Washington State Department of Social & Health Services

Transforming lives

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

CHILD CARE SUBSIDY PROGRAMS (CCSP)

CCSP Application

Date: _____

_____

PARENT/GUARDIAN

_____

CASE NUMBER

FOLD

Dear Applicant:

We are sending this application because you requested Child Care Subsidies.

We will process your application and determine eligibility once you provide the following information:

- CCSP application (you must complete a child care application even if you are in a WorkFirst activity).
- Child care provider information (you must provide this information for us to authorize payments to your child care provider).
- Proof of the last three months of household income (such as pay stubs, child support, Social Security Income, Supplemental Security Income (SSI), and any other income received by someone in your family). Include your employment schedule. You don't need to provide proof of income for cash assistance from the state (TANF).
- If you are newly employed and have no pay stubs, we will accept a statement from your employer with a hire date, how much you are making (per hour, salary, etc.), and what your schedule will be. If your employer is unable to verify this information, we can take your verbal or written statement. You must provide us a copy of your wage stubs within 60 days WAC 170-290-0012.
- Proof of court or administrative ordered child support payments (if applicable) and verification of payments made.
- Working Connections Child Care **Only**: If care is provided by a Family / Friends / Neighbors provider, the provider must meet the qualifications listed on the Application Part 2B and you must submit:
  - Legible copy of the provider's picture identification, such as a driver's license, state identification card, passport, or military identification.
  - Legible copy of the provider's valid Social Security card.
  - Proof that the provider is legally able to work in the U.S., such as a Green Card, Resident Alien Card, or Employment Authorization Document (EAD).
  - Background Authorization form, DSHS 09-653. You may get this form from your WCCC authorizing worker. **No payment will be made for care provided prior to the date all background check results are received for all required persons.**

Report Changes

Call: 1-877-501-2233; Fax: 1-888-338-7410 (with your Client ID on each page); or www.washingtonconnection.org

Washington State Department of Social & Health Services

Transforming lives

CHILD CARE SUBSIDY PROGRAMS (CCSP)

CCSP Application

Part 1. Application Information

Incomplete information may delay approval for Services and payment. Type or print clearly.

☐ Seasonal Child Care

Applicants must:

- **Live in** Adams, Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, Skagit, Walla Walla, Whatcom or Yakima Counties;
- **Work in** a farm-based employment which includes cultivation, production, harvesting or processing of fruit trees or crops.

		DATE
APPLICANT'S NAME	CLIENT ID NUMBER	BIRTHDATE
APPLICANT'S ADDRESS	SSN (OPTIONAL)	TELEPHONE NUMBER
CITY STATE ZIP CODE	APPLICANT'S ETHNICITY RACE	APPLICANT'S GENDER ☐ Male ☐ Female

Is your family experiencing homelessness? ☐ Yes ☐ No (Examples include: living in a motel, shelter, transitional housing, car, public space, or doubled-up with others due to loss of housing or economic hardship.

CHILDREN FOR WHOM YOU ARE RESPONSIBLE LIVING IN THE HOUSEHOLD

NAME (LAST, FIRST, MIDDLE INITIAL)	BIRTHDATE	MALE/ FEMALE	ETHNICITY	SSN (OPTIONAL)	U.S. CITIZEN OR LEGAL RESIDENT	RELATIONSHIP TO APPLICANT
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

SPOUSE OR THE CHILD'S OTHER PARENT / GUARDIAN LIVING IN THE HOUSEHOLD (REQUIRED)

Are you married? ☐ Yes ☐ No

NAME	BIRTHDATE	SSN (OPTIONAL)	RELATIONSHIP TO APPLICANT	RELATIONSHIP TO ABOVE CHILDREN

APPLICANT	**SPOUSE OR SECOND PARENT/GUARDIAN**
NAME OF EMPLOYER, WORKFIRST ACTIVITY, OR SCHOOL	NAME OF EMPLOYER, WORKFIRST ACTIVITY, OR SCHOOL
ADDRESS (EMPLOYMENT, WORKFIRST ACTIVITY,OR SCHOOL)	ADDRESS (EMPLOYMENT, WORKFIRST ACTIVITY,OR SCHOOL)
TELEPHONE NUMBER DATE STARTED	TELEPHONE NUMBER DATE STARTED
IF YOU ARE EMPLOYED, HOW OFTEN ARE YOU PAID **AND** YOUR WAGE PER PAY PERIOD?	IF YOU ARE EMPLOYED, HOW OFTEN ARE YOU PAID **AND** YOUR WAGE PER PAY PERIOD?
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly $	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly $

