DEPARTMENT OF HUMAN SERVICES

Minnesota Child Care Assistance Program Application

This is the Minnesota Child Care Assistance Program (CCAP) Application. You may be eligible to get help for your child care expenses so you can work, look for work, or attend school. CCAP can pay any legal child care provider who registers for payments including licensed, certified, and unlicensed providers, 18 years of age or older. If you do not have a child care provider, you can apply for CCAP and ask for help finding a child care provider.

To qualify, your family must:

- Be income eligible;
- Meet employment and training requirements:
  - Work at least an average of 20 hours per week (10 hours per week if a full-time student) at minimum wage, *or*
  - Participate in job search, attend school or training classes, *or*
  - Comply with the activities of an approved Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP) employment plan.
- Cooperate with child support enforcement for all children in the family who have an absent parent.

Read these instructions before you fill out the application.

The Child Care Assistance Program booklet Do you need help paying for child care? (DHS-3551) gives you information about the Child Care Assistance Program and choosing a child care provider.

Please follow these instructions as you complete your application.

- Print using black ink.
- Read all instructions and answer all questions completely.
- If you need more room, use space on page 17 or attach additional sheets of paper.
- **Provide proof of all requested information.** This includes proof of:
  - Identity for each adult in your family
  - Residence/Address
  - Age and relationship to you for each child in your family
  - Citizenship or immigration status for each child in your family who needs child care
  - School schedule and program completion date for each adult in your family
  - All counted earned and unearned income and work schedules
  - Allowable deductions such as insurance premiums and child/spousal support paid
- The county or tribe must ask for your Social Security number. You are not required to provide this to be eligible for assistance.
- Read the "Penalty Warning", "Your responsibilities" and "Your rights" sections of this form.
- Sign and date the application.
- Mail, fax or bring the completed application and all other needed items to the address listed below.
- **If you have questions or have problems getting the information you need, contact the county or tribal human services office where you live.**

Once your application is received, you will receive a written notice about your eligibility within 30 calendar days, or 45 days if needed.

A child care worker will write or call you if more information is needed.

Mail application to: →

AFFIX COUNTY LABEL HERE

If you want help, please call this phone number.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီအပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

DEPARTMENT OF HUMAN SERVICES

DHS-3550-ENG 5-19

Minnesota Child Care Assistance Program Application

Child care assistance staff only			
CASE NUMBER	CCAP WORKER NAME	MFIP WORKER NAME	COUNTY DATE STAMP
MFIP BEGIN DATE	MFIP END DATE	EMPLOYMENT SERVICES AGENCY	EMPLOYMENT SERVICES WORKER

1. Applicant

Tell us about you and where you live.

- Include *proof of your identity*, such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate.
- Include *proof of your residence/address*, such as one of the items listed above or a copy of a recent utility bill, rental lease, or mortgage document.

PERSON 1

LAST NAME	FIRST NAME	MIDDLE NAME

OTHER NAMES YOU MIGHT BE KNOWN AS	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
	◯ Male ◯ Female		

ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS *(if different)*	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	OTHER PHONE NUMBER	MARITAL STATUS
			◯ Married ◯ Divorced ◯ Separated ◯ Single

What is your preferred spoken language?	What is your preferred written language?	Do you need an interpreter?
		◯ Yes ◯ No

ETHNICITY *(optional)*	RACE *(optional)*
Hispanic? ◯ Yes ◯ No	☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Pacific Islander or Native Hawaiian ☐ White

Have you ever received or requested child care assistance? ◯ Yes ◯ No

IF YES, WHEN?	WHERE? (MN CITY)	MN COUNTY

Do you get a housing or Section 8 subsidy? ◯ Yes ◯ No

Living situation: *(optional, choose one)*

◯ Own housing; lease, mortgage or roommate
◯ Family/friends due to economic hardship
◯ Emergency shelter
◯ Service provider - foster care, group home
◯ Hospital, treatment facility, detox center or nursing home
◯ Unknown
◯ Jail, prison or juvenile detention facility
◯ Hotel or motel
◯ Declined
◯ Place not meant for housing (anywhere outside, a vehicle, an abandoned building, or bus/train/airport)

2. Family members

Tell us about all the other people living in your home.

