Kansas Department for Children and Families

Application for Foster Care Child Care Benefits

ES-3100FC
Rev. 05-19

This is your application for Foster Care Child Care (FC-CC) offered through the Department for Children and Families (DCF). Please answer all the questions truthfully, to the best of your ability. If English is not your primary language, an interpreter will be provided at no cost to you. Please be aware, you are subject to severe penalties for any false or misleading information you supply on this application.

Agency Use Only

Date Received: _____

Date Interviewed: _____

_____ Initial _____ Review

Interview completed by: _____

Case Number(s): _____

This form provides us with the information we need to determine child care eligibility for you as a foster family for the child(ren) in your temporary care. Supporting documentation for your employment or school attendance must be included with this application.

Follow These Steps to Apply

- Complete this form to apply. Once complete, submit this form to DCF.FosterCareCC@ks.gov. If you need help or have questions, call (785) 368-8594.
- Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Sign and date this form. Your application is not complete until it is signed.
- Return this form as soon as possible. If you are eligible, some benefits start from the date a signed application is received in our office.
- Mail, fax or bring this form to your child's case management provider or your child's placing agency. It may take 30 to 45 days before your application is processed.
- If an interview is required, we will contact you.

Return this form to:

A. Tell Us About Yourself and the People in Your Home

Provide the following information and sign this section of the application.

Name: _____
First Name, Middle Initial, Last Name

Street Address: _____City: _____County: _____ Zip: _____

Mailing Address: _____City: _____County: _____ Zip: _____

Home Phone: _____Work: _____Cell: _____E-mail: _____

Are You: ☐ Never Married ☐ Married ☐ Common Law Married ☐ Divorced ☐ Separated
☐ Widowed ☐ Member of an Unmarried Couple

Please list everyone living in your home, even if they do not need assistance (do not include children in foster care here).
Failure to provide client's SSN will require additional steps in obtaining the EBT card, as the SSN is used for security purposes in setting up the EBT card.

First name, Mi, Last name	Relationship to you	Sex	DOB	SSN	Is this person a U.S. citizen?
	Self				☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes

Your information is private:
- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify for benefits.

B. Tell Us How to Communicate with You

We provide interpreter and translation services. Complete this section to help us meet your needs.

Do you have a primary language other than English? ☐ No ☐ Yes

If yes, write in the names of spoken and/or written language below. Also include other communication needs such as braille, relay, signed English, TDD/TTY, large print, Voice Synthesizer Program, etc.

Spoken Language	Written Language	Other needs

C. Tell Us About the Foster Children for Whom You Are Applying

Who is the child or children in foster care temporarily living with you? Attach additional pages as necessary.

You may choose not to list race or ethnic heritage, and it will not be used against you. We only ask this information for federal reporting purposes. Answers will in no way affect eligibility or benefits.

PERSON 1

First name	Middle name	Last name	Suffix

Social Security number	Date of birth (month/day/year)	Sex
		☐ M ☐ F

Which Child Placing Agency or Case Management Provider is Person 1 with? _____

Is Person 1 transitioning to a new agency? ☐ No ☐ Yes If yes, which agency? _____

Date placement started: _____

Is Person 1 a citizen of the United States? ☐ No ☐ Yes ☐ Unknown ☐ Pending

Disability: Is Person 1 disabled? ☐ No ☐ Yes

Ethnicity: Is Person 1 Hispanic or Latino? ☐ No ☐ Yes

Race: Check all that apply to Person 1. For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

☐ White
☐ Black or African American
☐ Chinese
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

PERSON 2

First name	Middle name	Last name	Suffix

Social Security number	Date of birth (month/day/year)	Sex
		☐ M ☐ F

Which Child Placing Agency or Case Management Provider is Person 2 with? _____

Is Person 2 transitioning to a new agency? ☐ No ☐ Yes If yes, which agency? _____

Date placement started: _____

Is Person 2 a citizen of the United States? ☐ No ☐ Yes ☐ Unknown ☐ Pending

Disability: Is Person 2 disabled? ☐ No ☐ Yes

Ethnicity: Is Person 2 Hispanic or Latino? ☐ No ☐ Yes

Race: Check all that apply to Person 2. For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

