



Number of household members sharing income: \_\_\_\_\_

N/A **Employment**

**Applicant:** (If you work more than one job, attach additional information)

Employer:	Employers Town:	Occupation:	Work Phone #:
<b>Do you work shift work? Y/N</b>	<b>How often are you paid?</b>	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly
		<input type="checkbox"/> Monthly	<input type="checkbox"/> Other
	Mon	Tues	Wed
	Thur	Fri	Sat
	Sun		
<b>Work Schedule</b> (i.e. 7:00 am – 4:00pm)			
Additional Time Needed for Travel			
<b>From attached last 4 consecutive wage stubs, fill in the boxes:</b>	<b>Pay stub#</b>	<b>Gross wages</b> (before taxes)	<b>Date paid:</b>
<i>If this is a new job, you must provide a letter from your employer indicating hire date, wages/rate per hour and hours/days worked AND total weekly hours. Verification needs to be completed by submitting copies of your first four wage stubs.</i>	1	\$	
	2	\$	
	3	\$	
	4	\$	
			<b>For agency use only:</b>
			Total wages per wage stubs
			Divided by 4
			Total average gross wages

N/A **Other Adult Household Member:** (If you work more than one job, attach additional information)

Employer:	Employers Town:	Occupation:	Work Phone #:
<b>Do you work shift work? Y/N</b>	<b>How often are you paid?</b>	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly
		<input type="checkbox"/> Monthly	<input type="checkbox"/> Other
	Mon	Tues	Wed
	Thur	Fri	Sat
	Sun		
<b>Work Schedule</b> (i.e. 7:00 am – 4:00pm)			
Additional Time Needed for Travel			
<b>From attached last 4 consecutive wage stubs, fill in the boxes:</b>	<b>Pay stub#</b>	<b>Gross wages</b> (before taxes)	<b>Date paid:</b>
<i>If this is a new job, you must provide a letter from your employer indicating hire date, wages/rate per hour and hours/days worked AND total weekly hours. Verification needs to be completed by Submitting copies of your first four wage stubs</i>	1	\$	
	2	\$	
	3	\$	
	4	\$	
			<b>For agency use only:</b>
			Total wages per wage stubs
			Divided by 4
			Total average gross wages

N/A **Self-Employment/Rental Income and Source:**

Work Schedule (i.e. 7:00 am – 4:00 pm)

Name of Person	Type of Employment	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Please attach a copy of Schedule C and/or Schedule E from your most recent Tax Return or a monthly Profit and Loss Statement if your business has not yet filed a return. For new businesses, attach a statement estimating anticipated income and expenses for 1 month.

Calculation for Income from Self-Employment and Rental	Self Employment	Rental Income
1. Amount on IRS Form 1040, Schedule C, Line 31 and/or Schedule E, Line 22 for income from rental property.	\$	\$
2. Add amount of depreciation from Schedule C, Line 13 and/or from Schedule E, Line 20 for income from rental property.	\$	\$
3. Total Self Employment/Rental Income	\$	\$

The following expenses cannot be deducted in calculating self-employment. If deducted, they must be added back in as income:

- Payments on principal of the purchase price of income-producing real estate, capital assets, equipment, machinery and other durable goods.
- Net losses from previous periods.

- Federal, State and local income taxes.
- Retirement plans applicable to family members.
- Work related personal expenses.

N/A **Unearned or Other Income**

**Do you or any member of your household have any other income?** *Please attach a copy of proof of this income (i.e. example, check or award letter)*

Type of Income	Amount	How Often (Please circle one)	Name of benefit recipient
TANF	\$	Weekly Biweekly Monthly Annually	
SSI Benefits	\$	Weekly Biweekly Monthly Annually	
Social Security Benefits	\$	Weekly Biweekly Monthly Annually	
Veterans Benefits	\$	Weekly Biweekly Monthly Annually	
Workers Compensation	\$	Weekly Biweekly Monthly Annually	
Unemployment Compensation	\$	Weekly Biweekly Monthly Annually	
Disability payments	\$	Weekly Biweekly Monthly Annually	
Other	\$	Weekly Biweekly Monthly Annually	

N/A **Child Support Payments**

Please complete the following information for all children. *(If you have been a TANF or PaS client, you should have a support order)*

I do not have a child support order and I do not currently receive child support.

I have a child support order(s) *Attach copy of Orders*

Child: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Weekly Biweekly Monthly Annually  
 Child: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Weekly Biweekly Monthly Annually

I have a child support order but I do not currently receive support

*Attach proof of attempt to collect child support through DHHS Support Enforcement or legal system*

I do not have a child support order but I currently receive support

Child: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Weekly Biweekly Monthly Annually  
*Attach proof of amount*

N/A **Child Support Paid Out**

**Do you or any member of your household pay child support to an individual who is not a member of your current household?** *(Please document amounts paid.)*

Name of payer	Amount	How Often (Please circle one)	Name of person who receives this money
	\$	Weekly Biweekly Monthly Annually	
	\$	Weekly Biweekly Monthly Annually	

N/A **Education/Training Program Student Information**

*If the need for child care is based on a school/education schedule, a redetermination must be completed each semester. (Semester defined as Fall, Spring and Summer)*

**Applicant Name:**

Name of School and Location:							
Semester Start Date:		Semester End Date:		Anticipated Graduation Date:			
<b>Please attach a class/school schedule. Days and hours must be included.</b>							
	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Additional Time Needed for Travel							
Additional Time Needed for Studying:							

N/A **Other Adult Household Member Name:**

Name of School and Location:							
Semester Start Date:		Semester End Date:		Anticipated Graduation Date:			
<b>Please attach a class/school schedule. Days and hours must be included.</b>							
	Mon	Tues	Wed	Thur	Fri	Sat	Sun

Additional Time Needed for Travel							
Additional Time Needed for Studying:							

**Hours Child Care is Needed: (i.e. 7am – 5 pm)**

(Full time care = 30 to 50 hours. Part time care = 20 - 29 hours. Half time care = 19 or less hours.)

