



# Minnesota Child Care Assistance Program Application

This is the Minnesota Child Care Assistance Program (CCAP) Application. You may be eligible to get help for your child care expenses so you can work, look for work, or attend school.

## To qualify, your family must:

- be income eligible;
- meet employment and training requirements:
  - work at least an average of 20 hours per week (10 hours per week if a full-time student) at minimum wage, *or*
  - participate in job search, attend school or training classes, *or*
  - comply with the activities of an approved Minnesota Family Investment Program (MFIP)/ Diversionary Work Program (DWP) employment plan;
- cooperate with child support enforcement for all children in the family; and
- use a legal child care provider. (Legal providers include licensed and unlicensed providers, 18 years of age or older, who are registered with a county to provide care.

LR #2 (12-05)

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم

1-800-358-0377

កំណត់សំគាល់ បើអ្នកចង់បានព័ត៌មានបំប្រែភាសានេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរសព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, mug koj tus neeg lis dej mun (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນັກງານຊ່ວຍວຽກ ຂອງທ່ານ ຫຼື ໂທຫາ ຕາມເລກໂທ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoona kun sii hiikamu gargaarsa tolaa feeta ta'e. hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda machuumaadkani oo lacag la'naan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

This information is available in other forms to people with disabilities by calling your county worker. For TDD/TTY users, contact your county worker through the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

## Read these instructions before you fill out the application.

We have included the Child Care Assistance Program booklet Do you need help paying for child care? (DHS-3551) to give you information about the Child Care Assistance Program and choosing a child care provider.

**Please follow these instructions as you complete your application.**

- Print your answers using black ink.
- Read all instructions carefully and answer all questions completely.
- Attach additional sheets of paper if you need more space.
- Include proof of all requested information.
- Carefully read the "Your rights", "Your responsibilities" and "Penalty Warning" sections of this form (These sections are a tear-off page for you to keep).
- Sign and date the application.
- Mail, fax or bring the completed application and all other needed items to the address listed on the front of the application.
- **If you have questions about completing this application or have problems getting the information you need, please call the number listed on the front of the application.**

A child care worker will write or call you if we need more information.

Once we receive all information you will receive a written notice about your eligibility.

### 1. Applicant

**Tell us about you and where you live.**

- Include *proof of your identity*, such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate.
- Include *proof of your residence*, such as one of the items listed above or a copy of a recent utility bill, rental lease, or mortgage document.

LAST NAME		FIRST NAME		MIDDLE NAME	
OTHER NAMES YOU MIGHT BE KNOWN AS					
ADDRESS		CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (if different)			CITY	STATE	ZIP CODE
HOME PHONE		WORK PHONE		OTHER PHONE	
Preferred language spoken?		Preferred written language?		Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single					
Have you ever received or requested Child Care Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, when?		Where? (MN City)		(MN County)	

#### Child care assistance staff only:

Case number _____	CCAP worker name _____
MAXIS number _____	MFIP worker name _____
MFIP begin date _____	MFIP end date _____
ESP agency _____	ESP worker name _____

## 2. Family Members

### A. Tell us about your family members.

- Include family members, both adult and children, who currently live with you, and those who do not live with you, but are expected to return to your home.

#### Adults:

- Include your spouse or the parents of children in your family who live with you.
- Include proof of identity for each adult in your family, such as a copy of a driver's license, state identification card, passport, school identification card, or birth certificate.
- Include proof of residence for each adult in your family, such as one of the items listed above or a copy of a recent utility bill, rental lease or mortgage document.

#### Children:

- List all children under the age of 18 who live with you. List children in order from oldest to youngest.
- Include children 18 or older who live with you if they are full-time students and you provide 50% or more of their financial support.
- Include proof of each child's relationship to you, such as a birth certificate, adoption record, legal guardianship statement or baptismal record.
- Include proof of each child's age, such as one of the items listed above or a school or immunization record.

Name (Last, first, middle)	Date of birth	Sex		Social Security Number	Is each person listed Hispanic or Latino?		Circle each person's race* ( <i>you can circle more than one</i> )	Relationship to you
		F	M		Yes	No		
		Note: You do not have to answer these questions						
Yourself							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	
							N A B P W	

\* List all that apply: N = American Indian or Alaska Native      P = Pacific Islander or Native Hawaiian  
 A = Asian      W = White  
 B = Black or African American

## 2. Family Members (Cont.d)

**B. List all children in your family who have a parent who does not live in your home.** If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements.

Child's name	Name of parent not living in your home	Shared custody?		Shared custody schedule	Do you receive child support?	
		Yes	No		Yes	No

## 3. Request for Child Care Assistance

Complete the sections that apply to **adult members** of your family.

