child(ren).
- Your provider must complete a W-9 Request for Taxpayer Identification Number and Certification which must be submitted to the Child Care Assistance Program state office before payment can be made to either provider or parent.
- If your provider moves or changes provider type, a new W-9 Request for Taxpayer Identification Number and Certification must be completed and sent to the Child Care Assistance Program state office.
- Your provider may choose to receive the payment or have the payment sent to you. The provider must submit a signed and dated Provider's Request to Pay Parent Directly (SFN 848) form to the County Social Service Office if the payment is to be paid to you.

## CERTIFICATE

- When eligibility for the Child Care Assistance Program has been approved, a certificate will be issued for a prescribed number of months.
- A copy of the certificate will be mailed to you and to each provider.
- The certificate will state the Family Monthly Co-pay to be paid by you, the State Rate, the allowable activity you are approved for, children who are approved for child care, the period of time the certificate is effective and the mandatory reportable changes.
- The caretaker is responsible for any amount over the allowable maximum charge per child and any other costs not covered by the Child Care Assistance Program.

## CHILD CARE REQUEST FOR PAYMENT (SFN 616)

- This form must be used by child care providers to report hours of child care provided and the amount billed each calendar month.
- It is the provider's responsibility to complete the form each month with the actual hours of care provided and the amount billed.
- After the care has been provided for the month, the completed form must be signed and dated by both you and your provider.
- Submit the Child Care Request for Payment form to the County Social Service Office by the 5th of each month.

## REPORTING REQUIREMENTS

The following changes must be reported to the county social service office within 10 days from the date the event occurs.

Change in household size:

- Someone moves into the household,
- Someone moves out of the household,

Change in allowable activity:

- Start or end of activity search,
- Start of work activity (not previously in a work activity),
- End of work activity (no longer in a work activity),
- Start or end of TANF Assistance, TANF Transition Assistance, Crossroads, or Diversion,
- Start or end of school which includes:
  - a postsecondary student completes a bachelor's degree, an associate degree, postsecondary diploma, certificate of completion, or any other vocational training course or if the caretaker(s) changes to another course of study.
- Increase in monthly child care hours for a child,
- Changes in provider(s) or addition of provider(s),
- Changes in State residence (i.e. leaving the State to live elsewhere),
- Changes in income - household's monthly income exceeds the highest income level for the household's size

# CHILD CARE ASSISTANCE PROGRAM APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

SFN 598 (10-2016)

Clear Fields

| FOR OFFICE USE ONLY |
|---|
| Date Received: |

## APPLICATION - PART 2

Please print or type your answers. Read application carefully, answer each question completely. Attach another sheet if you need more space to answer questions. Make sure to submit all the required verifications. Failure to answer each question and provide required verifications may delay processing of your application. Make sure to date and sign the application. Applications that are not signed and dated will be returned. Return completed application to your local County Social Service Office. If you have any questions about completing this application, contact your local County Social Service Office.

### Tell us about you

| First Name | Middle Initial | Last Name | |
|---|---|---|---|
| Residential Address | City | State | ZIP Code |
| Mailing Address | City | State | ZIP Code |
| Telephone Number | Cell Phone Number | Work Telephone Number | |

If you do not speak English, what is your preferred spoken or written language?

| Have you ever received or applied for Child Care Assistance? ☐ Yes ☐ No | If yes, when? | | |
|---|---|---|---|
| Which city? | County | State | What name did you use? |

For which of the following activities/programs is child care needed?

☐ Work ☐ Activity Search ☐ High School ☐ Postsecondary Education ☐ TANF Assistance or Diversion ☐ Crossroads

Do you need child care assistance for last month? ☐ Yes ☐ No

If yes, for what activity?

☐ Work ☐ Activity Search ☐ High School ☐ Postsecondary Education ☐ TANF Assistance or Diversion ☐ Crossroads

### Tell us about the people in your home - List all persons in your household starting with you.

| Household Members (Enter Legal Name) (First, Middle Initial, Last) | Social Security Number (optional)* | Birth Date | Relationship/ Association to You | US Citizen Yes or No | Sex | Marital Status (use codes below) | Race (use codes below) |
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Marital Status Codes: **MA**-Married **DI**-Divorced **NM**-Never Married **WI**-Widow

Race Codes: **AI**-American Indian/Alaska Native **AP**-Asian **BL**-Black **HP**-Native Hawaiian/Pacific Island **WH**-White

*The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

## Tell us about the people in your home (continued)

List household members of Hispanic or Latino ethnicity (optional):

List other names used by household members (maiden name, prior married name or nickname):

