

Date Received: \_\_\_\_\_

Applying For:  Voucher  
 Transitional Voucher  
 Subsidized Slot

**MAINE DEPARTMENT OF HUMAN SERVICES  
COMMUNITY SERVICES CENTER  
APPLICATION FOR CHILD CARE SERVICES**

Date Completed: \_\_\_\_\_

Check one:  New Applicant  
 Redetermination  
 Waiting List Update

**Most funding sources require that both parents be employed, seeking employment, or attending an educational training program. All exceptions must be clearly documented.**

Date you need child care to begin: \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Applicant Social Security #:** \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_  
Street , RFD, PO Box \_\_\_\_\_ Town/City \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Town of Legal Residence: \_\_\_\_\_ Email address \_\_\_\_\_

<b>Household Information: (check all that apply)</b>	
<b>Marital Status</b>	<b>Living Arrangement</b>
<input type="checkbox"/> Married	<input type="checkbox"/> Alone with Children
<input type="checkbox"/> Single	<input type="checkbox"/> With Spouse
<input type="checkbox"/> Child*	<input type="checkbox"/> With live-in-partner
	<input type="checkbox"/> With Relative
	<input type="checkbox"/> With Other

\*Child in State Custody or in Guardianship status.

<b>Do you or any member of your household receive? (check all that apply)</b>	
<input type="checkbox"/> TANF (Temporary Asst. to Needy Families)	<input type="checkbox"/> ASPIRE (Additional Support for People In Retraining and Employment)
<input type="checkbox"/> Pas (Parents as Scholars)	<input type="checkbox"/> CDS (Child Development Services)
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Subsidized Housing
<input type="checkbox"/> MaineCare	<input type="checkbox"/> Head Start <input type="checkbox"/> Home Start <input type="checkbox"/> Early Head Start
<b>Have you been a TANF client at any time during the past 12 months?</b> <input type="checkbox"/> Y <input type="checkbox"/> N    If yes, date closed: _____	

**You must complete every section for each member of your household:** (Failure to do so will result in delays in processing your application)

Name	Sex M/F	Date of Birth m/d/yr	Social Security #	Relationship to Applicant (1)	Race/Ethnicity (2)	Is Child Care Needed for this child Y/N	If this child needs child care, does he/she have special needs? Y/N (3)	Is this child currently receiving child care in another Child Care facility (4)
				Self		N	N	NA

- (1) If you have been appointed the legal guardian of the child who needs service, you must attach court documentation.
- (2) Complete for children only. H/L = Hispanic/Latino, NA/A = Native American/Alaskan, A = Asian, B/AA = Black/African American, H/PI = Hawaiian/Pacific Islander, W = White
- (3) A diagnosed special need (cerebral palsy, autism, etc) or identified developmental delay such as a cognitive, behavioral, social/emotional, speech, and language, motor, self care delays or is at risk of health, social/ emotional or developmental problems as a result of biological or environmental factors. (If the child in need of child care has a special need and you meet eligibility criteria, you will be given priority on the waiting list and may receive services more quickly. To receive priority, you must provide us with documentation such as an ISFP, a statement from a doctor, therapist, public health, social service, school, etc.)
- (4) You must include documentation, including the amount paid to the provider.

**Number of household members sharing income:** \_\_\_\_\_

## Household Employment, Education/Training, and Additional Eligibility Related Information

### Employment

**Applicant: (if you work more than one job, attach additional information)**

Employer:		Employers Town:		Occupation:		Work Phone #:	
<b>Do you work shift work?</b> Y N	<b>How often are you paid?</b>		Weekly	Every 2 weeks	Twice a month		
	Mon	Tues	Wed	Thur	Fri	Sat	Sun
<b>Work Schedule</b> (i.e. 7:00 am – 4:00pm)							
Additional Time Needed for Travel							
<b>From your pay stubs for the last four pay periods, fill in the boxes:</b>			<b>Pay stub#</b>	<b>Gross wages before taxes</b>	<b>Date paid:</b>	<b>For office use only:</b>	
<i>Please attach copies of your last four pay stubs. If this is a new job, you must provide a letter from your employer indicating hire date, wages and hours/days AND total weekly hours. Verification needs to be completed by submitting first four pay stubs within eight weeks</i>			1	\$		Total wages per pay stubs \$ _____	
			2	\$		Divided by four pay stubs = \$ _____	
			3	\$		(Enter this amount into software)	
			4	\$			