**A. List all *adult* family members who need help with child care costs to be able to work.**

- Include proof of all work schedules, such as a time card or a letter from employer.

*If the work schedule varies, please provide this information for the past two months.*

Adult's name	Employer's Name	What days and times does this adult work?

**B. List all *adult* family members who need help with child care costs to be able to attend school or training classes.**

- Include family members participating in GED or ESL classes.
- Include proof of school schedules that shows the days and times classes meet.

Adult's name	Name of school or training site	Start date if not already attending	What days and times does this adult attend school or training?	When will this school program be completed?

**C. List all *adult* family members who need help with child care costs to be able to look for work.**

Adult's name

### 3. Request for Child Care Assistance (Cont.d)

**D. List all *adult* family members who need help with child care costs to be able to attend MFIP orientations or other MFIP/DWP activities in an approved employment plan.**

Adult's name	Does this adult have a Job Counselor?		Job Counselor's name	Job Counselor's telephone number
	Yes	No		

### 4. Income

List all income received by you and all members of your family.

- Include income received by family members temporarily absent from your home.
- Report self-employment income in question 4. B. *Self-Employment Income*.
- Include proof of all income, such as a check stub, income tax records, or a signed letter from the employer.

#### A. Earned income (Wages)

Name	Employer's name	Hourly wage	Hours worked per week	How often are you paid?	Total amount paid before deductions*
				<input type="checkbox"/> Weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Other	
				<input type="checkbox"/> Weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Other	
				<input type="checkbox"/> Weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Other	
				<input type="checkbox"/> Weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Other	

\*Include wages, tips, commissions, bonuses, and all other types of income

#### B. Self-Employment income

Complete this section if you or someone in your family is **self-employed**.

Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property.

Include proof of:

- all self-employment income and expenses, such as federal tax returns or business ledgers.
- work schedule, such as a calendar with work hours.

Name	Type of business	Start date	Hours worked per week	Monthly income before deductions	Monthly expenses

Do you expect any changes in work hours, income or expenses for any of the self-employment activities described above?  Yes     No

If yes, please describe in detail: \_\_\_\_\_

**4. Income (Cont.d)**

**C. Unearned income**

Complete this section for each type of **unearned income** you or someone in your family receives.

- Include proof of all unearned income, such as a check stub, an award letter, a financial aid form, or a written statement from the source of the income.

Type	Yes	No	Name of person receiving income	How often received	Amount
Public assistance (MFIP, DWP, GA, Tribal TANF)					
Relative custody assistance					
Child support/Spousal support					
Worker's Compensation					
Unemployment Insurance					
Insurance benefits					
RSDI (Retirement, survivors, disability insurance)					
Student grants or scholarships					
Post-secondary child care grant award					
Student loans					
Stipends					
Interest/dividends					
Tribal payments					
Other child care assistance					
Other (lottery or gambling winnings, inheritance, insurance disbursements)			Type:		
			Type:		
			Type:		
			Type:		

### 5. Deductions

Complete this section if you or someone in your family has any of the **expenses listed for which you are not reimbursed.**

- These expenses may be deducted from your gross income in determining your monthly co-payment.
- Include proof of deductions, such as check stubs, benefit statements, premium statements or award letters.

Expense	Amount	How often do you pay?
Medical insurance premiums		
Dental insurance premiums		
Vision insurance premiums		
Court ordered child support for a child not living in the home		
Court ordered spousal support		
Tuition, fees, books and educational supplies*		

*\*Only include these if student receives scholarships, grants, student loans or work-study income.*

### 6. Student information

Complete this section for all children in your family (kindergarten and older) who are **now in school or plan to go to school within the next six months.**

- Include children 18 or older who live with you if they are full-time students and you provide 50% or more of their financial support.
- Post-secondary students must include proof of their school schedule, such as a fee statement, transcript, or registration confirmation; and the expected completion date of their program.

Student name	School name	Start date if not currently attending	Days and times student attends school	Grade ( <i>half or full day if kindergarten</i> )

## 7. Child care needs

List all children who are attending or are in need of child care.

- Child care assistance is available for children under age 13 and for children with disabilities under age 15.
- Complete the provider questions if you currently use or have chosen a child care provider for your child.
- Call the number on the front of the application if your child has special needs and requires specialized care.
- Include proof of citizenship or immigration status for each child in need of child care assistance, such as a birth certificate, an adoption record or an INS card.

