

# 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 or 3\* 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 (IDSS-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.

PLEASE PRINT IN ALL CAPITAL LETTERS

Refer to application instructions (CFWB-012A) for details

OFFICE USE ONLY Case #: \_\_\_\_\_ Application Date: \_\_\_\_\_  New  Change/Recertification  Reopen

## Section 1 APPLICANT

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?  Yes  No If yes, does family currently reside in (check one):  Homeless shelter  Doubled-up with another family  Hotel/Motel  Car, Bus, Train  Park, Campsite  Other  
 Telephone (Work): \_\_\_\_\_ Telephone (Home): \_\_\_\_\_ Telephone (Cell or Other): \_\_\_\_\_ Email: \_\_\_\_\_  
 Do you receive Cash Assistance?  Yes  No CA#: \_\_\_\_\_  
 What is your primary language?  English  Spanish  Other \_\_\_\_\_  
 What is your preferred language?  English  Spanish  Other \_\_\_\_\_

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

Section 2A CHILD(REN) NEEDING CARE												
1.	Last Name	First Name	M.I.	Relationship	Date of Birth MM/DD/YY	Sex	Both of Child's Parents Reside in the Home?	Ethnicity Hispanic or Latino**	Race** (see legend below)	Social Security Number (Optional)	Child with a Disability?	Is child U.S. citizen/ U.S. National/ or person with satisfactory immigration status?
2.						<input type="checkbox"/> M <input type="checkbox"/> F	<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
3.						<input type="checkbox"/> M <input type="checkbox"/> F	<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
4.						<input type="checkbox"/> M <input type="checkbox"/> F	<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
5.						<input type="checkbox"/> M <input type="checkbox"/> F	<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
6.						<input type="checkbox"/> M <input type="checkbox"/> F	<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
7.						<input type="checkbox"/> M <input type="checkbox"/> F	<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
8.						<input type="checkbox"/> M <input type="checkbox"/> F	<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

\*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  
 \*\*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.

Category 2: Families eligible when funds are available  
 Category 3: Families eligible when funds are available and ACS has included them in its Child and Family Services Plan

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.

1	Last Name <i>(Include any aliases or maiden names in parentheses)</i>	First Name	M.I.	Relationship	Date of Birth MM/DD/YY	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity Hispanic or Latino** <input type="checkbox"/> Yes <input type="checkbox"/> No	Race** <i>(Select one to the right)</i>	Social Security Number <i>(Optional)</i>
				Self		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
8						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

OFFICE USE ONLY Family Size:

### Section 3 CHILD/FAMILY NEEDS

- What is your reason for requesting Child Care Assistance?
- Employment  Looking for Work
  - Vocational Training/Educational Activities  Homelessness
  - Receiving Domestic Violence Services  Is there a non-custodial parent available to provide child care?

- Is a parent currently active duty (full-time) in the US Military?  
 No  Yes
- Is a parent currently a member of a National Guard or Military Reserve Unit?  
 No  Yes

- Is the applicant receiving and/or applying for child care through a different application? If yes please indicate the agency:
- Department of Education (DOE)
  - Human Resources Administration (HRA)
  - Department of Youth and Community Development (DYCD)
  - Department of Homeless Services (DHS)
  - Consortium for Worker Education (CWE)

### Section 4 EMPLOYMENT *(if employment is reason for care)*

Applicant's Employer Name: \_\_\_\_\_ Tel#: \_\_\_\_\_ Address: \_\_\_\_\_ City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employment Start Date: \_\_\_\_\_ Does job have a rotating shift?  Yes  No Does job require overtime (OT)?  Yes  No

If applicant has a second job

Employer Name: \_\_\_\_\_ Tel#: \_\_\_\_\_ Address: \_\_\_\_\_ City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employment Start Date: \_\_\_\_\_ Does job have a rotating shift?  Yes  No Does job require overtime (OT)?  Yes  No

**Second parent, caretaker or stepparent in the household**

Employer Name: \_\_\_\_\_ Tel#: \_\_\_\_\_ Address: \_\_\_\_\_ City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employment Start Date: \_\_\_\_\_ Does job have a rotating shift?  Yes  No Does job require overtime (OT)?  Yes  No

If second parent, caretaker or stepparent in the household has a second job

Employer Name: \_\_\_\_\_ Tel#: \_\_\_\_\_ Address: \_\_\_\_\_ City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employment Start Date: \_\_\_\_\_ Does job have a rotating shift?  Yes  No Does job require overtime (OT)?  Yes  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	from	from	from	from	from	from
to	to	to	to	to	to	to

Typical work/activity schedule for second parent, caretaker or stepparent in the household

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

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

Check one of the following:  15 minutes  30 minutes  45 minutes  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?  15 minutes  30 minutes  45 minutes  More than 1 hour. Amount of time if more than 1 hour \_\_\_\_\_ Public Transportation?  Yes  No

Check one of the following:  15 minutes  30 minutes  45 minutes  More than 1 hour. Amount of time if more than 1 hour \_\_\_\_\_ Public Transportation?  Yes  No

Please complete the schedule below only if the parent has a second shift, job or activity

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

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

Check one of the following:  15 minutes  30 minutes  45 minutes  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?  15 minutes  30 minutes  45 minutes  More than 1 hour. Amount of time if more than 1 hour \_\_\_\_\_ Public Transportation?  Yes  No

Check one of the following:  15 minutes  30 minutes  45 minutes  More than 1 hour. Amount of time if more than 1 hour \_\_\_\_\_ Public Transportation?  Yes  No

**Section 6  
INCOME INFORMATION**

Source	Yes	No	Gross Amount	How often? (weekly, biweekly, monthly, etc?)	Who is the recipient?	Type of Documentation	Monthly Calculations
Applicant/Wages/Salary, including overtime, commissions, training programs, tips	<input type="checkbox"/>	<input type="checkbox"/>	\$		Self		
Second parent, caretaker or stepparent in the household Wages/Salary, incl. overtime, commissions, training programs, tips	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Net Self-Employment Income	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Child Support Payments (received)	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Alimony/Spousal Support (received)	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Unemployment Insurance Benefits, Workers' Comp	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Social Security Benefits (including SSI)	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Disability Benefits (NYS, VA, Private)	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Rental/Boarder/Lodger Income (received)	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Dividends/Interest - Stocks, Bonds, Savings	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Retirement, Pensions/Annuities	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Cash Assistance (CA) Grant, Safety Net Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	\$				
<b>Total Income</b>			\$				<b>0.00</b>

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

OFFICE USE ONLY

**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) \_\_\_\_\_  
Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Program # (if applicable) \_\_\_\_\_  
Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Program # (if applicable) \_\_\_\_\_  
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, alienage or citizenship status, physical or mental disability, gender, identity, sexual orientation, pregnancy, marital or partnership status.

You may obtain information on your rights and responsibilities at <http://ocda.ny.gov/progrm/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 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: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Print Name: \_\_\_\_\_  
Signature Second Parent/Caretaker: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Print Name: \_\_\_\_\_  
Signature Authorized Representative: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Authorized Days and Hours of Care:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From	From	From	From	From	From	From
To	To	To	To	To	To	To

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	From	From	From	From	From	From
To	To	To	To	To	To	To

Eligibility determined and approved by (print and initial): \_\_\_\_\_

Length of Eligibility from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ Codes: RFC: \_\_\_\_\_ PR: \_\_\_\_\_ FS: \_\_\_\_\_

**Section 9  
OFFICE ONLY**

**SAVE**

**PRINT**