

**OFFICE USE ONLY:**

Date Application/Redetermination Received \_\_\_\_\_  
Agency \_\_\_\_\_  
FIPS \_\_\_\_\_  
Case # \_\_\_\_\_  
Category of Care \_\_\_\_\_

**CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM**

**RIGHTS OF APPLICANTS FOR CHILD CARE SUBSIDY SERVICES**

Anyone may apply for child care services. You must apply in the city or county in which you live. You do not have to have lived in the county or city for any specific length of time. **The child(ren) for whom the child care service application is submitted must be a citizen of the United States or have legal alien status.**

You have the right to equal treatment regardless of race, color, religion, sex, national origin or handicap.

You have the right to receive and complete a Child Care Service Application on the day you request child care services. If you need help filling out the application, someone will assist you.

The process of determining eligibility for child care subsidy must be explained to you. You will be asked to verify certain information.

The local department of social services (local department) will decide on your application within 30 days. If this is impossible, you must be told why. The local department must send you a written Notice of Action if you are not eligible or if there is a delay.

If you are determined eligible, you have a right for child care services to begin within 30 days after the local department gets your signed and completed application unless the local department has a Fee Subsidy Waiting List for child care services. If your name is placed on this waiting list, the child care worker will explain the reason why and the waiting list process. The local department must send written notification explaining their decision to add you to the waiting list.

You have the right to mandated child care services for which you meet eligibility requirements, for which there is funding and for which a legally operating provider is available. Your right to other services depends on meeting eligibility requirements and on whether or not the local department offers the service. This application is for child care assistance only.

You have a right to see the information in your child care record.

The local department may not release information about you without your written consent except for purposes directly connected with the administration of social service programs or by court order.

Information about the Virginia Department of Social Services (VDSS) and the Child Care Subsidy and Services Program (child care services) may be found at: [www.dss.virginia.gov](http://www.dss.virginia.gov).

**Please provide the following information about yourself. (Please Print)**

Last Name		First Name		Middle Initial	
Physical Street Address					
City/State/Zip					
Mailing Address (if different)					
City/State/Zip					
Social Security # (OPTIONAL)		Telephone (Home)			
Telephone (cell)		Telephone (Other)			

**A. I am applying for child care assistance because: (Check all that apply)**

- I am employed full-time       I am employed part-time       I am in education or training

**B. I would also like information on the following: (Check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> TANF            | <input type="checkbox"/> Medical/Mental Health    | <input type="checkbox"/> Drug or Substance Abuse Counseling   |
| <input type="checkbox"/> Food Stamps     | <input type="checkbox"/> Domestic Violence        | <input type="checkbox"/> English as a Second Language Courses |
| <input type="checkbox"/> Heating/Cooling | <input type="checkbox"/> Money Management         | <input type="checkbox"/> Community Resources                  |
| <input type="checkbox"/> Food            | <input type="checkbox"/> Child Development        | <input type="checkbox"/> Other:                               |
| <input type="checkbox"/> Medicaid        | <input type="checkbox"/> Parenting                |   |
| <input type="checkbox"/> Child Support   | <input type="checkbox"/> Earned Income Tax Credit |   |
| <input type="checkbox"/> Education (GED) | <input type="checkbox"/> Family Planning          |   |
| <input type="checkbox"/> Housing         | <input type="checkbox"/> Head Start/Preschool     |   |

**C.  YES     NO Have you selected a child care provider? If yes, please provide the following information:**

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Type of Provider:     Center                       Child Care Provider

**D.  YES     NO Are you currently receiving, or have you received within the past twelve months, any benefits listed below from either this Department or another locality?**

	TANF	MEDICAID	FOOD STAMPS	CHILD CARE
Receiving Now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received within the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Never Received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Locality				

**F. LIST ALL HOUSEHOLD MEMBERS**

NAME (LAST/FIRST/MI) (List Applicant First)	DATE OF BIRTH MM/DD/YYYY	RELATION- SHIP TO APPLICANT	SOCIAL SECURITY NUMBER (OPTIONAL)	SEX (M/F)	RACE *	HISPANIC Y/N	SCHOOL ATTENDI NG	GRADE LEVEL	IN HEAD START Y/N	NEEDS CHILD CARE Y/N

- \* Race:
- 1=White
  - 2= African-American
  - 3 = Asian
  - 4 = American Indian/Alaskan Native
  - 5 = Other

**G. ENTER THE AMOUNT OF ALL INCOME RECEIVED BY YOU OR ANY OTHER HOUSEHOLD MEMBER.**

<b>NAME (LAST/FIRST/MI) (List Applicant First)</b>	<b>EMPLOYED (INCLUDES MILITARY) (Y/N)</b>	<b>SELF EMPLOYED (Y/N)</b>	<b>GROSS EARNINGS PER PAY PERIOD</b>	<b>PAY FREQUENCY *</b>	<b>SOCIAL SECURITY</b>	<b>PENSIONS</b>	<b>INTEREST/ DIVIDENDS</b>	<b>RENTAL INCOME</b>	<b>ALIMONY</b>	<b>CHILD SUPPORT</b>	<b>UNEMPLOYMENT</b>	<b>FARM INCOME</b>	<b>OTHER</b>

\* PAY FREQUENCY:  
 1 = Weekly  
 2 = Bi-Weekly (Every Two Weeks)  
 3 = Twice Monthly  
 4= Monthly

**H. Employment Information** (complete for everyone in the household)

**Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone Number:** \_\_\_\_\_ **Total hours worked weekly:** \_\_\_\_\_ **Travel Time:** \_\_\_\_\_