☐ White
☐ Black or African American
☐ Chinese
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

PERSON 3

First name	Middle name	Last name	Suffix

Social Security number	Date of birth (month/day/year)	Sex
		☐ M ☐ F

Which Child Placing Agency or Case Management Provider is Person 3 with? _____

Is Person 3 transitioning to a new agency? ☐ No ☐ Yes If yes, which agency? _____

Date placement started: _____

Is Person 3 a citizen of the United States? ☐ No ☐ Yes ☐ Unknown ☐ Pending

Disability: Is Person 3 disabled? ☐ No ☐ Yes

Ethnicity: Is Person 3 Hispanic or Latino? ☐ No ☐ Yes

Race: Check all that apply to Person 3. For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

☐ White
☐ Black or African American
☐ Chinese
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

PERSON 4

First name	Middle name	Last name	Suffix

Social Security number	Date of birth (month/day/year)	Sex
		☐ M ☐ F

Which Child Placing Agency or Case Management Provider is Person 4 with? _____

Is Person 4 transitioning to a new agency? ☐ No ☐ Yes If yes, which agency? _____

Date placement started: _____

Is Person 4 a citizen of the United States? ☐ No ☐ Yes ☐ Unknown ☐ Pending

Disability: Is Person 4 disabled? ☐ No ☐ Yes

Ethnicity: Is Person 4 Hispanic or Latino? ☐ No ☐ Yes

Race: Check all that apply to Person 4. For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

☐ White
☐ Black or African American
☐ Chinese
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

D. Tell Us About Your Child Care Needs

To help us determine if you can get child care benefits, tell us why you need help with child care expenses (check all that apply):

☐ I have a job. ☐ I go to school/training.

☐ Other - explain: _____

Do you need help finding quality child care? ☐ No ☐ Yes

Do you have enrollment fees to begin child care for your foster child? ☐ No ☐ Yes

If yes, what amount is being charged? _____

When do you need child care to start? _____

Please fill out the information below for each child who needs child care. If child care is needed for more than 4 children, please attach additional pages.

Provide the following for each child	**Child's name**	**Child's name**	**Child's name**	**Child's name**
List child care provider information below each child's name				
Provider's name				
Address				
Phone number				
Provider Type	KDHE licensed ☐ Relative In Home ☐ Relative Out of home ☐ If relative, relationship to child: _____	KDHE licensed ☐ Relative In Home ☐ Relative Out of home ☐ If relative, relationship to child: _____	KDHE licensed ☐ Relative In Home ☐ Relative Out of home ☐ If relative, relationship to child: _____	KDHE licensed ☐ Relative In Home ☐ Relative Out of home ☐ If relative, relationship to child: _____
Child's school schedule (daily) Circle days of the week for this schedule	**Start** **AM / PM** **End** **AM / PM** **S M T W T F S**	**Start** **AM / PM** **End** **AM / PM** **S M T W T F S**	**Start** **AM / PM** **End** **AM / PM** **S M T W T F S**	**Start** **AM / PM** **End** **AM / PM** **S M T W T F S**
Child's grade and name of school/ headstart				

Parent 1 work/school schedule

Work or school name: _____ Work or school phone: _____

Start Time (AM/PM)	End Time (AM/PM)	Circle Days of the Week this schedule is for:
		SUN MON TUE WED THU FRI SAT
		SUN MON TUE WED THU FRI SAT

Parent 2 work/school schedule

Work or school name: _____ Work or school phone: _____

Start Time (AM/PM)	End Time (AM/PM)	Circle Days of the Week this schedule is for:
		SUN MON TUE WED THU FRI SAT
		SUN MON TUE WED THU FRI SAT

Please Read This Information Before Signing

Rights, responsibilities and penalties

- I have read and understand my rights and responsibilities on this form.
- I understand the questions on this application form.
- I understand the penalties for hiding information.
- I understand the penalties for giving false information.