Include all household members, both adults and children. Include family members who do not live with you, but are expected to return to your home.

Adults:

- Include your spouse, the parents of children in your family who live with you, and all other adults living with you whether or not they are family members.
- Include proof of identity for each adult in your family, such as a copy of a driver's license, state identification card, passport, school identification card, or birth certificate.

Children:

- List all children under the age of 18 who live with you. List children in order from oldest to youngest.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support.
- Include proof of each child's relationship to you, such as a birth certificate, adoption record, legal guardianship statement or baptismal record.
- Include proof of each child's age, such as one of the items listed above or a school or immunization record.
- Include proof of citizenship or immigration status for each child in need of child care assistance, such as a birth certificate, an adoption record or a USCIS (United States Citizenship and Immigration Services) card.

Note: Proof of citizenship or immigration status will not be used for immigration purposes.

***RACE codes** *(list all that apply)*
A = Asian B = Black or African American N = American Indian or Alaska Native P = Pacific Islander or Native Hawaiian W = White

PERSON 2				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER ◯ Male ◯ Female	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No	RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No		
Do you need an interpreter? ◯ Yes ◯ No	What is your preferred spoken language?		What is your preferred written language?	

PERSON 3				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER ◯ Male ◯ Female	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No	RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No		
Do you need an interpreter? ◯ Yes ◯ No	What is your preferred spoken language?		What is your preferred written language?	

PERSON 4

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
	◯ Male ◯ Female		Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

RELATIONSHIP TO YOU	CITIZENSHIP
	If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No

Do you need an interpreter?	What is your preferred spoken language?	What is your preferred written language?
◯ Yes ◯ No		

PERSON 5

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
	◯ Male ◯ Female		Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

RELATIONSHIP TO YOU	CITIZENSHIP
	If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No

Do you need an interpreter?	What is your preferred spoken language?	What is your preferred written language?
◯ Yes ◯ No		

PERSON 6

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
	◯ Male ◯ Female		Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

RELATIONSHIP TO YOU	CITIZENSHIP
	If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No

Do you need an interpreter?	What is your preferred spoken language?	What is your preferred written language?
◯ Yes ◯ No		

For additional household members, use the blank page at the end of the application.

3. Child Support and custody arrangement

List all children in your family who have a parent who does not live in your home. If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements.

CHILD 1

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 2

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 3

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 4

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 5

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

4. Student information – children

Complete this section for all children in your family who are **now in school or plan to go to school within the next 12 months**.

- Include start date if not currently in school.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support. Include proof of their school status, such as a fee statement or registration confirmation, the expected completion date of their program, and your financial support.
- For preschool age children: Indicate "Head Start" or "preschool" in the "GRADE" field if child attends one of those programs.
- Include proof of school enrollment status for children with earned income.

STUDENT 1

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 2

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 3

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 4

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 5

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

5. Income

List all income received by you and all members of your family.

- Include income received by family members temporarily absent from your home.
- Report self-employment income in question *5.B. Self-employment income*.
- Include proof of work schedule and all income for the most current 30 days, such as wages, tips, commissions and bonuses.

A. Earned income (wages)

Income #1			
EMPLOYEE'S NAME	EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
WORK ADDRESS (if different)	CITY	STATE	ZIP CODE
HOURLY PAY RATE	NUMBER OF HOURS PER WEEK	HOW OFTEN PAID? ◯ Daily ◯ Weekly ◯ Every other week ◯ Two times a month ◯ Other _____	
TOTAL AMOUNT PAID BEFORE DEDUCTIONS	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK

Income #2			
EMPLOYEE'S NAME	EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
WORK ADDRESS (if different)	CITY	STATE	ZIP CODE
HOURLY PAY RATE	NUMBER OF HOURS PER WEEK	HOW OFTEN PAID? ◯ Daily ◯ Weekly ◯ Every other week ◯ Two times a month ◯ Other _____	
TOTAL AMOUNT PAID BEFORE DEDUCTIONS	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK

B. Self-employment income

Complete this section if you or someone in your family is **self-employed**. Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property.

Include proof of:

- All self-employment income and expenses, such as federal tax returns or business ledgers.
- Work schedule, such as a calendar with work hours.

