

## Application For Child Care Assistance

Please read instructions (CFWB-012A) and review the document checklist (CFWB-012B) for assistance when completing this and for information on what documents are required.

**ATTENTION:** This application is used to apply only for Category 2\* child care assistance (for families not in receipt of cash assistance). To apply for Cash Assistance or other benefits, including Category 1 Child Care Assistance (for families in receipt of cash assistance), you must use the New York State Application for Certain Benefits and Services (LDSS-2921).

**Please Note:** All sections of this form must be filled out to be considered complete unless the section is identified as optional. If you do not complete all required sections of this form, you may not be considered for Child Care Assistance.

The following applicants may be eligible for child care assistance without regard to income and do not need to complete this application:

- Foster parents who need child care assistance to allow them to work and are only applying for assistance for the foster child(ren).
- Families in receipt of protective or preventive services.

**Refer to application instructions (CFWB-012A) for details**    New    Change/Recertification    Reopen

<b>OFFICE USE ONLY</b>	Case #: _____	Application Date: _____
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<b>Section 1 - Applicant</b>	Last Name (Please include any aliases or maiden names in parentheses): _____		First Name: _____		M.I.: _____	Marital Status: _____	
	Home Address: _____			Apt. #: _____	City/Borough: _____	State: _____	ZIP Code: _____
	Is this a temporary address? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, does family currently reside in (check one):</i> <input type="radio"/> Homeless Shelter <input type="radio"/> Doubled-up with another family <input type="radio"/> Hotel/Motel <input type="radio"/> Car, Bus, Train <input type="radio"/> Park, Campsite <input type="radio"/> Other						
	Telephone (Work): _____		Telephone (Home): _____		Telephone (Cell or Other): _____		Email: _____
	Do you receive Cash Assistance? <input type="radio"/> Yes <input type="radio"/> No		CA#: _____		What is your primary language? <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____		
What is your preferred language? <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____							

Please list all children in your household needing child care. **(Only children needing care)**

<b>Section 2A</b>	<b>Child(ren) Needing Care</b>	Name (Last, First)	M.I.	Relationship	D.O.B.	Sex	Both of Child's Parents Reside in the Home?	Ethnicity Hispanic or Latino**	Race** <small>(See legend below)</small>	Social Security Number <small>(Optional)</small>	Child with a Disability?	Is child U.S. Citizen /U.S. National/ or person with satisfactory immigration status?
			1.									
	2.											
	3.											
	4.											
	5.											
	6.											
	7.											
	8.											

\* Category 1: Families eligible for a child care guarantee – applying for or receiving Cash Assistance (CA), or receiving Child Care Assistance in lieu of CA or receiving transitional child care.

Category 2: Families eligible when funds are available

\*\* Providing ethnicity and race information is voluntary and will not affect your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.

Racial Affiliation Codes:  
**AI** Native American or Alaskan Native  
**AS** Asian  
**BL** Black or African American  
**HP** Native Hawaiian or Pacific Islander  
**WH** White

Please list all other members in your entire household (not listed in Section 2A) including children under age 18 who do not need child care. List yourself first, followed by everyone who lives with you.

Section 2B Family Members	Name ( Last, First) <i>(Include any aliases or maiden names in parentheses)</i>	M.I.	Relationship	D.O.B.	Sex	Gender Identity** <i>(Optional)</i>	Ethnicity Hispanic or Latino**	Race** <i>(See legend to the right)</i>	Social Security Number <i>(Optional)</i>
	1.			Self					
	2.								
	3.								
	4.								
	5.								
	6.								
	7.								
	8.								

For additional family members, please attach a separate sheet. Include information for any spouse, parent or caretaker of the children applying for care who lives in the home.

Racial Affiliation Codes:

- AI** Native American or Alaskan Native
- AS** Asian
- BL** Black or African American
- HP** Native Hawaiian or Pacific Islander
- WH** White

\*\* Providing gender, ethnicity and race information is voluntary and will not affect your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.