MONTHLY SOURCES OF EARNED/UNEARNED INCOME FOR ALL FAMILY MEMBERS

Include copies (for the last three months):	NAME **SELF**	NAME	NAME	NAME
Employment (gross, before taxes, include tips)				
Self-employment				
Temporary Assistance to Needy Families (TANF)				
Child support received				
Social Security (SSI, SSA)				
VA, Disability, L&I, or Unemployment benefits				
Aged, Blind or Disabled (ABD benefits)				
Other (specify):				

Barcode label

14417

Do you pay court ordered child support? ☐ Yes ☐ No Monthly amount: $
Do you have a court order to receive child support? ☐ Yes ☐ No Monthly amount: $

AVAILABLE RESOURCES

Do you have available resources valued at $1,000,000.00 or more? ☐ Yes ☐ No
Examples of available resources are: cash, bank accounts, stocks / bonds, investment accounts, investment real estate.

PARENT / GUARDIAN'S ACTIVITY SCHEDULE

APPLICANT		SPOUSE OR SECOND PARENT/GUARDIAN
ACTIVITY (EMPLOYMENT, SCHOOL, WORFIRST ACTIVITY) INDICATE TIME WITH A.M./ P.M.		ACTIVITY (EMPLOYMENT, SCHOOL, WORFIRST ACTIVITY) INDICATE TIME WITH A.M./ P.M.
	WHAT IS YOUR SCHEDULE FOR EMPLOYMENT, SCHOOL, WORKFIRST ACTIVITY?	WHAT IS YOUR SCHEDULE FOR EMPLOYMENT, SCHOOL, WORKFIRST ACTIVITY?
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

What date will child care begin:
Applicant: If known, how long does it take you to travel from your provider to your activity (work, school, etc.)?

Other parent/guardian: If known, how long does it take you to travel from your provider to your activity (work, school, etc.)?

CHILDREN'S ACTIVITY SCHEDULE. FOR ADDITIONAL CHIDREN, ATTACH A SEPARATE PIECE OF PAPER WITH THEIR INFORMATION.

CHILDREN'S NAMES	SCHOOL SCHEDULE (EXACT DAYS AND TIMES)	CHILD CARE SCHEDULE (EXACT DAYS AND TIMES)

Will your school age children need care during school and summer breaks? ☐ Yes ☐ No

Do you have a child with Special Needs? ☐ Yes ☐ No
If yes, please contact the Authorizing Worker for information about special needs payment rates.

Voter Registration

The Department offers voter registration services as required by the National Voter Registration Act of 1993. **Applying to register or declining to register to vote will not affect the services or amount of benefits that you may be provided by this agency.** If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private. If you believe that someone has interfered with your right to register to vote, to decline to register to vote, your right to privacy in deciding whether or not to register, or your right to choose your own political party or other political preference, you may file a complaint with: Washington State Elections Office, PO Box 40229, Olympia WA 98504-0229 (1-800-448-4881).
Do you want to register to vote or update your voter registration? ☐ Yes ☐ No

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 98507-2489. 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.

I declare under penalty of perjury that the information given by me in this declaration is true, correct and complete to the best of my knowledge and realize that willful falsification of this information by me may subject me to penalties as provided in Washington State Law. (RCW 74.08.055)

FIRST PARENT/LEGAL GUARDIAN'S SIGNATURE	DATE	SECOND PARENT/LEGAL GUARDIAN'S SIGNATURE	DATE

Discrimination is prohibited in all programs and activities: No one shall be excluded on the basis of race, color, religion, creed, national origin, gender, age, marital status, disabled veteran or Vietnam-era veteran status, or handicap.