*Proof of citizenship or immigration status will not be used for immigration purposes.*

CHILD'S NAME		Is child a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS AND DAYS CHILD CARE IS NEEDED:			
CHILD CARE PROVIDER'S NAME		PROVIDER'S TELEPHONE NUMBER	START DATE:
PROVIDER'S ADDRESS			
Is provider related to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, relationship:			
Where is care provided? <input type="checkbox"/> Provider's home <input type="checkbox"/> Child care center <input type="checkbox"/> Child's home			

CHILD'S NAME		Is child a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS AND DAYS CHILD CARE IS NEEDED:			
CHILD CARE PROVIDER'S NAME		PROVIDER'S TELEPHONE NUMBER	START DATE:
PROVIDER'S ADDRESS			
Is provider related to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, relationship:			
Where is care provided? <input type="checkbox"/> Provider's home <input type="checkbox"/> Child care center <input type="checkbox"/> Child's home			

CHILD'S NAME		Is child a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS AND DAYS CHILD CARE IS NEEDED:			
CHILD CARE PROVIDER'S NAME		PROVIDER'S TELEPHONE NUMBER	START DATE:
PROVIDER'S ADDRESS			
Is provider related to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, relationship:			
Where is care provided? <input type="checkbox"/> Provider's home <input type="checkbox"/> Child care center <input type="checkbox"/> Child's home			

### 7. Child care needs (Cont.d)

CHILD'S NAME		Is child a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS AND DAYS CHILD CARE IS NEEDED:			
CHILD CARE PROVIDER'S NAME		PROVIDER'S TELEPHONE NUMBER	START DATE:
PROVIDER'S ADDRESS			
Is provider related to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, relationship:			
Where is care provided? <input type="checkbox"/> Provider's home <input type="checkbox"/> Child care center <input type="checkbox"/> Child's home			

CHILD'S NAME		Is child a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS AND DAYS CHILD CARE IS NEEDED:			
CHILD CARE PROVIDER'S NAME		PROVIDER'S TELEPHONE NUMBER	START DATE:
PROVIDER'S ADDRESS			
Is provider related to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, relationship:			
Where is care provided? <input type="checkbox"/> Provider's home <input type="checkbox"/> Child care center <input type="checkbox"/> Child's home			

CHILD'S NAME		Is child a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS AND DAYS CHILD CARE IS NEEDED:			
CHILD CARE PROVIDER'S NAME		PROVIDER'S TELEPHONE NUMBER	START DATE:
PROVIDER'S ADDRESS			
Is provider related to the child? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, relationship:			
Where is care provided? <input type="checkbox"/> Provider's home <input type="checkbox"/> Child care center <input type="checkbox"/> Child's home			

### 8. Family services

<p><b>The state and federal governments require the Child Care Assistance Program to report data on families who receive child care assistance. This information <i>will not affect</i> your eligibility for child care assistance.</b></p>	
1. Do you receive a housing or section 8 subsidy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you receive food support (other than MFIP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do any children in your household attend Head Start?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does your family attend Early Childhood Family Education (ECFE) classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does any member of your family participate in the School Readiness Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Important! Please read and sign this application.**

**Fraud Investigation Release.** I give third parties permission to share information about me with authorized state and county staff conducting investigations regarding fraud, fraud prevention and misrepresentation. Third parties include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission for release is effective for six months after my benefits stop.

**Provider Release.** State and federal privacy laws protect my information. If I am eligible for child care assistance, CCAP staff can share information about the hours and amount of child care assistance I get with my child care provider(s). I understand:

- This information must be shared so that my child care provider knows how much CCAP will pay for the child care provided.
- This information can be shared only if I give my written permission or if the law allows it.
- I can refuse to sign or cancel this release, but if I do, CCAP may not be able to pay my provider for the child care provided.
- I may cancel this authorization with written notice anytime. This written notice will not affect information already released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it. Minnesota Data Privacy Act (Minn. Stat., Ch. 13).

**If I get Child Care Assistance I understand:**

- I must cooperate with child support enforcement and assign my child care support portion to the Minnesota Department of Human Services. I have the right to claim "good cause" for not cooperating with child support enforcement.
- I may be required to pay a co-payment fee.
- If my child care provider charges more than the maximum rate paid in my county, I will pay the additional costs, as well as my co-payment fee.
- I must report all changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment, school and training schedules, marital status, income, address or residence, or anyone moving in or out of my household.
- I must give the county agency and my child care provider 15 calendar days' notice before changing my child care provider(s). This notice is not needed in cases of alleged abuse by a provider or when the health and safety of a child in care is in immediate danger.
- My eligibility for Child Care Assistance must be redetermined at least every six (6) months.
- I have the right to choose any legal child care provider, including licensed child care centers, licensed family child care providers and legally unlicensed family child care providers that meet program requirements.
- If I choose a provider to provide child care in my home, I am considered the employer of the provider and have legal and tax responsibilities.

