CHILD CARE SUBSIDY PROGRAMS (CCSP)

CCSP Eligibility Letter
Waitlist Space Available

CUSTOMER SERVICE CONTACT CENTER PHONE NUMBER	CUSTOMER SERVICE CONTACT CENTER FAX NUMBER
CLIENT IDENTIFICATION NUMBER	DATE

☐ Seasonal Child Care

☐ Working Connections Child Care

Your name has been removed from the waitlist and you are now eligible for child care subsidy payment to an eligible provider.

You are eligible for child care with a monthly copayment beginning: _____ and ending _____.

Please contact us to confirm your continued need for child care subsidy and provide the following information so that we can authorize payment to your child care provider. If you do not contact us, we will be unable to authorize payments to your child care provider. WAC 110-15-2270

☐ Your child care schedule (the days and times you need child care).

☐ Your provider information (even if you supplied this with your application, you must confirm who your provider is).

You will receive a letter with more information when payment to your provider has been authorized.

Copayment

A copayment is your share of your child care cost and must be paid directly to your provider. Your copayment is based on your family size and your monthly income at the time you were placed on the waitlist. If your income has decreased, or your family size has increased, your copayment may be reduced.

☐ Your monthly copayment will be $15.00 from _____ to _____.

☐ Your monthly copayment will be $_____ from _____ to _____.

You must report within 10 days if your family monthly income exceeds $ or resources exceed $1,000,000.00. WAC 110-15-0031

1. Family size
2. Gross earned income (before taxes) $ _____
3. Self-employment income (after allowable deductions) $ _____
4. Unearned income equals (SSI, SSA, child support received, lump sum payments) $ _____
5. TOTAL INCOME (add lines 2 through 4 above) $ _____
6. Court ordered child support paid $ _____
7. Determine countable income (subtract line 6 from line 5) $ _____
   (Countable income is used to determine eligibility and copayment)
8. Co-payment is calculated as follows:

Countable Income	Monthly Copayment
At or below 82% of Federal Poverty Level (FPL)	$15
Above 82% and up to 137.5% of FPL	$65

Over 137.5% and up to 200% of FPL view: http://www.del.wa.gov/publications/subsidy/docs/WCCC_copays.pdf

Hearing Rights

If you disagree with this decision, you may request a hearing by contacting this office or write to Office of Administrative Hearings, P.O. Box 42489, Olympia, WA 98504-2489. You must request your hearing:

- On or before the effective date of this action or no more than 10 days after we send you notice of this action, IF you receive benefits now and you want them to continue, or
- Within 90 days of the date you receive this letter.
- At the hearing, you have the right to represent yourself, be represented by an attorney or by any other person you choose. You may be able to get free legal advice or representation by contacting an office of legal services.

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Reporting Changes

Call 1-877-501-2233 or Fax 1-888-338-7410
Online at: Washingtonconnection.org

Mail: DSHS Customer Service Contact Center
P.O. Box 11699
Tacoma WA 98411
Include your Client ID on each page you submit.