Washington State Department of Social & Health Services
Transforming lives

CHILD CARE SUBSIDY PROGRAMS (CCSP)

CCSP Application
Part 2A. Licensed Provider Information

(TO BE COMPLETED BY PARENT/GUARDIAN AND PROVIDER)

Type or print clearly. Incomplete information may delay approval for payment.

DATE	
CALL CENTER TELEPHONE NUMBER	
FAX NUMBER	

1. PROVIDER'S NAME AND ADDRESS

The provider's name and address given to us is public information and can be given to anyone who requests it.

PROVIDER'S NAME	PROVIDER NUMBER
PROVIDER'S ADDRESS	PROVIDER TELEPHONE NUMBER
CITY STATE ZIP CODE	EXPECTED START DATE FOR CARE
CLIENT IDENTIFICATION NUMBER	
PARENT/GUARDIAN'S NAME	

2. TYPE OF CARE: CHECK THE CORRECT BOX IDENTIFYING THE TYPE OF CARE YOU PROVIDE. PROVIDER COMPLETE SECTIONS 3 AND 4.

☐ Licensed Child Care Center	PROVIDER'S SSN OR FEDERAL TAX IDENTIFICATION NUMBER	☐ Licensed Family Home Child Care	PROVIDER'S SSN OR FEDERAL TAX IDENTIFICATION NUMBER

3. ENTER THE DAYS AND TIMES YOU WILL PROVIDE CARE FOR THE FOLLOWING CHILDREN (PLEASE USE SECTION FIVE FOR ADDITIONAL CHILDREN YOU CARE FOR)

NAMES	BIRTHDATE	DAYS AND TIMES CARE WILL BE PROVIDED, SPECIFY BEFORE AND AFTER SCHOOL TIMES

4. LICENSED PROVIDER: ENTER YOUR DAILY RATES

What are the usual rates you charge to parents / guardians?

This information must be provided before payment is authorized.

If you need assistance, call the Provider line at 1-800-394-4571 or email the Provider line at providerhelp@dshs.wa.gov.

INFANT (ZERO – 11 MONTHS) $	ENHANCED TODDLER (12 – 17 MONTHS) $	TODDLER (18 – 29 MONTHS) $	IF YES, AMOUNT: $_____ ☐ PER CHILD ☐ PER FAMILY
PRESCHOOL (30 MONTHS – FIVE YEARS NOT IN SCHOOL) $	SCHOOL AGE (FIVE – 12 YEARS) $	REGISTRATION FEE ☐ NONE ☐ ONE-TIME ☐ YEARLY ☐ FIELD TRIP FEE	$_____ PER MONTH RATE

Contact the Call Center for payment rates for children with special needs.

I understand completing this form does not guarantee payment. If child care is authorized, I agree to child care payment at my usual rate or the state rate, whichever is less.

PROVIDER'S SIGNATURE	DATE	TELEPHONE AND FAX NUMBER (INCLUDE AREA CODE)
☐ Director ☐ Owner ☐ Other		

Washington State Department of Social & Health Services
Transforming lives

WORKING CONNECTIONS CHILD CARE (WCCC)

WCCC Only Application

Part 2B. Family / Friends / Neighbors Provider Information

(TO BE COMPLETED BY PARENT/GUARDIAN AND PROVIDER)

Type or print clearly. Incomplete information may delay approval for payment.

	DATE
	CALL CENTER TELEPHONE NUMBER
	FAX NUMBER

SECTION 1. PROVIDER'S NAME AND ADDRESS

The provider's name and address given to us is public information and can be given to anyone who requests it.

	CLIENT IDENTIFICATION NUMBER
	PARENT/GUARDIAN'S NAME
PROVIDER'S NAME	PROVIDER NUMBER
PROVIDER'S ADDRESS (IF CARE IS IN PROVIDER HOME, PROVIDE PHYSICAL ADDRESS, NOT MAILING ADDRESS)	PROVIDER TELEPHONE NUMBER
CITY STATE ZIP CODE	EXPECTED START DATE FOR CARE

SECTION 2. TO BE COMPLETED BY PARENT APPLYING FOR CHILD CARE

1. Is the provider your child (natural, step, adopted, or foster) aged 18 through 20 years old. ☐ Yes ☐ No
2. Is the provider your parent (natural, step, adopted, or foster). ☐ Yes ☐ No

   If yes to #2, please check the box below that applies to you.

