

PLEASE PRINT IN ALL CAPITAL LETTERS

# APPLICATION FOR CHILD CARE SUBSIDY

☐ NEW  
☐ RECERTIFICATION  
☐ TRANSITIONAL CHILD CARE

nyc **ACS**  
NYC Administration for  
Children's Services

OFFICE USE ONLY	Case #:	Application Date: ____/____/____
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Section 1 APPLICANT	LAST Name (Please include any aliases or maiden names in parentheses):		FIRST Name:		M.I.:	
	ADDRESS Residence:		APT. #:	CITY/BOROUGH:	STATE:	ZIP CODE:
	ADDRESS Mailing (if different than above):		APT. #:	CITY/BOROUGH:	STATE:	ZIP CODE:
	TELEPHONE (Work): ( ) _____		TELEPHONE (Home): ( ) _____		TELEPHONE (Cell or Other): ( ) _____	
	Do you receive PA? <input type="checkbox"/> YES <input type="checkbox"/> NO PA #: _____		Do you receive Medicaid? <input type="checkbox"/> YES <input type="checkbox"/> NO MA #: _____		What is your primary language?	

Please fill out the information below for your entire household. List yourself first, followed by everyone who lives with you.

Section 2 FAMILY MEMBERS	LAST Name (PLEASE INCLUDE ANY ALIASES OR MAIDEN NAMES IN PARENTHESES)	FIRST Name	M.I.	RELATIONSHIP	DOES THIS PERSON NEED CHILD CARE? YES/NO	BOTH OF CHILD'S PARENTS RESIDE IN THE HOME? YES/NO	DATE OF BIRTH MM/DD/YY	SEX M/F	HISPANIC OR LATINO YES/NO	RACE (SEE LEGEND BELOW)	SOCIAL SECURITY NUMBER (OPTIONAL)
	1.			SELF							
	2.										
	3.										
	4.										
	5.										
	6.										
RACE: 1. Native American or Alaskan Native 2. Asian 3. African American/ Black 4. Native Hawaiian/Pacific Islander 5. Caucasian/ White											

For additional family members, please attach a separate sheet.

Include information for any spouse/other parent of the children applying for care who lives in the home.

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Family Size: ____

Section 3 EMPLOYMENT	APPLICANT'S EMPLOYER Name:		Hours per week:	Tel #: ( ) _____
	ADDRESS:	CITY/BOROUGH:	STATE:	ZIP CODE:
	APPLICANT'S Scheduled Days and Hours of Employment(i.e.: Mon – Fri, 9 a.m. – 5 p.m.):		Does Job have a Rotation Shift? <input type="checkbox"/> YES <input type="checkbox"/> NO Does Job Require O/T? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	SPOUSE/OTHER PARENT EMPLOYER Name:		Hours per week:	Tel #: ( ) _____
	ADDRESS:	CITY/BOROUGH:	STATE:	ZIP CODE:
	SPOUSE/OTHER PARENT Scheduled Days and Hours of Employment(i.e.: Mon – Fri, 9 a.m. – 5 p.m.):		Does Job have a Rotation Shift? <input type="checkbox"/> YES <input type="checkbox"/> NO Does Job Require O/T? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Section 4 CHILD/ FAMILY NEEDS	Are you requesting child care primarily so that you can work? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is the child for whom you are requesting care living with someone other than his/her mother or father? Does your child have any conditions that require special help or attention? Does your child have health insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If not, please read the instruction section titled "Child/Family Needs" and write your reason for care here: _____			<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

Please complete income information for yourself AND anyone applying with you. See instructions for documentation requirements.  
(This includes children in need of care, their parents, step-parent and any other children under the age of 18 in household.)

