Child Care Application and Authorization

Authorization	☐ **INITIAL AUTHORIZATION**	☐ **REDETERMINATION**	☐ **UPDATE**

If UPDATE, change in:	☐ Hours	☐ Children	☐ Address	☐ Custody	☐ Eligibility Extension	☐ Other

Name of Staff initiating Referral: (Print)	☐ Coordinating Agency	☐ DCF	☐ Welfare Transition Contracted Provider	☐ Privatization Provider
Unit, Number & Address:				
City, Zip Code		Phone #:		

SECTION A: CLIENT/FAMILY INFORMATION

(Print name, SSN, Date of Birth and Gender. Check appropriate box indicating ethnicity and race, enter letter designation for each race indicated by participant. i.e., (W) White, (B) Black, (A) Asian, (H) Hawaiian and (AI) American Indian. (Use comma to separate each race, i.e., B, A and AI)

RFA #:

Parent/Guardian/Foster Parent/Caregiver Name: (L,F,MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity ☐ Hispanic ☐ NonHispanic	Race(Enter letter designations for each race indicated)
Spouse's Name: (L,F.MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity ☐ Hispanic ☐ NonHispanic	Race(Enter letter designations for each race indicated)

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

If there is NO spouse: enter the Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Parent/ (if different from above): (L,F,MI)	SSN	DOB (MM/DD/YY)	Gender (M/F)	Ethnicity ☐ Hispanic ☐ NonHispanic	Race(Enter letter designations for each race indicated)

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

SECTION B: ELIGIBILITY

I. Status: ☐ **Assistance** ☐ **Non-Assistance**

☐ **At Risk**: ○ PI ○ PS ○ FS	☐ **Project Safety Net**
☐ In Home ☐ Out of Home: Relative/Non-Relative	☐ Foster Care

☐ **TCA**	☐ **Transitional**	○ Applicant	○ Recipient
○ Respite	○ Unemployed Parent	○ Refugee	
☐ **TCC** ☐ Transitional Education & Training	**TCC Begin Date:** _____	**TCC End Date:** _____	

II. Purpose of Care

☐ Protection ☐ Therapeutic Plan ☐ TANF At Risk (RCG) ☐ Emergency

☐ Employment ☐ Work Activity ☐ Education Activity

SECTION C: CHILD CARE AUTHORIZATION (Print Legal names of children authorized for care**)**

Child care service is authorized for the participant for approved activity(ies) not to exceed a total of _____ hours per week and includes _____ hours transportation time.

Name (F,MI,L)	SSN	DOB (MM/DD/YY)	Gender(M/F)	Ethnicity	Race(Enter letter designations for each race indicated)
				☐ Hispanic ☐ NonHispanic	
				☐ Hispanic ☐ NonHispanic	

Gross Monthly Family Income: $_____ Attach Documentation (if available)

CHILD CARE AUTHORIZED From _____/_____/_____ Through _____/_____/_____

Comments: _____

SECTION D: AUTHORIZING SIGNATURE(S)

I hereby certify that the information provided above is correct.

Applicant Signature: _____ Date: _____

Authorizing Worker: _____ Date: _____

Supervisory Approval: _____ Date: _____

4C Agency: _____ Date: _____

THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE

Privacy Act Statement: *You have not been asked to provide your social security number on this form. For your information however, the Social Security Act (42 U.S.C. 1137) provides that your social security number may be used to administer the program, including determination of eligibility, attributing the receipt of services, correspondence and participation, as well as for reporting purposes.

DEO – WTP 5002, May 2015 (Replaces DEO - WTP 5002, September 2012

Instructions for Completing the Child Care Authorization and Referral Form

Check the appropriate box to indicate if form is being used for an initial authorization, a redetermination or an update. If form is being used to update prior authorization information, check appropriate box to indicate which information is new and use comment section of Section C to explain "Other" Category. In the 'From' section, print staff person's name who initiated the referral, check the appropriate box identifying the authorizing entity, and enter return address and staff person's telephone #. If the agency is a contracted provider for the Welfare Transition Program or a Private Provider for the Protective Service Program, the appropriate box should be checked. **NOTE:** A redetermination authorization must be sent to the coordinating agency prior to the end of the initial referral.

Section A: Client/Family information

RFA #:	Enter RFA number for applicant/participant
Participant's Name and SSN:	Enter participant's (Parent/Guardian/Caregiver) name, SSN, Date of Birth, Gender,
DOB/Gender/Ethnicity/Race	Ethnicity and Race (Use letter as designated on form to identify race. Use multiple letters if needed to indicate more than one race and separate each letter with comma.)
Spouse's Name, SSN:	Enter participant's spouse or name of child's other parent living in home. If no spouse/other parent is in the home enter "N/A" and indicate the marital status below address line. Enter Spouse's SSN,
DOB/Gender/Ethnicity/Race	Date of Birth, Gender, Ethnicity, and Race (Use letter as designated on form to identify race. Use multiple letters if needed to indicate more than one race and separate each letter with comma.)
Address:	Enter the family's address and phone numbers as appropriate. If the address is a P.O. Box, indicate location in the comment section to assist the coordinating agency in locating care near the individual's residence.
Parent:	Enter child's other parent's name if parent is different from spouse listed above.
Address:	Enter address of other parent if it is not the same address listed for spouse above.

Section B: Eligibility

Status:	In Part I, indicate if family is receiving or not receiving cash assistance in the appropriate box.
At-Risk status:	Indicate if child is an At-Risk or Project Safety Net eligible category and for at-risk child check only one category, PI,PS, or FS
Type of Care:	Indicate whether care is in participant's home, out-of-home, or in foster care.
Program Status:	Indicate whether participant is a Welfare Transition(TCA) or Transitional(former TCA) program participant
TCC Authorized:	Check appropriate box to indicate if participant is receiving TCC and/or TEd child care and enter the eligibility beginning date and ending date.
Purpose of Care:	In Part II, at least one box must be checked to establish the need for child care.

Section C: Authorization

Hours Authorized:	Indicate in the spaces provided the total hours per week that child care is authorized and indicate travel hours allowed. (NOTE: This is required for referral to subsidized child care).
Children Authorized, SSN, DOB, Gender, Ethnicity, and Race:	Indicate in the spaces provided child's Legal Name, SSN, Date of Birth, Gender, Ethnicity and Race for each child authorized to receive care. Use an additional page if there are more than 3 children for one referral.
Gross Monthly Family Income:	Indicate in the space provided the family's Gross Monthly Income (add total monthly earned and unearned income). Attach documentation if available.
Care Authorized:	Indicate the authorized start date and end date.
Comments:	Identify which information is being changed if form is used to update prior information. Also, enter any other explanatory or pertinent information.

Section D: Authorizing Signatures

Applicant Signature:	Applicant (if available) must sign and date in the space provided.
Authorizing Worker:	Authorized worker must sign and date the referral on the date of authorization.
Supervisor's Signature:	Supervisor must sign if local procedures require.
Coordinating Agency:	The authorized Coordinating Agency worker must sign and date on the line indicated.

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