   Are you: ☐ Widowed. ☐ Divorced. ☐ Married, separated, or never married.

   ☐ Living with my disabled spouse who is unable to care for my child for at least four continuous weeks in a calendar quarter.
3. ☐ Neither 1 or 2 apply.

SECTION 3. TO BE COMPLETED BY FAMILY / FRIENDS / NEIGHBORS PROVIDER

PROVIDER'S SSN	RELATIONSHIP TO CHILD	PROVIDER'S EMAIL ADDRESS
PROVIDER OVER 18? ☐ Yes ☐ No	BIRTH DATE	US CITIZEN OR A RESIDENT LEGALLY ABLE TO WORK IN THE U.S.? ☐ Yes ☐ No

You must:

Provide care only in the children's home. Care may be in the provider's home if he/she is one of the following relatives to the children: aunt, uncle, grandparent, sibling living outside of the home, great aunt, great uncle, or great grandparent.

Do you live with the child you are providing care for? ☐ Yes ☐ No	☐ Care will be done in the children's home. Go to Section 5. ☐ Care will be done in the provider's home. Complete Section 4.

SECTION 4. PROVIDER COMPLETES IF THE CHILD CARE OCCURS IN PROVIDER'S HOME AND THE CHILD DOES NOT LIVE THERE

When care occurs in your home and the child does not live there, provide the department with the names, birth dates, and sex offender status of all persons, 16 years of age or older, who live with you:

NAME	BIRTH DATE	REGISTERED SEX OFFENDER	
1.		☐ Yes ☐ No	**Failure to report a sex offender in the provider's home where care is provided will result in permanent disqualification of the provider. WAC 170-290-0160**
2.		☐ Yes ☐ No	
3.		☐ Yes ☐ No	
4.		☐ Yes ☐ No	

I certify the persons listed above are the only individuals, 16 years of age or older, who reside with me. I understand these individuals will be subject to the same background inquiry process as me. I also understand if another person, 16 years of age or older, moves into my home while I am an authorized provider for WCCC, I must immediately notify the parent.

PROVIDER'S SIGNATURE	DATE

SECTION 5. TO BE COMPLETED BY FAMILY / FRIENDS / NEIGHBORS PROVIDER

Family / Friends / Neighbors providers can bill the state for no more than six (6) children at the same time.

ENTER DAYS, TIMES, AND AT WHAT RATES YOU WILL PROVIDE CARE FOR THE CHILD(REN).

CHILD'S FIRST AND LAST NAME	BIRTHDATE	DAYS AND TIMES CARE WILL BE PROVIDED, SPECIFY BEFORE AND AFTER SCHOOL TIMES

My usual hourly rate per child is: $. I understand that I will be paid my rate or the state rate, whichever is less.

CONTACT THE CALL CENTER FOR PAYMENT RATES FOR CHILDREN WITH SPECIAL NEEDS.

SECTION 6. TO BE READ AND SIGNED BY THE PROVIDER

Provider Responsibilities:

- Complete a background check authorization. If you care for a child in your own home, also submit a completed background authorization for anyone 16 years of age or older who lives with you or moves into your home.
- Report to DSHS within 24 hours any criminal convictions or pending charges against you or anyone 16 years or older in hour home if care is provided in your home.
- Report to DSHS within 10 days if you change your legal name, address, or telephone number.

