



APPLICATION FOR CHILD CARE ASSISTANCE

IMPORTANT NOTICE: If you need any of the following assistance, please ask. These services are free:
• Language Interpreter. (Nosotros proveemos los servicios de un interprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
• Help filling out this form.
• Accommodation for a disability.
INSTRUCTIONS: Read all questions and instructions carefully. The instructions include tips to help you fill out the application quickly and easily. Read the back side of each page for more information. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken \_\_\_\_\_ Written \_\_\_\_\_
Do you want an interpreter if you are interviewed? One will be provided at no cost to you. [ ] No [ ] Yes
¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted. [ ] No [ ] Sí

Tell Us Who You Are

Form with fields for: First Name, Middle Initial, Last Name, Date of Birth, Former Names, if any; Home Address, City, State, Zip Code, County; Mailing Address, City, State, Zip Code, County; Daytime Phone Number, If none, where can we leave a message?, E-Mail Address.

List all household members living in your home.

Four identical household member forms, each with fields for: Name (First, Middle, Last), Date of Birth, Social security #, Relationship to Self; Sex, Marital Status, Race, Hispanic or Latino? (Optional), U.S. Citizen? [ ] YES [ ] NO, Birth State (if born in US), Birth Country; Alien ID #.

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**CHILD CARE ASSISTANCE** is provided by the Idaho Child Care Program (ICCP) to help parents and caretakers pay part of the costs of child care while they are working, attending school or training, or participating with the Department's Enhanced Work Services contractor.

**TO APPLY** for Child Care Assistance, complete and sign an application and return it to the ICCP Consolidated Unit :

REGION IV MSC4355  
SELF RELIANCE  
IDAHO DEPARTMENT OF HEALTH AND WELFARE  
PO BOX 83720  
BOISE ID 83707-9815

Email: [ICCPUnit@dhw.idaho.gov](mailto:ICCPUnit@dhw.idaho.gov)

**You may need to provide the following proof:**

- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Child care costs.
- Immunization records for any children not yet in school. (If you do not immunize due to medical or religious reasons, please provide a written statement stating your reason.)
- Name of childcare provider.
- Current school schedule (if attending school) for parents/caretakers - this must include days and times in class.
- Child support paid for a child not living with you. Your child care benefit amount may increase if you provide this proof.

**To receive Child Care Assistance, you must meet the following program requirements:**

- If both parents are in the household, each parent must be working, attending school or training or participating with the Department's Enhanced Work Services contractor in order for the family to be approved for Child Care Assistance.
- You must be working, attending school/training, or participating with the Department's Enhanced Work Services contractor to receive Child Care Assistance.
- ICCP only covers a part of your child care costs while you are actually at work or attending school or training or participating in Enhanced Work Services. You must pay the remaining costs not covered by the Child Care program. ICCP will never pay 100% of your child care costs.
- ICCP will cover part of your child care costs only when care is provided by an ICCP registered child care provider.

**If you receive Child Care Assistance, you must report changes such as:**

- Change in income.
- Change in the number of hours your child is in care.
- Change in the amount of money you are charged for childcare.
- Change in child care provider.

If you have questions about applying for Child Care Assistance, please call 1-866-343-2027 or by emailing [ICCPUnit@dhw.idaho.gov](mailto:ICCPUnit@dhw.idaho.gov). For information on how a child care provider can become registered with ICCP please contact the Idaho CareLine by dialing 2-1-1 or 1-800-926-2588.

## Tell Us Who You Are (continued)

List all household members living in your home.

Name: (First) (Middle) (Last)				Date of Birth:	Social security #:	Relationship to Self:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:	Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO Alien ID #:	Birth State (if born in US):	Birth Country:

  

Name: (First) (Middle) (Last)				Date of Birth:	Social security #:	Relationship to Self:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:	Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO Alien ID #:	Birth State (if born in US):	Birth Country:

  

Name: (First) (Middle) (Last)				Date of Birth:	Social security #:	Relationship to Self:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:	Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO Alien ID #:	Birth State (if born in US):	Birth Country:

Do You Have Any Students In Your Home? List any household member age 16 or older who is a student or planning to attend school.

STUDENT NAME	WHERE ATTENDING SCHOOL	HOURS PER WEEK	EXPECTED GRADUATION DATE

If you have any children in your home, are they current on immunizations?

No  Yes

## Tell Us About Your Household Income

\* If you need to provide more information, please attach extra sheets

Please list all money received and/or expected by all household members. Include all income from wages, Social Security, Child Support, unemployment, tips, gifts or loans of cash, student financial aid, etc.

TYPE OF MONEY RECEIVED	WHO EARNED / RECEIVED MONEY	NAME OF EMPLOYER	HOW OFTEN PAID	\$ PER HOUR	HOURS PER WEEK	TOTAL MONTHLY AMOUNT
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually			

Is anyone in the household self-employed?  No  Yes

Who? \_\_\_\_\_

Name of business: \_\_\_\_\_

Years in business: \_\_\_\_\_

## **DO I HAVE TO BE A CITIZEN?**

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including Medicaid, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a green card, becoming a U.S. citizen, or sponsoring relatives in the future.

## **DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?**

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Medicaid only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSN's will not be given to the U.S. Citizen and Immigration Services.

## **IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?**

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS:

U.S. Department of Health & Human Services  
Room 506 F, 200 Independence Ave. SW  
Washington, D.C. 20201  
ocrcomplain@hhs.gov  
(202) 619.0403 (Voice)  
(202) 619.3257 (TTY)

HHS are equal opportunity providers and employers.

## Rights and Responsibilities

### By initialing the following provisions, I understand that . . .

\_\_\_\_\_ I could be sanctioned and required to return any benefits I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

\_\_\_\_\_ I consent to the gathering, use, and disclosure of my information by the Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

\_\_\_\_\_ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.

\_\_\_\_\_ I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

\_\_\_\_\_ My signature indicates I have received a copy of the Department Privacy Practices.

\_\_\_\_\_ My signature certifies that the citizenship / immigration status marked on page 1 is correct for each person applying.

Under penalty of perjury, I swear or affirm that the information I provide is true and complete.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date