**Other Adult Household Member: (if you work more than one job, attach additional information)**

Employer:		Employers Town:		Occupation:		Work Phone #:	
<b>Do you work shift work?</b> Y N	<b>How often are you paid?</b>		Weekly	Every 2 weeks	Twice a month		
	Mon	Tues	Wed	Thur	Fri	Sat	Sun
<b>Work Schedule</b> (i.e. 7:00 am – 4:00pm)							
Additional Time Needed for Travel							
<b>From your pay stubs for the last four pay periods, fill in the boxes:</b>			<b>Pay stub#</b>	<b>Gross wages before taxes</b>	<b>Date paid:</b>	<b>For office use only:</b>	
<i>Please attach copies of your last four pay stubs. If this is a new job, you must provide a letter from your employer indicating hire date, wages and hours/days AND total weekly hours. Verification needs to be completed by submitting first four pay stubs within eight weeks</i>			1	\$		Total wages per pay stubs \$ _____	
			2	\$		Divided by four pay stubs = \$ _____	
			3	\$		(Enter this amount into software)	
			4	\$			

### Self-employment/rental income and Source:

**Do you or anyone in your household have income from a business they own?** Yes No **Name of person who owns business**

Type of Employment:		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
	Work Schedule (i.e. 7:00 am – 4:00pm)							
	Work Schedule (i.e. 7:00 am – 4:00pm)							

**Do you or anyone in your household have rental income?** Yes No **Name of person with rental income**

<i>Please attach a copy of your most recent tax return. or other documentation of your self-employment earnings</i>	SCHEDULE C	SCHEDULE E
1. Amount on <b>IRS Form 1040, Schedule C, Line 31</b> and/or <b>Schedule E, Line 22</b> for income from rental property.	\$	\$
2. Add amount of depreciation from <b>Schedule C, Line 13</b> and/or from <b>Schedule E, Line 20</b> for income from rental property.	+ \$	+ \$
3.* Add any other expenses claimed for:	+ \$	+ \$
a. Payments on principal of the purchase price of income-producing real estate, capital assets, equipment machinery or other durable goods.	+ \$	+ \$
b. Net losses from previous periods	+ \$	+ \$
c. Federal, state and local income taxes	+ \$	+ \$
d. Retirement plans applicable to family members. <i>Note: do not include the employer's share of FICA tax.</i>	+ \$	+ \$
e. Work related personal expenses	+ \$	+ \$
4. Total Self Employment/Rental Income	= \$	= \$

**Unearned Income**

Do you or any member of your household have any other income? *Please send a copy of proof of this income (for example, check or award letter)*

Type of Income	Amount	How Often (Please select one)	Name of person who receives this money
TANF	\$	Weekly Biweekly Monthly Annually	
SSI Benefits	\$	Weekly Biweekly Monthly Annually	
Social Security Benefits	\$	Weekly Biweekly Monthly Annually	
Veterans Benefits	\$	Weekly Biweekly Monthly Annually	
Workers Compensation	\$	Weekly Biweekly Monthly Annually	
Unemployment Compensation	\$	Weekly Biweekly Monthly Annually	
Disability payments	\$	Weekly Biweekly Monthly Annually	
Other	\$	Weekly Biweekly Monthly Annually	

**Child Support Statements:**

Please complete the following information for all children. (If you have been a TANF or Pas client, you should have a support order)

I have a child support order(s) (**Please attach**) Amount: \$ \_\_\_\_\_ Weekly Biweekly Monthly Annually

I have a child support order but I do not currently receive support (**Please attach proof of attempt to collect child support**)

I do not have a child support order but I currently receive support ) (**Please attach proof of amount**) Amount: \$ \_\_\_\_\_ Weekly Biweekly Monthly Annually