**Work Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone Number:** \_\_\_\_\_ **Total hours worked weekly:** \_\_\_\_\_ **Travel Time:** \_\_\_\_\_

**Work Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone Number:** \_\_\_\_\_ **Total hours worked weekly:** \_\_\_\_\_ **Travel Time:** \_\_\_\_\_

**Work Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone Number:** \_\_\_\_\_ **Total hours worked weekly:** \_\_\_\_\_ **Travel Time:** \_\_\_\_\_

**Work Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**I. Education/Training Information** *(complete for everyone in the household)*

**Name:** \_\_\_\_\_

School/Training Program: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_ Total hours: \_\_\_\_\_ Travel time: \_\_\_\_\_

**Class Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**Name:** \_\_\_\_\_

School/Training Program: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_ Total hours: \_\_\_\_\_ Travel time: \_\_\_\_\_

**Class Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**Name:** \_\_\_\_\_

School/Training Program: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_ Total hours: \_\_\_\_\_ Travel time: \_\_\_\_\_

**Class Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

**Name:** \_\_\_\_\_

School/Training Program: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_ Total hours: \_\_\_\_\_ Travel time: \_\_\_\_\_

**Class Schedule:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (EXAMPLE: 8-5)							

J.  YES  NO  UNKNOWN **Do any children have special needs or medical issues?  
If yes, please explain.**

NAME	_____	NEED:	_____
NAME	_____	NEED:	_____
NAME	_____	NEED:	_____

K.  YES  NO  UNKNOWN **Have children received all immunizations required according to their age? If no or unknown, please explain.**

NAME	_____	REASON:	_____
NAME	_____	REASON:	_____
NAME	_____	REASON:	_____

L.  YES  NO  UNKNOWN **Are all children U.S. citizens or do they have legal alien status? If no, please explain.**

NAME	_____	EXPLAIN:	_____
NAME	_____	EXPLAIN:	_____
NAME	_____	EXPLAIN:	_____

## **RESPONSIBILITIES OF CHILD CARE SERVICE WORKERS**

Child Care workers are responsible for assisting applicants for and recipients of child care services to find quality child care. Workers help the family locate child care and arrange for child care subsidy payments to the legally operating child care provider of the parent's choice. Workers assist the family to find any other services needed and available in the locality.

## **APPEAL INSTRUCTIONS**

If you are not satisfied with a local department's decision about your case, you have the right to ask for an appeal by means of a conference or a hearing. You may request a hearing instead of or after the conference. A conference is administered by the local department and should be arranged by your Child Care Worker. This request must be made **within 30 days** after receiving written notice of the local agency's decision. If you request a conference **within 10 days** from the effective date of the notice, your service or service payment will continue until a decision is made.

If you are not satisfied with the outcome of the conference, you may request a hearing. A hearing is an evaluation by staff from the office of the Director of the Division of Appeals and Fair Hearings at the Virginia Department of Social Services. A request for a hearing on your appeal must be made **within 30 days** after receiving written notice of the local agency's decision. If you ask for a hearing **within 10 days** of the effective date of the notice, your service or service payment will continue until a decision is made.

You may appeal to the local department or write directly to:

Director, Division of Appeals and Fair Hearings  
Virginia Department of Social Services  
7 North Eighth Street  
Richmond, Virginia 23219

If you feel you were discriminated against at any time, you may file a complaint within 180 days of the alleged discriminatory act with the local department, the Commissioner of the Virginia Department of Social Services, or the Region III Office of Civil Rights at:

Office of Civil Rights, Region III  
U.S. Department of Health and Human Services  
150 South Independence Mall West, Suite 372  
Public Ledger Building  
Philadelphia, PA 19106

More information about this process may be found at [www.dss.virginia.gov/about/civil\\_rights/](http://www.dss.virginia.gov/about/civil_rights/).

**ACKNOWLEDGEMENT OF APPLICANT’S RESPONSIBILITIES**

Please initial the following items and sign below:

**My signature authorizes the release to the local department of social services all information necessary to both determine and review my eligibility for child care services. I authorize the release of any employment, medical, or child care information obtained from any source to the state or local department that may review this application for child care assistance.**

**I understand that it will be necessary to release certain information to my child care provider.**

**This authorization is valid during the eligibility period of my case. I understand that this time limit does not apply to investigations regarding possible fraud.**

**I understand my appeal rights (see Appeal Instructions).**

**I understand that the Virginia Department of Social Services (VDSS) has limited funding available for the purchase of Fee Child Care services. The funding for Fee Child Care changes from year to year. I further understand that the availability of funding for child care services cannot be guaranteed. I understand that if this funding ends or runs out, I will receive at least 10 days written advance notice of this action, and my name may be placed on the local department’s waiting list.**

**I understand that to qualify for these funds I must have a current need for child care services; I must be working or participating in an approved educational or training program; and my total household gross monthly income must not exceed the maximum monthly household income determined by VDSS.**

**I must give complete and accurate information needed for determining initial and on-going eligibility for child care services. The local department may have to ask for such things as pay stubs or permission to contact agencies or individuals to get proof of my income. If I give incorrect information, I could be prosecuted for perjury, larceny, or welfare fraud, and may no longer be eligible for child care assistance. I must repay any money paid on my behalf to which I was not entitled.**

**I must notify the local department within 10 days of any changes that could affect my eligibility for child care services.**

**My rights and responsibilities have been explained, and I have received a written copy of this application.**

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Applicant Signature

Date

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Representative or Witness (if signed by mark)

Date

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Child Care Worker Signature

Phone

Date