Provider Eligibility:

- Be 18 years of age or older and a citizen or legal resident of the United States.
- Provide care only in the children's home. Care may be provided in the provider's home only if he/she is one of the following relatives to the children; aunt, uncle, grandparent, sibling living outside the home, or a great aunt, great uncle or great grandparent.
- Not have a disqualifying criminal background under WAC 170-290-0160 or WAC 170-290-0165.
- Be physically and mentally healthy enough to meet all the needs of the child in care. If staff ask for it, the parent(s) must provide written proof you are physically and mentally healthy enough to be a safe child care provider.
- Be able to care for the child without using physical punishment or mental abuse.
- Provide care to the child in a safe home.
- Be informed about basic health practices, prevention and control of infectious disease, and immunizations.
- Provide constant care, supervision, and activities based on the developmental needs of the child.
- Immediately report, to the parent, any notice of criminal convictions or pending charges against yourself or of anyone in the household, 16 years of age or older, when care occurs outside the child's home.
- Not be the child's biological, step or adoptive parent, legal guardian, adult acting in loco parentis, or the spouse of any of these individuals.

Attendance Records:

- Records must:
  - Show both days and times you cared for each child
  - Have the parent/guardian sign and date the attendance records at least weekly
  - Be kept for five (5) years
  - Be provided within 14 days if DSHS or DEL asks to see them

Billing:

- You will not be paid for child care provided prior to the date all background check results are cleared by DSHS. If you provide care before your background check clears, the family is responsible for paying you.
- You may bill DSHS for no more than six (6) children during the same hours of care.
- Review daily attendance records in order to determine the number of units to bill based on a child's attendance and authorization.

SECTION 6. CONTINUED

Service Employees International Union Local 925 (SEIU 925)

SEIU 925 represents Family/Friends/Neighbor providers. The Collective Bargaining Agreement outlines the provisions and benefits for SEIU 925 members. Members pay dues of 2 percent of the child services paid by the state. Dues are capped at a maximum of $50 per month.

Additional information is available in: *A Guide for Family, Friends and Neighbors Child Care Providers* located at: http://www.del.wa.gov/requirements/info/subsidy.aspx

I understand completing this form **does not guarantee payment**. If child care is authorized, I agree to child care payment at my usual rate or the State rate, **whichever is less**. I understand that payment cannot occur prior to the date the department receives all background check results. I have read and understand Section 6 of this form.

I declare under penalty of perjury the information given by me in this declaration is true, correct and complete to the best of my knowledge and realize willful falsification of this information by me may subject me to penalties as provided in Washington State Law. (RCW 74.08.055)

PROVIDER'S SIGNATURE	DATE	☐ Non-relative caretaker ☐ Relative caretaker

SECTION 7. TO BE READ AND SIGNED BY THE PARENT

I, as the parent/guardian, certify my Family / Friends / Neighbors provider meets the requirements listed above. I understand:

- If I cannot make these assurances, payment will not be authorized.
- Certain background information may disqualify my provider. It is my provider's responsibility to immediately tell me if they, or any person, 16 years of age or older living with the provider, when care occurs outside of the child's home are charged or convicted of any crime. I am then responsible to immediately tell my WCCC authorizing worker.
- No payment will be made for care provided prior to the date all background check results are received.
- I must notify CCSP staff, within five days, if this provider stops child care.
- My provider will not be paid for the care of more than six children at the same time (same hours and days).
- I may not have more than three Family/Friends/Neighbors providers authorized for WCCC payment at the same time during my eligibility period. Only one of these three providers can be a back-up (alternate) provider. I may use a licensed/certified provider for back-up care.
- As the employer of your Family/Friends/Neighbors provider, it is your responsibility to have your provider complete the USCIS Employment Eligibility Verification Form I-9.
  - All U.S. employers must complete and retain a Form I-9 for each individual they hire for employment in the United States.
  - This includes citizens and noncitizens.
  - On the form, the employer must examine the employment eligibility and identity document(s) an employee presents to determine whether the document(s) reasonably appear to be genuine and relate to the individual and record the document information on the Form I-9.
  - The list of acceptable documents can be found on the last page of the form. *The form and instructions can be found at:* ***http://www.uscis.gov/i-9***
- If the living situation changes between you and the provider please report this immediately (this type of change can impact what tax document will be sent to the providers for their service).

I declare under penalty of perjury the information given by me in this declaration is true, correct and complete to the best of my knowledge and realize willful falsification of this information by me may subject me to penalties as provided in Washington State Law. (RCW 74.08.055)

PARENT/GUARDIAN'S SIGNATURE	DATE