**By signing below:**

- I acknowledge that my worker gave me a copy of my Notice of Privacy Practices (DHS-3979) and the "Your rights", "Your responsibilities" and "Penalty warning" sections of this form and explained them to me.
- I agree to assign my child support as stated above.
- I agree to the sharing of information as stated on the provider and fraud release information above.
- I declare that I have examined this application and, to the best of my knowledge and belief, it is a true and correct statement of every material point.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	AGENCY SIGNATURE	DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE	<input type="checkbox"/> Client given <input type="checkbox"/> R&R <input type="checkbox"/> Notice of Privacy Practices (DHS-3979) <input type="checkbox"/> ADA brochure (DHS-4133)	

(Tear off here)

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## Your Responsibilities

- **You may be required to pay a co-payment fee.** If you do not pay the fee, your Child Care Assistance will be terminated until fees are paid in full or satisfactory payment agreements have been made with the county and your child care provider. Your Child Care Assistance worker will tell you whether to pay this fee to your child care provider or to the county agency.
- **You may be required to pay additional costs** when your child care provider charges a rate that is more than the maximum rate in your county.
- **You must document** the immigration or citizenship status of the children in your family for whom you are applying for child care assistance.
- **You must cooperate with child support enforcement** for all children in your household. You must assign the child care portion of your child support to the State of Minnesota for all children receiving Child Care Assistance. If you do not cooperate or assign your child care support, Child Care Assistance will be denied or terminated. You have the right to claim "good cause" for not cooperating with child support enforcement. Ask your child care worker to help you.
- **You must report the following changes** for each family member to your Child Care Assistance worker within 10 calendar days.

Failure to report these changes within 10 days may result in an overpayment, termination of your Child Care Assistance, a fraud investigation and/or possible criminal charges.

- Employment status
- Names of family members who move in or out of your household
- Marriages, separations, divorces

- Income, wage or salary increases and receipt or changes in child support, social security, MFIP, GA, unemployment insurance, insurance benefits and other cash payments
- Child support paid by you to someone who does not live with you
- Address or residence
- Health and dental insurance premiums
- Work, school or job search hours
- Child custody arrangements

*Note: If you receive other types of assistance from your local county agency and your Child Care Assistance worker is not your worker for these programs, report changes to your Child Care Assistance worker to avoid possible overpayment.*

You must sign the application to acknowledge that you have read and understand your rights and responsibilities under the CCAP. Please keep these pages for your records.

## Penalty Warning

If you get child care assistance benefits, you must follow these rules. Do not give false information or hide information:

- to get or continue to get child care assistance benefits
- to help someone else to get or to continue to get child care assistance payments.

The state may bar a family with a member who breaks either of these rules from the Child Care Assistance Program. The bar lasts three months for the first fraud, six months for the second fraud, two years for the third fraud and is permanent for the fourth fraud. The maximum penalty is a fine of \$100,000 or a jail term of 20 years, or both.

## Your Rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet. This sheet explains:
  - Why we are asking you to give us your private information
  - How we may use and share private information about you
  - Why we ask for your Social Security number
  - Your rights about your private information. You can:
    - Ask about how we can use information and with whom we will share this information
    - Ask to get this information in another format
    - Ask to see your information
    - Ask whom we have given your information to
    - File a privacy complaint.
  - How we must legally protect your private information
  - Whom you can contact if you think your private information has been mishandled.Please read it carefully. For more information about your data privacy rights or a copy of the Notice of Privacy Practices, ask your worker. You can also get a copy of this notice at <http://edocs.dhs.state.mn.us/lfservlet/Legacy/DHS-3979-ENG>.
- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application within 30 days.**
- **You have the right to know the rules of the program you are applying for** and for us to tell you how we figured your benefits.
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. You may appeal within 30 days from the date you receive the notice by writing

to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your child care within 30 days, the agency can accept your appeal for up to 90 days from the date you receive the notice.)

*If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.*

- **Access to free legal services.** You may contact your worker for information on free legal services.
- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of a public assistance application or payment because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability (including access to buildings or programs), you may file a complaint with one or more of these agencies:

### *State agencies*

Minnesota Department of Human Services  
Office for Equal Opportunity  
PO Box 64997  
St. Paul, MN 55164-0997  
(651) 431-3040 (Voice)  
(651) 431-3041 (TTY/TDD)

Minnesota Department of Human Rights  
190 East 5th Street, Suite 700  
St. Paul, MN 55101  
(800) 657-3704 (Voice)  
(651) 296-1283 (TTY/TDD)

### *Federal agencies*

U.S. Department of Health and Human Services  
Office for Civil Rights, Region V  
233 North Michigan Avenue, Suite 240  
Chicago, IL 60601  
(312) 886-2359 (Voice)  
(312) 353-5693 (TTY/TDD)

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*(Tear off here)*