**OFFICE USE ONLY** Family Size: \_\_\_\_\_

Section 3 Child/Family Needs	What is your reason for requesting Child Care Assistance?	Is a parent currently active duty (full-time) in the US Military?	Is the applicant receiving and/or applying for child care through a different application?
	<input type="radio"/> Employment <input type="radio"/> Vocational Training/Educational Activities <input type="radio"/> Receiving Domestic Violence Services <input type="radio"/> Looking for Work <input type="radio"/> Homelessness <input type="radio"/> Participating in an approved substance abuse treatment program	<input type="radio"/> Yes <input type="radio"/> No Is a parent currently a member of a National Guard or Military Reserve Unit? <input type="radio"/> Yes <input type="radio"/> No Is there a non-custodial parent available to provide child care? <input type="radio"/> Yes <input type="radio"/> No	If yes please indicate the agency: <input type="radio"/> Department of Education (DOE) <input type="radio"/> Human Resources Administration (HRA) <input type="radio"/> Department of Youth and Community Development (DYCD) <input type="radio"/> Department of Homeless Services (DHS) <input type="radio"/> Consortium for Worker Education (CWE) <input type="radio"/> Administration for Children's Services (ACS)

Section 4 - Employment (if employment is reason for care)	<b>Applicant's Employer Name:</b> _____	<b>Tel#:</b> _____	<b>Address:</b> _____	<b>City/Borough:</b> _____	<b>State:</b> _____	<b>ZIP Code:</b> _____
	Employment Start Date: _____	Does job have a rotating shift? <input type="radio"/> Yes <input type="radio"/> No		Does job require overtime (OT)? <input type="radio"/> Yes <input type="radio"/> No		
	<i>If applicant has a second job</i>					
	<b>Applicant's Employer Name:</b> _____	<b>Tel#:</b> _____	<b>Address:</b> _____	<b>City/Borough:</b> _____	<b>State:</b> _____	<b>ZIP Code:</b> _____
	Employment Start Date: _____	Does job have a rotating shift? <input type="radio"/> Yes <input type="radio"/> No		Does job require overtime (OT)? <input type="radio"/> Yes <input type="radio"/> No		
	<b>Second parent, caretaker or stepparent in the household</b>					
	<b>Applicant's Employer Name:</b> _____	<b>Tel#:</b> _____	<b>Address:</b> _____	<b>City/Borough:</b> _____	<b>State:</b> _____	<b>ZIP Code:</b> _____
	Employment Start Date: _____	Does job have a rotating shift? <input type="radio"/> Yes <input type="radio"/> No		Does job require overtime (OT)? <input type="radio"/> Yes <input type="radio"/> No		
	<i>If second parent, caretaker or stepparent in the household has a second job</i>					
	<b>Applicant's Employer Name:</b> _____	<b>Tel#:</b> _____	<b>Address:</b> _____	<b>City/Borough:</b> _____	<b>State:</b> _____	<b>ZIP Code:</b> _____
	Employment Start Date: _____	Does job have a rotating shift? <input type="radio"/> Yes <input type="radio"/> No		Does job require overtime (OT)? <input type="radio"/> Yes <input type="radio"/> No		

Section 5 Work/Activity/Travel Time Schedule	Typical work/activity schedule (i.e., educational/vocational activity)													
	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
	from	to	from	to	from	to	from	to	from	to	from	to	from	to
	Typical work/activity schedule for second parent, caretaker or stepparent in the household													
	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
	from	to	from	to	from	to	from	to	from	to	from	to	from	to
	Please complete the schedule below only if the parent has a second shift, job or activity													
	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
from	to	from	to	from	to	from	to	from	to	from	to	from	to	
Please complete the schedule below only if the second parent, caretaker or stepparent in the household has a second shift, job or activity														
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
from	to	from	to	from	to	from	to	from	to	from	to	from	to	

**Travel Time** Drop off: Travel time from the child care provider to work/activity?  
Check one of the following:  15 minutes  30 minutes  45 minutes  1 hour  More than 1 hour. Amount of time if more than 1 hour \_\_ Public Transportation?  Yes  No

Pick-up: Travel time from work/activity to the child care provider?  
Check one of the following:  15 minutes  30 minutes  45 minutes  1 hour  More than 1 hour. Amount of time if more than 1 hour \_\_ Public Transportation?  Yes  No

Spouse/Other Parent: Travel time from the child care provider to work/activity?  
Check one of the following:  15 minutes  30 minutes  45 minutes  1 hour  More than 1 hour. Amount of time if more than 1 hour \_\_ Public Transportation?  Yes  No