Is any household member temporarily out of the home? ☐ Yes ☐ No

| Name of Absent Person | Relationship to Children Receiving Child Care |
|---|---|
| Reason for Absence | Date Expected to Return |

Are both parents in the home? ☐ Yes ☐ No

Is a parent currently active duty in the U.S. Military? ☐ Yes ☐ No

Is a parent currently a member of the National Guard or a military unit? ☐ Yes ☐ No

Is your household currently homeless? ☐ Yes ☐ No

## Tell us about your household's assets

Total Estimated Value of Your Household's Assets

## Tell us about your household's earned income

Complete the next section for each person that is employed. List information about full-time, part-time, seasonal, or temporary employment for all household members.

| Household Member's Name | Employer | Gross Amount for Application Month | Hours Worked Per Week | Salary/ Hourly Wage | Amount of Tips/ Commission | How Often Paid | Day(s) of Week/Month Paid | Date of Next Paycheck |
|---|---|---|---|---|---|---|---|---|
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Has anyone's employment stopped? ☐ Yes ☐ No

If yes, who?

Last Day Worked

Date of Last Check

Do you or anyone in your household anticipate a change in earned income this month or next month? ☐ Yes ☐ No

If yes, who?

Explain the Change (provide verification of the anticipated change.)

You must attach proof of income

- Paystubs received in the month of application up to the date the application is submitted.
- All income for the month prior to the application month.
- Employer statement for all new jobs or any changes in anticipated income.
- If anyone in the household is self-employed, a complete copy of the most recent income tax return, including all schedules (if current tax return is not available, provide income and expense ledgers).

## Tell us about your household's earned income (continued)

| | |
|---|---|
| Is any household member self-employed? ☐ Yes ☐ No | If Yes, Name of Business |
| Type of Business | |
| Does anyone in the household expect a change in self-employment income? ☐ Yes ☐ No | |
| If yes, what change is expected? | |

## Tell us about your household's unearned income

This section must be completed for each household person including all children. Check each item yes or no. If yes, show the amount received, who received it, date received and provide proof of the income.

| Income | Yes | No | Amount | Date Received | Who Receives |
|---|---|---|---|---|---|
| Alaska Dividend | | | | | |
| BIA/Tribal General Assistance | | | | | |
| Child Support | | | | | |
| Contract or Contracts for Deed | | | | | |
| CRP (Conservation Reserve Payment) | | | | | |
| Dividends or Interest | | | | | |
| Fund Raising Received Directly by Family | | | | | |
| Income from Roomer/Boarder | | | | | |
| Individual Indian Monies Account | | | | | |
| Insurance/Lawsuit Settlement | | | | | |
| Private Insurance or Disability Income | | | | | |
| Mineral Lease | | | | | |
| Money from Friends, Relatives, or Others | | | | | |
| Oil/Mineral Rights/Royalties | | | | | |
| Railroad Benefits | | | | | |
| Rental Income | | | | | |
| Social Security Benefits | | | | | |
| Spousal Support | | | | | |
| SSI (Supplemental Security Income) | | | | | |
| Tribal Gaming Distribution | | | | | |
| Tribal Spirit Lake Social Impact Payment | | | | | |
| Trust Income | | | | | |
| Unemployment Benefits | | | | | |
| Veteran's Benefits | | | | | |
| Workforce Safety Insurance | | | | | |
| Other | | | | | |

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|---|---|
| Do you or anyone in your household anticipate a change in unearned income this month or next month? ☐ Yes ☐ No | |
| If Yes, Who? | Explain the Change (provide verification of the anticipated change) |

## Tell us about Court-Ordered Child Support and Court-Ordered Spousal Support

Do you or anyone in your household pay court-ordered child support and/or court-ordered spousal support? ☐ Yes ☐ No

| If Yes, Who? | Court-Ordered Amount | Amount Paid Monthly |
|---|---|---|
| | | |

Do you or anyone in your household anticipate a change in court-ordered child support and/or court ordered spousal support this month or next month? ☐ Yes ☐ No

| If Yes, Who? | Explain the Change (provide verification of the anticipated change) |
|---|---|
| | |

You must attach proof of the court-ordered child support and court-ordered spousal support.

- Verification of amount paid in the month of application up to the date the application is submitted.
- Verification of the amount paid in the month prior to the application month.