Income #1			
ADULT'S NAME		TYPE OF BUSINESS	
START DATE	NUMBER OF HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE EXPENSES	MONTHLY EXPENSES

Income #2			
ADULT'S NAME		TYPE OF BUSINESS	
START DATE	NUMBER OF HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE EXPENSES	MONTHLY EXPENSES

C. Unearned income

Complete this section for each type of **unearned income** you or someone in your family receives.

- Include proof of all unearned income, such as a check stub, an award letter, a financial aid form, or a written statement from the source of the income for the most current 30 days.

Type	Yes	No	Name of person receiving income	How often received	Amount
Public assistance (MFIP, DWP, GA, Tribal TANF)	◯	◯			
Child support/Spousal support	◯	◯			
Unemployment Insurance	◯	◯			
Insurance payments (settlements, short- or long-term disability, etc.)	◯	◯			
RSDI (Retirement, Survivors, Disability Insurance)	◯	◯			
Supplemental Security Income (SSI)	◯	◯			
Veteran benefits (VA)	◯	◯			
Contract for deed	◯	◯			
Trust income	◯	◯			
Interest/dividends	◯	◯			
Tribal payments	◯	◯			
Cost-effective health care reimbursement	◯	◯			
Other (lottery or gambling winnings, inheritance, capital gains, etc.) - list below:	◯	◯			

D. Do you expect any changes to work hours or income listed in A, B, or C above?

◯ Yes ◯ No

IF YES, DESCRIBE IN DETAIL

6. Deductions

Complete this section if you or someone in your family has any of the expenses listed for which you are not reimbursed.

- These expenses may be deducted from your gross income in determining your co-payment.
- Include proof of deductions, such as check stubs, benefit statements or premium statements.

Expense	How often do you pay?	Amount
Medical insurance premiums		
Dental insurance premiums		
Vision insurance premiums		
Child support paid for a child not living in the home		
Court ordered spousal support		

7. Assets

Assets include cash, bank accounts, vehicles, investments, and real estate (other than your home). Do not include the home you live in, personal belongings, or self-employment assets. How much are your family's assets?

◯ My family's assets are **LESS THAN $1 million** (or equal to $1 million), **OR**

◯ My family's assets are **MORE THAN $1 million** (your worker will contact you for more information)

8. Request for child care assistance

Complete the sections that apply to adult members of your family.

A. List all *adult* family members who need help paying for child care to attend school or training classes.

- Include family members participating in GED or ESL classes.
- Include proof of school schedules that show the days and times classes meet, including school breaks.

ADULT 1							
ADULT'S NAME			NAME OF SCHOOL OR TRAINING SITE				
SCHOOL PROGRAM ATTENDING						START DATE	
Days and times this adult attends school or training							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

ADULT 2							
ADULT'S NAME			NAME OF SCHOOL OR TRAINING SITE				
SCHOOL PROGRAM ATTENDING						START DATE	
Days and times this adult attends school or training							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

B. List all *adult* family members who need help paying for child care to be able to work.

- Include proof of all work schedules, such as a time card or a letter from employer.
  If the work schedule varies, please provide this information for the past two months.

ADULT 1							
ADULT'S NAME				EMPLOYER'S NAME			
Days and times this adult works							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

ADULT 2							
ADULT'S NAME				EMPLOYER'S NAME			
Days and times this adult works							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

C. List all *adult* family members who need help paying for child care to look for work.

ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)
ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)

D. List all *adult* family members who need help paying for child care to attend MFIP orientations or other MFIP/DWP activities in an approved employment plan.

ADULT'S NAME	JOB COUNSELOR ASSIGNED?	JOB COUNSELOR'S NAME	JOB COUNSELOR'S PHONE NUMBER
ADULT'S NAME	JOB COUNSELOR ASSIGNED? ◯ Yes ◯ No	JOB COUNSELOR'S NAME	JOB COUNSELOR'S PHONE NUMBER

9. Child care needs

List all children who are attending or are in need of child care.

- Child care assistance is available for children under age 13 and for children with disabilities under age 15.
- Complete the provider questions if you currently use or have chosen a child care provider(s) for your child.
- Contact your county or tribal human services office if your child has special needs and needs specialized care.
- Child care assistance can only pay two providers per child, one primary and one secondary provider.

