



School Plus Scholarship Application

2011-2012 School Year

In an effort to allow the current assistance program to work at its full potential all scholarship recipients will be required to provide a state assistance award or denial letter from the Missouri Department of Social Services: Family Support Division

Please complete the attached Child Care Application/Eligibility Statement and return it to

Family Services Division
601 Commercial Street
Joplin, MO 64804
417-629-3050 ext. 1

With a denial letter your scholarship will then be processed since you have completed step one and a scholarship can be awarded according to your income and dependents. Your weekly fee will then be reduced by the percentage of your scholarship and you will receive confirmation through either a phone call or letter.

Note: if a child is already receiving state or tribe assistance through a 3rd party, the maximum possible scholarship will be 25%.

Requirements for Scholarship Applicants:

- JFY Child Care Financial Aid Applications
- CDBG Survey MUST Be completed
- 2 forms of income verification-one MUST be a 2010 tax return
- State aid denial letter

All other forms in your scholarship application should be turned in fully completed to the front desk at either facility. Please allow up to 2 weeks for scholarship approval after all necessary documents have been received. Scholarship applications will not be accepted without all required documents.

For additional information, please contact Chance Nigh, School Plus Program Director, at 417-623-4597, cnigh@joplinfamilyy.org

JFY Childcare Financial Aid Application

What program is participant applying for? School Plus & Activity Days

Parent/Guardian Name (first, last) _____ Phone # _____

Address _____ City/State _____ Zip _____

School children/child attends _____ Is child a current member of the Joplin Family Y? _____

List all children that you are applying assistance for this program.

Participants' Name(s)	Grade	Date of birth	Age
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	

How many persons are currently living in your household? _____

IF YOUR CHILD/CHILDREN ARE ABLE TO RECEIVE STATE ASSISTANCE FOR CHILDCARE YOU MAY STOP NOW AND GO TO THE LAST PAGE OF THIS PACKET AND FILL IT OUT COMPLETELY. THE LAST PAGE OF THIS PACKET IS TO BE RETURNED TO THE MISSOURI DEPARTMENT OF SOCIAL SERVICES: FAMILY SUPPORT DIVISION at 601 Commercial Street/Joplin/MO/64801.

INCOME

YOU MUST INCLUDE 2 FORMS OF VERIFICATION: ONE OF THESE FORMS MUST BE A TAX RETURN FROM THE PREVIOUS TAX YEAR (2009)

You must list everyone who is employed.

1. Name of employed person _____ Relationship to child? _____

Please name employer _____ How much are you paid before taxes\$ _____

_____ weekly _____ every 2 weeks _____ twice monthly _____ monthly

2. Name of employed person _____ Relationship to child? _____

Please name employer _____ How much are you paid before taxes \$ _____

_____ weekly _____ every 2 weeks _____ twice monthly _____ monthly

IF ANYONE IN THE HOUSEHOLD IS CURRENTLY UNEMPLOYED AND AT HOME PLEASE REASONS CHILDCARE IS NEEDED.

Does anyone in your household receive other income, such as child support, alimony, unemployment, social security benefits, food stamps or other?

Person receiving	Who provides the money?	Amount received	How often?

If there are other circumstances you would like us to consider, please list them here _____

THE INFORMATION I HAVE PROVIDED ON THIS FORM IS CORRECT AND I AGREE TO PROVIDE ADDITIONAL INFORMATION IF NEEDED.

Printed Name _____ Signature _____ Date _____

Person filling out form

Person filling out form

***** Office use only *****

Aid approved for _____ notification made _____ date completed _____

**Community Development Block Grant Program
Program Eligibility Form
2010
(To Be Completed By Participant)**

INSTRUCTIONS: _____ (insert name of organization)
is participated in a federal program which is required to meet certain eligibility standards. Completion of this form is voluntary and the information is kept confidential, with access only to the grantee, administrating staff of the City of Joplin, and officials of the US Department of Housing and Urban Development.