Child Name	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Hours	Does this child attend Head Start or School If yes, where?	Hours Attending Head Start/School

**Eligibility Related Information**

	Y/N	Documentation Required
<i>Do you have an open Child Protective Case?</i>		<i>You will need a written referral from your Caseworker</i>
<b><i>The following applies only to ongoing slots client and to applicants who want to be on the waiting list</i></b>		
<i>Is any adult member of your household currently unemployed and seeking employment?</i>		<i>You will need to obtain employment to qualify/continue to qualify for a child care subsidy. If you are currently a subsidized slot client and become unemployed, eligibility must be redetermined and you may be eligible for job search services. Please discuss this with your eligibility specialist/agency staff person.</i>
<b><i>The following applies only to households with two or more adults</i></b>		
<i>Is any adult member of your household a person who has a disability and is unable to work?</i>		<i>Please attach a Doctor's statement that the disability prevents the adult from caring for the child.</i>
<b><i>The following subsidies are only available through a Voucher Management Agency</i></b>		
<i>Is any adult member of your household in a substance abuse rehabilitation program?</i>		<i>Please attach referral from a rehabilitation caseworker and proof that you are participating in a rehabilitation program..</i>
<i>Are you requesting temporary child care services due to a current family emergency/crisis?</i>		<i>Please attach a referral from a professional such as a doctor, a social service agency, a public health agency, etc. which documents your need for temporary services.</i>

Voucher Clients Only: Please check if applicable

This is my application for Redetermination and my Child Care Provider information has not changed. *(If changed, you must complete supplemental sheet.)*

**I certify under penalty of perjury that to the best of my knowledge the above information is true. I understand that this information may be provided to the central office of the Department of Health & Human Services for use in administration of this program. I authorize the agency to verify this information by whatever means necessary. I agree to notify the agency within 10 days of any change in income, family size, work or school schedule or employment status.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Preparer

\_\_\_\_\_  
Date

Comments:	Return to: CCDF Voucher Program DHHS/OCFS 2 Anthony Avenue, State House Station #11 Augusta, Maine 04333
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**CHILD CARE PROVIDER INFORMATION SHEET-THIS PAGE MUST BE RETURNED WITH YOUR APPLICATION FOR CHILD CARE SERVICES. OMISSION COULD RESULT IN DELAYS.**

*(To be completed by Voucher Applicants/Clients Only)*

Applicant Name: \_\_\_\_\_

Check One:    New Applicant       Redetermination       Change      Eff.

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

Reason: \_\_\_\_\_

Name of Child(ren) enrolled with this Provider: \_\_\_\_\_

<b>First Child Care Provider</b>			
If the Provider is not currently licensed or certified, the Department of Health & Human Services requires the following background checks: SBI, Child Protective and Motor Vehicle. These checks must be done prior to payments being issued for child care. This process may take up to six weeks.			
Name: _____		Phone: _____	
Address _____ <i>Street/RFD/PO Box</i>		EIN/SS#: _____	
_____		_____	
<i>Town/City</i>		<i>Zip</i>	
<b>Provider Rate per Child:</b>			
Full Time (30-50 hours)    \$	Part Time (20-29 hours)    \$	Half Time (1-19 hours)    \$	
<b>Check the Type of Child Care:</b> <i>(If you are unsure of what type of provider you have, ask the provider to assure accuracy.)</i>			
<input type="checkbox"/> Certified Family Child Care Home	<input type="checkbox"/> Legal Unregulated Child Care Provider (Care provided in your home)		
<input type="checkbox"/> Licensed Center	<input type="checkbox"/> Legal Unregulated Child Care Provider (Care provided in provider's home)		
<input type="checkbox"/> Legal Unregulated School Age Program	<input type="checkbox"/> Relative Care (Care provided in provider's home)	Relationship to Provider: _____	
	<input type="checkbox"/> Relative Care (Care provided in your home)	Relationship to Provider: _____	

Name of Child(ren) enrolled with this Provider: \_\_\_\_\_

<b>Second Child Care Provider (if applicable)</b>			
If the Provider is not currently licensed or certified, the Department of Human Services requires the following background checks: SBI, Child Protective and Motor Vehicle. These checks must be done prior to payments being issued for child care. This process may take up to six weeks.			
Name: _____		Phone: _____	
Address _____ <i>Street/RFD/PO Box</i>		EIN/SS#: _____	
_____		_____	
<i>Town/City</i>		<i>Zip</i>	
<b>Provider Rate per Child:</b>			
Full Time (30-50 hours)    \$	Part Time (20-29 hours)    \$	Half Time (1-19 hours)    \$	
<b>Check the Type of Child Care:</b> <i>(If you are unsure of what type of provider you have, ask the provider to assure accuracy.)</i>			
<input type="checkbox"/> Certified Family Child Care Home	<input type="checkbox"/> Legal Unregulated Child Care Provider (Care provided in your home)		
<input type="checkbox"/> Licensed Center	<input type="checkbox"/> Legal Unregulated Child Care Provider (Care provided in provider's home)		
<input type="checkbox"/> Legal Unregulated School Age Program	<input type="checkbox"/> Relative Care (Care provided in provider's home)	Relationship to Provider: _____	

	Relative Care (Care provided in your home) Relationship to Provider:
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