CHILD 1

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 2

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 3

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 4

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 5

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Important! Please read and sign this application.

Authorization to share information for fraud investigation and audits.

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation, and conducting federal or state audits. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission to share information about me remains in effect for six months after my benefits stop.

Provider release.

State and federal privacy laws protect my information. If I am eligible for child care assistance, CCAP staff can share information about the hours and amount of child care assistance I get with my child care provider(s). My provider will be notified when my redetermination is due. I understand:

- This information must be shared so that my child care provider knows how much CCAP will pay for the child care provided.
- This information can be shared only if I give my written permission or if the law allows it.
- I can refuse to sign or cancel this release, but if I do, CCAP may not be able to pay my provider for the child care provided.
- I may cancel this authorization with written notice anytime. This written notice will not affect information already released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it. Minnesota Data Privacy Act (Minn. Stat., Ch. 13).

Penalty warning.

If you get child care assistance benefits, do not give false information or hide information:

- To get or continue to get child care assistance benefits
- To help someone else to get or to continue to get child care assistance payments.

The state may bar a family with a member who breaks either of these rules from the Child Care Assistance Program. The bar lasts one year for the first fraud, two years for the second fraud, and is permanent for the third fraud. A person who supplies false information in order for them or someone else to receive Child Care Assistance may also be prosecuted criminally.

If I get child care assistance I understand:

- I must cooperate with child support enforcement and assign my child care support portion to the Minnesota Department of Human Services. I have the right to claim "good cause" for not cooperating with child support enforcement.
- I may be required to pay a co-payment fee.
- If my child care provider charges more than the maximum rate paid in my county, I will pay the additional costs, as well as my co-payment fee.
- I must report changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment and activity status and schedules, family status, significant income changes, address or residence, or anyone moving in or out of my household. Refer to Reporting Responsibilities for CCAP families (DHS-6953) for specific requirements.
- I must give the county agency and my child care provider 15 calendar days' notice before changing my child care provider(s). This notice is not needed in cases when:
  - A provider's Minnesota child care license has been temporarily immediately suspended or
  - There is an imminent risk of harm to the health, safety, or rights of a child in the care of a provider not licensed by Minnesota.
- My eligibility for child care assistance will be redetermined every 12 months.
- I have the right to choose any legal child care provider, including certified licensed child care centers, licensed family child care providers and legally nonlicensed child care providers that meet program requirements.
- If I choose a provider to provide child care in my home, I am considered the employer of the provider and have legal and tax responsibilities. This care must be approved by DHS before child care assistance can be paid.

Perjury and general declarations

I declare under the penalties of perjury that I have reviewed this form and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than $10,000, or both. [Minnesota Statute, section 256.984, subd. 1]

By signing below:

- I have received a copy of the Notice of Privacy Practices (DHS-3979) and the Client Responsibilities and Rights (DHS-4163). I have read, and understand this information. If I have questions about this information, I will ask a worker to explain them to me.
- I agree to continue to assign my child care support to the state of Minnesota. I understand that I have the right to claim good cause for not cooperating with child support enforcement.
- I agree to the sharing of information as stated in the provider release and fraud investigation authorization information above.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE

AGENCY SIGNATURE	DATE	CLIENT GIVEN:
		☐ Client Responsibilities and Rights (DHS-4163) ☐ Notice of Privacy Practices (DHS-3979)

AGENCY NOTES

Use this space if you need additional room

Use this space if you need additional room

DEPARTMENT OF HUMAN SERVICES

Client Responsibilities and Rights

Note: Cash on an Electronic Benefit Transfer (EBT) card is provided to help families meet their basic needs, including: food, shelter, clothing, utilities and transportation. These funds are provided until families can support themselves. It is illegal for an EBT user to buy or attempt to buy tobacco products or alcohol with the EBT card. If you do, it is fraud and you will be removed from the program. Do not use an EBT card at a gambling establishment or retail establishment, which provides adult-orientated entertainment in which performers disrobe or perform in an unclothed state for entertainment.