Changes you must report

- I agree to report changes such as changes in my address, changes in choice of child care provider, and/or changes in hours of child care needed/used (other than hours needed for school age children for times that school is not in session). This includes when child care is no longer being used or has not been used for an entire calendar month for any or all children receiving assistance.
- I understand I will be notified about the changes I am required to report.
- I will tell my foster care worker of any changes that would impact my eligibility.

We will verify the information you give us

- I understand you will verify the information I provide on this application form.
- I understand you may contact other agencies such as federal, state, local officials, employers, medical providers, businesses, financial organizations and child care providers to verify information.
- I understand you will use the information you verify and that it could affect my eligibility or benefit level.

Fraud Penalties

Child Care Assistance – If you or any adult member of your foster care child care household intentionally break any of the following rules or are otherwise found to have committed fraud (civil, criminal or administrative), in child care, all adults in your household are permanently ineligible for child care assistance. If you would be eligible in the future or currently are receiving TANF benefits, you would become permanently ineligible as well.

- Do not lie, make misleading statements, hide information or fail to report changes, as required, to get benefits that your household should not get.
- Do not use or have in your posession Kansas Benefits Cards that are not yours.
- Do not trade or sell Benefits Cards.

The remainder of your foster care child care household can get benefits if they are otherwise eligible. Adults in the household will still be responsible for paying the amount of any benefits overpayment that was received by the person disqualified.

DCF Rights

DCF has a right to:

- Verify the alien status of applicant household members by submitting information from the application to the U.S. Citizenship and Immigration Service (USCIS). The information received may affect the household's eligibility and amount of benefits.
- Deny benefits to your household if you do not provide requested information.
- Disclose the information on your application to other federal and state agencies for official examination, and to law enforcement officials for the purpose of arresting people who are running from the law.
- Refer the information on this application to federal and state agencies, as well as private claims agencies, for claims collection if overpayments arise against your household.
- Conduct a full investigation of your eligibility, including contacting employers, child care providers, banks, doctors or by visiting your home.
- Deny your application or prosecute you for fraud if you knowingly give us false information so you can receive assistance.

Your Responsibilities

You have a responsibility to:

- Report changes as required;
- Pay your child care provider for services;
- Cooperate with Quality Assurance staff if your case is reviewed;
- Cooperate with a fraud investigation.

Your Rights

You have a right to:

- Have an interpreter provided at no cost if English is not your primary language;
- Have information given to DCF kept confidential, unless directly related to the administration of DCF programs;
- Withdraw your application at any time;
- Request a fair hearing within 30 days for child care assistance;
- Have your benefits determined from the date this application is received by DCF.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Foster Care Case Management Provider or Child Placing Agency

My signature on this application certifies that the foster child(ren) for whom child care assistance is requested are in the custody of the Secretary of the Kansas Department for Children and Families (DCF). It also certifies that child care is needed due to the foster family's verified work or school schedule for each child whom child care assistance is requested. All documentation must be maintained and cannot be destroyed until after the child care assistance case has been closed for 36 months and must be made available to DCF in the event of an audit.

_____

Foster Care Case Management Provider (CMP)/Child Placing Agency (CPA)

_____ _____

Printed Name of FC CMP/CPA Representative | Representative Contact Email

_____ _____

Signature of FC CMP/CPA Representative | Date

Permission to Release Information and Signature

My signature on this application authorizes employers, child care providers, health care providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to Kansas Department for Children and Families (DCF) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program (including Child Support Services) for which I applied.

I authorize DCF to share medical information for administrative purposes with other agencies and contractors.

I understand all information provided on this application and all information provided to DCF staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge, including the information concerning citizenship and alien status. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person to obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 21-5801 and amendments, which could be a felony offense punished by imprisonment, fine, or both, and the offender may also be subject to prosecution under other applicable state and federal law.

Your Signature (required)	**Date**
Your Spouse's Signature or Another Adult in Your Home (not required)	Date
Signature of First Witness (required if you cannot sign your name)	Date
Signature of Second Witness (required if you cannot sign your name)	Date
Signature of Court-Appointed Guardian/Conservator (if applicable)	Date

Kansas
Department for Children and Families