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Section 5 OTHER INCOME EARNINGS	ITEM	GROSS INCOME	TYPE OF DOCUMENTATION	OFFICE USE MONTHLY CALCULATIONS
	<b>APPLICANT:</b> Job earnings before deductions. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other	\$		
	<b>SPOUSE/OTHER PARENT:</b> Job earnings before deductions. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other			
	For all other income/ benefits please itemize below. Include the amount for yourself <b>AND</b> your spouse <b>AND</b> child(ren) who live with you.	INCOME	<b>FOR OFFICE USE ONLY</b> DOCUMENTATION CALCULATIONS	
	Alimony and/or child support. <b>(Received)</b> <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other			
	Unemployment and/or worker's compensation. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other			
	Net income from self-employment and/or rental income. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other			
	<b>BENEFITS:</b> Social Security, SSI, Disability, Retirement and/or Pensions & Annuities. <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> other			
	<b>OTHER INCOME/BENEFITS</b> (Check All That Apply): <input type="checkbox"/> Cash or monetary assistance through the Temporary Assistance to Needy Families (TANF) program or Public Assistance (PA). <input type="checkbox"/> Housing voucher or cash assistance. <input type="checkbox"/> Food stamps. <input type="checkbox"/> Other federal cash income programs (such as SSI).			
	<b>TOTAL INCOME:</b>	\$		

Section 6 PROVIDER	If your child is already in care, or you know the name of the program/provider where you plan to enroll your child, please list the provider name and address below. You may list a second choice.			
	Name: _____	<b>PROGRAM #</b>	Name: _____	<b>PROGRAM #</b>
	Address: _____		Address: _____	
Please check the types of care that you would consider if there are no available slots with the provider(s) you listed above or if you do not have a provider in mind: <input type="checkbox"/> Center Based Care <input type="checkbox"/> Head Start <input type="checkbox"/> Informal Care <input type="checkbox"/> Family Day Care				

Section 7 CITIZEN -SHIP	Is/are the child/children for whom you are applying a U.S. citizen(s)? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	
	If <b>Yes</b> , Parent/Guardian must sign and date to certify that the child/children in receipt of child care assistance/subsidy _____ / _____ / _____ is/are a U.S. citizen(s). <span style="float: right;">PARENT/CARETAKER/WIFE/HUSBAND DATE</span>	
	If <b>No</b> , your eligibility must be determined at the Resource Area (R.A.), please make an appointment at your R.A. and bring the documentation listed in the instructions for this form.	

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 and that the information will only be used for the purposes of determining child care eligibility. 2. The social security numbers (if provided) will not be released as they are confidential under federal law and can be released/used only for the purposes specified in federal law. 3. I agree to inform the agency immediately of any change in my income, living arrangement, household composition or address, where care is provided, who is providing child care, provider fees, hours for which child care is needed, and that New York State Law and Federal Law provides that any applicant may be investigated for fine or jail or both, for a person found guilty of obtaining child care assistance/subsidy by concealing information or providing false information.		4. I understand that this application is used only for the expressed purpose of child care subsidy. To obtain other assistance such as Food Stamps, Medicaid, Temporary Assistance, or other services, additional applications will be required. 5. I certify under the penalty of law that all the information I have supplied on this form is true and correct.
	<b>Please provide the signature of the parent/caretaker who is applying for child care assistance or the signature of an authorized representative.</b> X _____ / _____ / _____ <b>SIGNATURE PARENT/CARETAKER/WIFE/HUSBAND</b> <span style="float: right;">DATE</span>		X _____ / _____ / _____ <b>SIGNATURE AUTHORIZED REPRESENTATIVE</b> <span style="float: right;">DATE</span>
	PRINT NAME _____		PRINT NAME _____

Section 9 OFFICE ONLY	Enrollment <b>Application</b> Completed by: _____ / _____ / _____ <span style="float: right;">PRINT AND INITIAL DATE</span>		<b>Length of Eligibility:</b> from: _____ / _____ / _____ to: _____ / _____ / _____ <b>I.S. – Verified by:</b> _____ / _____ / _____ <span style="float: right;">PRINT AND INITIAL DATE</span> <b>CODES: ♦RFC: _____ ♦PR: _____ ♦FS: _____</b>
	ACS – <b>Eligibility</b> Approved by: _____ / _____ / _____ <span style="float: right;">PRINT AND INITIAL DATE</span>		
	Parent Fee: _____ / _____ / _____ <span style="float: right;">INITIAL DATE</span>		