I do not have a child support order and I do not currently receive support

**Child Support Paid Out**

Do you or any member of your household pay child support to an individual who is not a member of your current household? (**Please document amounts paid.**)

Name of payer	Amount	How Often (Please select one)	Name of person who receives this money
	\$	Weekly Biweekly Monthly Annually	
	\$	Weekly Biweekly Monthly Annually	

**Education/Training**

**Applicant:**

Are you a student? Y N | If yes, name of school: \_\_\_\_\_

Semester Start Date: \_\_\_\_\_ Semester End Date: \_\_\_\_\_ Anticipated Graduation Date: \_\_\_\_\_

**Please attach a class/school schedule. Days and hours must be included.**

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Additional Time Needed for Travel							
Additional Time Needed for studying:							

**Other adult household member:**

Are you a student? Y N | If yes, name of school: \_\_\_\_\_

Semester Start Date: \_\_\_\_\_ Semester End Date: \_\_\_\_\_ Anticipated Graduation Date: \_\_\_\_\_

**Please attach a class/school schedule. Days and hours must be included.**

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Additional Time Needed for Travel							
Additional Time Needed for studying:							

**Hours Care is Needed: (i.e. 7am – 5 pm)** (Full time care = 30 to 50 hours. ¾ care = 20 - 29 hours. ½ care = 19 or less hours.)

Child Name	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Hours	Does this child attend Head Start or School Y/N	Where?	Hours Attending Head Start/School
									Y N		
									Y N		
									Y N		
									Y N		

**Eligibility Related Information**

	Y/N	Proof Needed
Do you have an open Child Protective Case?	Y N	You will need a referral from your Caseworker
<b>The following applies only to ongoing slots client and to applicants who want to be on the waiting list</b>		
Is any adult member of your household currently unemployed and seeking employment?	Y N	You will need to obtain employment to qualify/continue to qualify for a child care subsidy. If you are a subsidized slot client redetermining eligibility, You may be eligible for job search services. Please discuss this with your eligibility specialist.
<b>The following applies only to households with two or more adults</b>		
Is any adult member of your household a person who has a disability and is unable to work?	Y N	Please attach a Doctor's statement that the disability prevents the adult from caring for the child.
<b>The following subsidies are only available through a Voucher Management Agency</b>		
Is any adult member of your household in a substance abuse rehabilitation program?	Y N	Please attach referral from a rehabilitation caseworker and proof that you are participating in a rehabilitation program..
Are you requesting temporary child care services due to a current family emergency/crisis?	Y N	Please attach a referral from a professional such as a doctor, a social service agency, a public health agency, etc. which documents your need for temporary services.

**Child Care Provider (Voucher Applicants/Clients Only)**

If the provider is not currently licensed or certified, the Department of Human Service requires the following background checks: SBI, Child Protective, and Motor Vehicle. These checks must be done prior to payments issued for child care. This process may take up to a six weeks.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ ID/SS# \_\_\_\_\_

Street , RFD, PO Box                      Town/City                      Zip

Provider Rate Per Child:

Full Time (30-50 hours) \$ \_\_\_\_\_                      ¾ Time (20-29 hours) \$ \_\_\_\_\_                      ½ Time (1-19 hours) \$ \_\_\_\_\_

**Check the Type of Child Care:** (If you are unsure of what type of provider you have, ask the provider to assure accuracy,)

<input type="checkbox"/> Certified Family Child Care Home	<input type="checkbox"/> Legal Unregulated Child Care Provider (Care provided in your home)
<input type="checkbox"/> Licensed Center	<input type="checkbox"/> Legal Unregulated Child Care Provider (Care provided in provider's home)
<input type="checkbox"/> Legal Unregulated School Age Program	<input type="checkbox"/> Relative Care (Care provided in provider's home) Relationship to Provider: _____
	<input type="checkbox"/> Relative Care (Care provided in your home) Relationship to Provider: _____

**I certify under penalty of perjury that to the best of my knowledge the above information is true. I understand that this information may be provided to the central office of the Department of Human Services for use in administration of this program. I authorize the agency to verify this information by whatever means necessary.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Preparer

\_\_\_\_\_  
Date

Comments:	Return to:
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