## Tell us about your Postsecondary Education/Training

| What is your highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree | Date Completed |
|---|---|
| If there is a second parent in your household, what is their highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree | Date Completed |

Do you need help paying for child care in order for any household member to attend postsecondary school or training? ☐ Yes ☐ No

You must complete a Postsecondary Education Information form (SFN 113) for each adult family member attending postsecondary education and submit an official school schedule for each person attending postsecondary education or training.

| Student's Name | Course of Education/ Anticipated Degree | Credit Hours | Start Date | End Date |
|---|---|---|---|---|
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## Tell us about your child care needs

### ACTIVITY SCHEDULE

Name of Parent Participating in Activity

Allowable Activity

☐ Employment ☐ High School/GED ☐ Education or Training ☐ Activity Search ☐ Applied/Receiving TANF
☐ Applied/Receiving Crossroads ☐ Applied/Receiving Diversion
☐ Other - Specify: _____

**Provide a schedule of when you participate in each activity** - if additional space is needed, attach a separate sheet

If attending postsecondary education, is child care needed for study time? ☐ Yes ☐ No

If yes, list the day(s) of the week and the time of the day(s) child care is needed for study time

| Name of Child Needing Care<br><br>(If child goes to more than one provider during this activity, complete a separate line for each provider.)<br>**Complete a line for each child needing care for this activity.** | Time Child is: | | Does this child attend preschool, Head Start, elementary, school, etc.? | Grade & School Child is in<br><br>Time School Day Starts and Ends<br><br>**Provide a copy of the child's school year schedule.** | Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider<br><br>License Number and Expiration Date of Provider | Type of Provider (use codes below) |
|---|---|---|---|---|---|---|
| | Dropped off at Provider | Picked up from Provider | | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |

**AR** - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
**RF** - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

**ACTIVITY SCHEDULE** - complete this section if participating in more than one activity or for a second parent if both parents are in the home)

Name of Parent Participating in Activity

Allowable Activity

☐ Employment ☐ High School/GED ☐ Education or Training ☐ Activity Search ☐ Applied/Receiving TANF
☐ Applied/Receiving Crossroads ☐ Applied/Receiving Diversion
☐ Other - Specify: _____

**Provide a schedule of when you participate in each activity -** if additional space is needed, attach a separate sheet

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|---|---|---|---|---|---|---|
| | Dropped off at Provider | Picked up from Provider | | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |

**AR** - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
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## RIGHT AND RESPONSIBILITIES

Please read each bullet and sign at the bottom of the page.

- I declare under the penalties of perjury that the information on this application is true and correct.
- I understand that is my responsibility to provide proof of income and other requested information needed to determine eligibility for this program and that failure to do so can result in my application being denied.
- I understand that it is my responsibility to notify my County Social Service Office of changes within 10 days from the date the event occurred.
- I understand that I am responsible for payment of any child care expenses not covered by the Child Care Assistance Program.
- I understand that if I receive assistance to which I am not entitled as a result of providing false information, I must repay the costs of that assistance.
- I understand that I have the right to appeal any decision made by the Child Care Assistance Program and that the request must be made within 30 days of the print date of my denial or benefit notices.
- I understand I have the right to confidentiality concerning my circumstances except as they may relate directly to the administration of this program.
- I understand that I have the right to file a written complaint if I believe that I or members of my family have been unlawfully discriminated against by reason of race, color, religion, sex, national origin, age, political beliefs, handicap, or status with respect to marriage or public assistance. I understand that I can contact my local County Social Service Office or the state office to file the complaint.

I understand that the amount of Child Care Assistance I receive will be based on the information I have provided on this form. I also understand that the amount of Child Care Assistance may be changed without advance notice. I understand that the County Social Service Office will verify the information I have provided, and that federal and state laws provide for fines or imprisonment of any person who fraudulently receives, or attempts to receive public assistance to which he or she is not entitled. I understand that I must report all mandatory reportable changes. I understand that I am responsible for paying my Family Monthly Co-pay and any additional costs over the allowable maximum not covered by the program.

Please read and sign the authorization to furnish or release information for verification of wages, student status and child care costs. This authorization must be signed and dated in order to process your application.

## TO WHOM IT MAY CONCERN:

I hereby authorize any person, agency or institution to supply information, other than protected health information, concerning me or my family requested by County Social Service Office and to allow inspection and reproduction of records in their possession by any duly authorized representative of county social services. I further authorize County Social Service Office to release such information, other than protected health information, to cooperating state or federal agencies. I authorize County Social Service Office to inform my provider(s) of my eligibility or ineligibility of payment for child care. I/We authorize Child Support to release any records of child support payments I/we have made or received.

I release any person, agency, or institution from any and all liability to me or my family for supplying such information, other than protected health information.

This authorization is given only in connection with its use by county social service office in its administration of the Child Care Assistance Program and for no other purpose.

| | |
|---|---|
| Parent/Caretaker Signature | Date |
| Other Signature (spouse, other parent/caretaker, or other adult) | Date |