

<b>You must complete ALL sections and sign OR the application will be returned to you.</b>							Today's Date:					
<b>APPLICANTS MAY RECEIVE UP TO FIVE YEARS OF CHILDCARE SERVICES PENDING THE AVAILABILITY OF FUNDS</b>												
<b>CASEHEAD INFORMATION:</b> Must be 18 years of age or an emancipated minor and have full-time custody of the child requiring child care services.												
Social Security #		First Name		MI	Last Name		Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race (see codes):	
Mailing Address				City / State			ZIP	U.S. Citizen or Permanent Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Phone /Cell ( ) -		
Street Address				City / State			County	ZIP	Message Phone ( ) -			
Highest Grade Completed		# of Parents in home		Primary Language		Have you ever received TEA or ESS Child Care? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>HOUSEHOLD INFORMATION:</b> Include information for all persons living in household. Do not include yourself. Attach additional sheets if necessary.												
Social Security #	First Name	MI	Last Name		Date of Birth	Gender	Race (see codes)	Citizen/Legal Resident	Relationship to Casehead	Child Care needed?	List any Special Needs	
						<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Use these codes to describe your race(s):</b>		A = Asian		B = Black/African American		H = Native Hawaiian/Pacific Islander		I = American Indian or Alaskan Native		S = Hispanic/Latino		W=White/Caucasian
<b>CHILD CARE INFORMATION:</b> Complete information below for ALL children who require child care.												
Child's Name	Age	Name of Child Care Provider Selected:		Is child now attending?	Is provider a relative?	If yes, list relationship:	List days and hours of care you need for this child	Child Attend ABC or HeadStart	List School Attending:			
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>EMPLOYMENT/SCHOOL:</b> Adults in the household must be employed 30 hours per week, be enrolled in school full-time or qualify as a working student.												
Name:		Career Pathways?	List work/school schedule below (include travel time):							If in school, list major or course of study:		
			Mon	Tue	Wed	Thu	Fri	Sat	Sun			
Employer/School:		<input type="checkbox"/> Yes <input type="checkbox"/> No										
			School Information: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter							Start Date:	End Date:	Hours Enrolled:
Name:		Career Pathways?	List work/school schedule below (include travel time):							If in school, list major or course of study:		
			Mon	Tue	Wed	Thu	Fri	Sat	Sun			
Employer/School:		<input type="checkbox"/> Yes <input type="checkbox"/> No										
			School Information: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter							Start Date:	End Date:	Hours Enrolled:
Name:		Career Pathways?	List work/school schedule below (include travel time):							If in school, list major or course of study:		
			Mon	Tue	Wed	Thu	Fri	Sat	Sun			
Employer/School:		<input type="checkbox"/> Yes <input type="checkbox"/> No										
			School Information: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter							Start Date:	End Date:	Hours Enrolled:

<b>HOUSEHOLD INCOME:</b> Proof of all income must be provided and frequency noted: <b>Weekly, Bi-Weekly, Twice Monthly, Monthly</b>												
Name of Adult	Wages		Child Support		SSI		SSA		TEA/Work Pays		Other	
	Amt	Frequency	Amt	Frequency	Amt	Frequency	Amt	Frequency	Amt	Frequency	Amt	Frequency