Your responsibilities

- **If you receive cash assistance and/or child care assistance,** you must report changes which may affect your benefits to the county agency within 10 days after the change has occurred. If you receive Supplemental Nutrition Assistance Program (SNAP) benefits, report changes by the 10th of the month following the month of the change. Each program may have different requirements for reporting changes. Talk to your caseworker about what you must report.

  You may be required to report changes in:
  - **Employment** – starting or stopping a job or business; change in hours, earnings or expenses
  - **Income –** receipt or change in child support, Social Security, veteran benefits, unemployment insurance, inheritance or insurance benefits
  - **Property –** purchase, sale or transfer of a house, car or other items of value, or if you receive an inheritance or settlement
  - **Household –** When a person dies or becomes disabled, moves in or out of your home or temporarily leaves; pregnancy; birth of a child.
  - **Citizenship or immigration status**
  - **Address**
  - **Housing costs and/or rent subsidy**
  - **Utility costs**
  - **Filing a lawsuit**
  - **Absent parent custody or visits**
  - **Drug felony conviction**
  - **Marriage, separation or divorce**
  - **School attendance**
  - **Health insurance coverage and premiums**

  Note: If you change child care providers, you must tell your child care worker and provider at least 15 days before the change goes into effect.

  If you have any questions or are unsure about any reporting rules, contact your worker. If your worker is not available, leave a message so the worker can get back to you.

- **The county, state or federal agency may check any of the information you provide.** To obtain some forms of information we must have your signed consent. If you don't allow the county to confirm your information, you might not receive assistance.

- **If you give us information you know is untrue, withhold information or do not report as required, or we discover your information is untrue,** you **may** be investigated for fraud. **This may result in you being disqualified from receiving benefits, charged criminally, or both.**

- **The state or federal quality control agency** may randomly choose your case for review. They will review statements you provided and will check to see if your eligibility was figured correctly. The state may seek information from other sources and will inform you about any contact they intend to make. **If you do not cooperate, your benefits may stop.**

- **Cooperation requirements:**
  - If the county approves you for the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP), you must cooperate with employment services, unless you are exempt. You must develop and sign an employment plan or your DWP application will be denied.
  - To receive MFIP, DWP, and/or child care assistance, you must cooperate with child support enforcement for all children in your household. You have the right to claim "good cause" for not cooperating with child support enforcement. You must assign your child support to the state of Minnesota for all eligible children. If you do not cooperate or assign your child support, benefits will be denied or terminated.

  After the county approves your MFIP or DWP, if you receive child support directly from the noncustodial parent, you must report it to your worker.

For Cash and Supplemental Nutrition Assistance Program (SNAP) benefits:

- **Each time you use your Electronic Benefits Transfer (EBT) card or sign your check**, you state that you have informed the county agency about any changes in your situation which may affect your benefits.
- **Each time your EBT** card is used we assume you have received your cash or SNAP benefits, unless you reported your card lost or stolen to the county agency.

For Child Care Assistance:

- **You may be required to pay a co-payment fee to your child care provider.** If you do not pay the fee, your child care assistance will be terminated until fees are paid in full or satisfactory payment agreements have been made with the county and your child care provider.
- **You may be required to pay additional costs** when your child care provider charges a rate that is more than the maximum rate in your county.
- **You must document** the immigration or citizenship status of the children in your family for whom you are applying for child care assistance.

Note: If you sign the application as an authorized representative of a person who is requesting or receiving assistance, you are agreeing to assume all of the responsibilities listed above on behalf of that person.

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet explaining these rights.
- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application within:**
  - 30 days for cash, SNAP and child care assistance
  - 60 days for cash related to disability.
- **You have the right to know the rules of the program you are applying for** and for the agency to tell you how your benefit amount was figured.
- **You have the right to choose where and with whom you live.**
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care assistance and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care **within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.)

  For SNAP, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

  If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.
- **Access to free legal services.** Contact your worker for information on free legal services.

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency.

Contact **DHS** directly only if you have a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019 (voice)
1-800-537-7697 (TDD)
Complaint Portal:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

In accordance with Federal civil rights law and **U.S. Department of Agriculture (USDA)** civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 1-866- 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410;
(2) fax: 202-690-7442; or
(3) email: program.intake@usda.gov

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