Pick-up: Travel time from work/activity to the child care provider?  
Check one of the following:  15 minutes  30 minutes  45 minutes  1 hour  More than 1 hour. Amount of time if more than 1 hour \_\_ Public Transportation?  Yes  No

Indicate if you or anyone who is applying with you receives money from the following sources. See checklist (CFWB-012B) for documentation requirements. PLEASE PRINT

Section 6 Income Information	Sources	Yes /No	Gross Amount	How often? (weekly, biweekly, monthly, etc?)	Who is the recipient?	OFFICE USE ONLY	
						Type of Documentation	Monthly Calculations
	Applicant Wages/Salary, including overtime, commissions, training programs, tips		\$		Self		
	Second parent, caretaker or stepparent in the household Wages/Salary, incl. overtime, commissions, training programs, tips		\$				
	Net Self-Employment Income		\$				
	Child Support Payments (received)		\$				
	Alimony/Spousal Support (received)		\$				
	Unemployment Insurance Benefits, Workers' Comp		\$				
	Social Security Benefits (including SSI)		\$				
	Disability Benefits (NYS, VA, Private)		\$				
	Rental/Boarder/Lodger Income (received)		\$				
	Dividends/Interest – Stocks, Bonds, Savings		\$				
	Retirement, Pensions/Annuities		\$				
	Cash Assistance (CA) Grant, Safety Net Benefits		\$				
	Other (please specify):		\$				
	<b>Total Income</b>		<b>\$</b>				

**Section 7 Provider**

If you qualify for Child Care Assistance funded by the New York State Child Care Block Grant, you have the option to choose: center-based or home-based child care. If you choose a provider that is not licensed or registered, the provider must be enrolled as a Legally-Exempt provider. Provide below the name(s) and address(es) of your choice of provider(s). You may list additional choices on an attached sheet.

Name: \_\_\_\_\_ Program # (if applicable): \_\_\_\_\_ Name: \_\_\_\_\_ Program #(if applicable): \_\_\_\_\_ Name: \_\_\_\_\_ Program #(if applicable): \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_ Address: \_\_\_\_\_

**Section 8 Certification**

1. I understand that the information contained on this form will be used to determine my or my family's eligibility for services/subsidy. I understand that by signing this application form, I agree to cooperate fully with any investigation to verify or confirm the information I have given or any other investigation in connection with my request for child care assistance. I will provide additional information if requested.

2. Social Security Numbers, if provided, may be used by federal, state, and local agencies to prevent duplication of services, fraud and for federal reporting.

3. I agree to inform the agency immediately of any change in my needs, income, address, living arrangement, household composition or address where care is provided, who is providing child care, provider fees and/or hours for which child care is needed.

4. I certify that the children indicated as needing child care are United States (U.S.) citizens, U.S. nationals, or persons with satisfactory immigration status. I understand that this information about these children may be submitted to the Immigration and Naturalization Service (INS) for verification of immigration status, if applicable. I further understand that the use or disclosure of this information about these children is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of provisions of the Child Care Assistance Program.

5. I understand that this application is used only for the expressed purpose of child care assistance. To obtain other assistance such as SNAP, Medicaid, Cash Assistance, or other services, additional applications will be required. However, this application and any information obtained as part of an investigation of this application may be shared with any City, State or Federal agency to which you apply or have applied for any other assistance or benefits.

6. Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Child Care Assistance, or when you are questioned about your eligibility, or if you cause someone else not to tell the truth regarding your application or continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial or continuing eligibility for Child Care Assistance; or if you conceal or fail to disclose facts that would affect the right of someone, for whom you have applied, to obtain or continue to receive Child Care Assistance. If you are the authorized representative applying on behalf of someone else, Child Care Assistance must be used for that person and not yourself. It is unlawful to obtain Child Care Assistance by concealing information or providing false information.

7. I certify that my family resources do not exceed \$1,000,000.00.

It is the policy and commitment of the New York City Administration for Children's Services that it does not discriminate on the basis of race, creed, age, color, sex, religion, national origin, alien-age or citizenship status, physical or mental disability, gender, gender identity, sexual orientation, pregnancy, marital or partnership status.