**RIGHTS AND RESPONSIBILITIES:** Read carefully and sign at the bottom.

1. You cannot be denied child care assistance on the basis of race, color, sex, age, disability, religion, national origin, political belief or failure to disclose a Social Security Number.
2. You may choose any child care provider that meets the requirements of DHS and the Child Care Assistance Program.
3. Information you provide will not be released without your written consent, except to parties allowed by law. Your name and Social Security Number may be furnished to employers, government agencies, educational institutions or any other party deemed necessary by DHS to determine your eligibility.
4. If any adverse action is taken on your application or child care case, you have the right to an Internal Review. You may appeal any review decision by sending a written request to: Arkansas Department of Human Services, Office of Appeals and Hearings, P.O. Box 1437, Slot N-401, Little Rock, AR 72203.
5. You must help establish your eligibility by FULLY completing this application and providing as much information as possible about your circumstances. Providing false information or withholding information may result in criminal prosecution.
6. You must report **ALL changes** that affect eligibility to your Program Eligibility Specialist within ten (10) days of the change. These changes include but are not limited to: Address or Telephone, Household Members, Employment, Child Care Needs, Training/Education Hours or Monthly Income. Failure to report changes may result in your case being closed and a referral to the Fraud Unit. You are responsible for any overpayments resulting from changes in your status.
7. You understand that DHS will not retroactively pay or reimburse you for child care expenses. The first day that DHS will pay for child care is the day DHS determines eligibility requirements have been met and you are approved for services.
8. You agree to cooperate in any DHS investigation concerning your case. You understand that failure to cooperate will result in termination of assistance.
9. If you wish to change child care providers, you must submit a Child Care Arrangement Verification Form (DCC-552) to your assigned Program Eligibility Specialist and allow up to 10 days for processing. If notification is not given, you will be responsible for any payments to the new child care provider until the Program Eligibility Specialist completes the change.
10. Social Security Numbers shall be used for identification purposes only and are not required for eligibility.

**STUDENTS ONLY:** Students enrolled in education or training programs must maintain full-time status to retain eligibility. Grade reports are checked each term to verify completion of courses. If you reduce your hours, you MUST report this to your Program Eligibility Specialist within ten (10) days, and you will be required to obtain work of up to 30 hours per week to remain eligible for assistance. Grades are checked at the end of every full term in which you receive assistance. You must maintain a "C" average (2.00 GPA) in order to continue receiving assistance. If you drop below a 2.00 average, you will be placed on academic probation for one (1) term. If your grades do not meet this requirement the following semester, the case will be closed, unless the student obtains employment at a minimum of 30 hours per week within 30 days.

**CERTIFICATION:** I certify that I have read and understand my Rights and Responsibilities. I authorize DHS to collect information from other sources to determine my eligibility for assistance. I authorize any source DHS deems necessary to determine eligibility to release information concerning me. I certify under penalty of perjury and fraud that all information I have supplied is true and correct. I understand that giving false information or withholding information may result in criminal prosecution and the repayment of financial assistance made on my behalf.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

## Arkansas Department of Human Services Verification of Earnings

**TO EMPLOYER:**

To determine eligibility and correct benefits for your employee we need the information requested below. **This will enable us to ensure that the public funds are used only for the actual and correct benefits to which a household is entitled.** PLEASE COMPLETE THE ITEMS CIRCLED AS WELL AS THE SIGNATURE SECTION AT THE BOTTOM OF THIS FORM.

**If you need this material in a different format such as large print, contact your local DHS county office.**

Address Department of Human Services

Caseworker \_\_\_\_\_

Telephone Number \_\_\_\_\_ TDD# \_\_\_\_\_

Employee \_\_\_\_\_ Casehead \_\_\_\_\_

SSN of Employee \_\_\_\_\_ Case Number \_\_\_\_\_

1. The above employee began work \_\_\_\_\_ and earns \$ \_\_\_\_\_ per hour. He/she works an average of \_\_\_\_\_ hours per week. Date first pay to be received \_\_\_\_\_.

Anticipated gross amount of 1st pay \$ \_\_\_\_\_.

Employee is paid:  Weekly  Monthly  Other -- Please indicate how often \_\_\_\_\_  
 Every 2 weeks  Twice Monthly

2. Please show GROSS EARNINGS (before any deductions) PAID TO this employee as indicated. Please list each pay check separately **including vacation pay and bonuses.**

Pay Period Ending	Date Received	Hours Worked	Gross Wages	Tips	Housing/Utilities Paid above wages

REC'D in the Month of \_\_\_\_\_

For the past consecutive pay periods

3. **Earnings:** Are any of the earnings funded by JTPA - On The Job Training Program?  Yes or  No

4. **Termination:** If employee no longer is employed by you, what was the date and reason for leaving this job?

Date last check will be received \_\_\_\_\_ and gross amount \_\_\_\_\_

5. Additional Information/Expected Changes: (such as layoffs, raises, increased or reduced hours, vacation pay, bonuses, and sick pay).  
 \_\_\_\_\_

6. **Insurance:** If employee has insurance through this job, what is the name and address of the insurance carrier? \_\_\_\_\_

Claims processing address if different than insurance carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Effective date of policy \_\_\_\_\_

Type of coverage \_\_\_\_\_ Policy:  individual or  group

Policyholder and covered individuals \_\_\_\_\_

I do hereby certify that the above information is factual and correct to the best of my knowledge.

\_\_\_\_\_  
Employer/Payroll Clerk Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Place of Business

\_\_\_\_\_  
Address



**ARKANSAS DEPARTMENT OF HUMAN SERVICES**  
**Division of Child Care and Early Childhood Education**

**DECLARATION OF U.S. CITIZENSHIP OR SATISFACTORY IMMIGRATION STATUS**

Name of Casehead \_\_\_\_\_

**Please check all boxes which apply to you and your household and list any names which are requested.**

- I declare that I am a U.S. Citizen or National.
- I declare that the persons listed as household members on my Application for Child Care Assistance are U.S. Citizens or Nationals.
- I declare that the following persons are aliens who are either:
  - lawfully admitted for permanent residence
  - refugees
  - asylees
  - parolees with status granted for at least one (1) year
  - individuals whose deportation is withheld OR
  - conditional entrants:

NAME	USCIS* REGISTRATION NUMBER
_____	_____
_____	_____
_____	_____

- I declare that the following persons are lawfully admitted aliens who are either:
  - U.S. military veterans with an honorable discharge
  - active duty servicepersons OR
  - spouses or children of one of the above:

NAME	FORM NUMBER
_____	_____
_____	_____

- OTHER: Please specify status \_\_\_\_\_

NAME	USCIS* REGISTRATION NUMBER
_____	_____
_____	_____

I declare under penalty of perjury that the foregoing information is true and correct (28 USC 1746). I understand that providing false information or withholding information for the purpose of obtaining child care assistance may result in criminal prosecution and repayment of any financial assistance made on my behalf.

\_\_\_\_\_  
SIGNATURE OF CASEHEAD

\_\_\_\_\_  
DATE

If you need this material in a different format, such as large print, or if you have any questions regarding this form, please contact your Child Care Eligibility Specialist or the DCC-ECE Family Support Unit at 1-800-322-8176.

*\*-U.S. Citizenship and Immigration Service*



**ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**Division of Child Care and Early Childhood Education**  
**Child Care Arrangement Verification**

This is NOT an approval for services.

Name of Casehead/Applicant \_\_\_\_\_

**The information below must be completed by the CHILD CARE PROVIDER where children are either currently attending or will be attending.**

**CHILD CARE PROVIDER:** List children of casehead who are enrolled and complete all applicable information for each child. Return form to casehead upon completion.

Child's Name	Age	Start Date	Head Start/ABC	Type of Service Requested	Time of Service Requested	Cost Per Day
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$
			<input type="checkbox"/> Head Start (Full Day) <input type="checkbox"/> Head Start (Half Day) <input type="checkbox"/> ABC	<input type="checkbox"/> Full Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Half-Time <input type="checkbox"/> Part-Time	___ am ___ am ___ am ___ pm ___ am ___ pm	\$

**\*Types of Service:**

- Full Day: More than 5 hours per day and up to 10 hours
- Half-Time: 3-5 hours per day, inclusively (Hours do not have to be consecutive.)
- Part-Time: Less than 3 hours per day
- Night: Weekday when more than 1/2 of total care is after 6:00 p.m.
- Weekend: Care on Saturday and/or Sunday

Signature of Facility Director of Designee		Print Name	
Name of Child Care Facility		Telephone Number	
Mailing Address	City	Zip Code	County
License No.	<input type="checkbox"/> YES <input type="checkbox"/> NO Quality Approved?		

Check type of facility:  Child Care Center  Licensed Child Care Family Home  Registered Child Care Family Home  
 Voluntary Registered Home  Other: \_\_\_\_\_

**Casehead: Complete and return this form to your Child Care Eligibility Specialist. If you have any questions, please contact your specialist or the Family Support Unit at 1-800-322-8176 or 501-682-8947.**