You may obtain information on your rights and responsibilities at <http://otda.ny.gov/programs/applications/4148A.pdf>  
**If you do not have access to the Internet, you can call NYC ACS at (212) 835-7610 to request physical copies of the following booklets.**  
**LDSS-4148A:** What You Should Know About Your Rights and Responsibilities; **LDSS-4148B:** What You Should Know About Social Services Programs; **LDSS-4148C:** What You Should Know If You Have an Emergency

**Certification:** I swear and/or affirm under the penalties of perjury that all of the information I have given or will give to NYC ACS relating to Child Care Assistance is correct. I have read and understand the notices both above and attached. I understand and agree to the above-listed certifications.

Please provide the signatures of both parents/caretakers if two parent/caretaker household.

Signature Parent/Caretaker: \_\_\_\_\_ Signature Parent/Caretaker: \_\_\_\_\_ Signature Parent/Caretaker: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 9 Office Only**

Authorized Days and Hours of Care:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
from	to	from	to	from	to	from	to

Eligibility determined and approved by (print and initial): \_\_\_\_\_  
 Length of Eligibility from \_\_\_\_\_ to \_\_\_\_\_ Codes: RFC: \_\_\_\_\_ PR: \_\_\_\_\_ FS: \_\_\_\_\_

Authorized Days and Hours of Care for Second Shift/Work/Activity Schedule  
 (Complete only if parent provides second shift/work/activity schedule in Section 5)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
from	to	from	to	from	to	from	to

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

### Additional Children (if applicable)

Please list all children in your household needing child care. (Only children needing care)

Section 2A Child(ren) Needing Care	Name (Last, First)	M.I.	Relationship	D.O.B.	Sex	Both of Child's Parents Reside in the Home?	Ethnicity Hispanic or Latino**	Race** <i>(See legend below)</i>	Social Security Number <i>(Optional)</i>	Child with a Disability?	Is child U.S. Citizen/ U.S. National/ or person with satisfactory immigration status?
	9.										
	10.										
	11.										
	12.										
	13.										
	14.										
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28.											

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\*\* Providing ethnicity and race information is voluntary and will not affect your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.

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- HP** Native Hawaiian or Pacific Islander
- WH** White

### Additional Family Members (if applicable)

Please list all **other** members in your entire household (not listed in Section 2A) including children under age 18 who do **not** need child care. List yourself first, followed by everyone who lives with you.

Section 2B Family Members	Name ( Last, First) <i>(Include any aliases or maiden names in parentheses)</i>	M.I.	Relationship	D.O.B.	Sex	Ethnicity Hispanic or Latino**	Race** <i>(See legend below)</i>	Social Security Number <i>(Optional)</i>
	9.							
	10.							
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	24.							
	25.							
	26.							
	27.							
28.								

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Family Size: \_\_\_\_\_

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Racial Affiliation Codes:

- AI** Native American or Alaskan Native
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- BL** Black or African American
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- WH** White

### Additional Providers (if applicable)

<b>Provider</b>	If you qualify for Child Care Assistance funded by the New York State Child Care Block Grant, you have the option to choose: center-based or home-based child care. If you choose a provider that is not licensed or registered, the provider must be enrolled as a Legally-Exempt provider. Provide below the name(s) and address(es) of your choice of provider(s). You may list additional choices on an attached sheet.					
	Name: _____	Program # (if applicable): _____	Name: _____	Program #(if applicable): _____	Name: _____	Program #(if applicable): _____
<b>Provider</b>	Address: _____					
	Name: _____	Program # (if applicable): _____	Name: _____	Program #(if applicable): _____	Name: _____	Program #(if applicable): _____
<b>Provider</b>	Address: _____					
	Name: _____	Program # (if applicable): _____	Name: _____	Program #(if applicable): _____	Name: _____	Program #(if applicable): _____
<b>Provider</b>	Address: _____					
	Name: _____	Program # (if applicable): _____	Name: _____	Program #(if applicable): _____	Name: _____	Program #(if applicable): _____
<b>Provider</b>	Address: _____					
	Name: _____	Program # (if applicable): _____	Name: _____	Program #(if applicable): _____	Name: _____	Program #(if applicable): _____
<b>Provider</b>	Address: _____					

### Income Notes