1. **FAMILY SIZE:** _____ person(s)
Family Size: give the number of persons in your family living with you in your household including husband, wife, and all dependents, as defined by the Internal Revenue Service (IRS) for income tax purposes.
2. **FAMILY INCOME:** \$ _____ .00
Family Income: give the total annual income from all family members, as determined on today's date; in IRS terms, this would be adjusted gross income.
3. **ELDERLY:** _____ person(s)
Elderly: how many persons in your family are 62 years of age and over?
4. **HANDICAPPED:** _____ person(s)
Handicapped: how many persons in your family have a physical or mental impairment that substantially limits one or more of the individual's major life activities.
5. **ETHNICITY (Check one box only):** Hispanic or Latino Not Hispanic or Latino
6. **HEAD OF HOUSEHOLD:** Male Female
7. **RACIAL DESIGNATION** :(select one or more) for each household, enter the number by race.
 - White.** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
 - Black/African American.** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
 - Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
 - American Indian/Alaskan Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains affiliation or community attachment.

- Native Hawaiian/Other Pacific Islander.** A person having origins in any of the original people of Hawaii, Guam, Samoa or other Pacific Islands.
- American Indian/Alaskan Native & White.** A person having these multiple race heritages as defined above.
- Asian & White.** A person having these multiple race heritages as defined above.
- Black/African American & White.** A person having these multiple race heritages as defined above.
- American Indian/Alaskan Native & Black/African American.** A person having these multiple race heritages as defined above.
- Other Multi-Racial.** For reporting individual responses that are not included in any of the other categories listed above

CERTIFICATION:

To the best of my knowledge, the above information is true and can be verified if requested by proper officials of the Grantee, City of Joplin and the US Department of Housing and Urban Development." I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I can be prosecuted. I understand that by filling out this form, it does not guarantee that my household will receive assistance.

Print Name

Date

Sign Name

If you need assistance completing this form, please check with the Grantee for assistance.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

CHILD CARE APPLICATION/ELIGIBILITY STATEMENT

The following information is necessary to determine your eligibility for Child Care assistance. You must answer each question accurately and completely. You may be required to provide proof of your statements. Please complete this form in ink. If you need help with this form, please contact your local FSD office at:

APPLICANT NAME _____ Phone: _____
 HOME TELEPHONE NUMBER _____ WORK TELEPHONE NUMBER _____
 COMPLETE MAILING ADDRESS INCLUDING ZIP CODE _____
 DO ALL HOUSEHOLD MEMBERS INTEND TO REMAIN IN MISSOURI?
 YES NO

HOUSEHOLD MEMBERS (LIST YOUR NAME FIRST)

NAME	DATE OF BIRTH	RACE/ GENDER	MARRITAL STATUS	SOCIAL SECURITY NUMBER	RELATIONSHIP	INDICATE PERSON AND CARE NEEDED		EXPLANATION OF NEED FOR CARE
						Y/N	HOURS DAY/EVE	
								CHECK ALL THAT APPLY TO YOU. MY CHILD(REN) NEED(S) CARE BECAUSE I: PARENT PARENT <input type="checkbox"/> AM WORKING <input type="checkbox"/> ATTEND SCHOOL <input type="checkbox"/> AM IN JOB TRAINING <input type="checkbox"/> AM DISABLED <input type="checkbox"/> AM BEING EVALUATED FOR TRAINING AND/OR EMPLOYMENT <input type="checkbox"/> I/WE HAVE A CHILD WITH A SPECIAL NEED. (My child receives SSI, is under court ordered supervision, in foster care, receives services through Department of Mental Health, or is functionally challenged according to medical evidence.)

LIST AMOUNT OF INCOME AND SOURCE OF INCOME FOR ALL HOUSEHOLD MEMBERS. List person and amount received from child support, SSA, SSI, food stamps, Temporary Assistance, housing assistance, state/federal assistance, or any other source of income.

NAME OF PERSON WITH INCOME	AMOUNT OF INCOME	HOW OFTEN RECEIVED	SOURCE OF INCOME

DEDUCTIONS

IF YOU PAY FOR HEALTH/DENTAL/HOSPITAL INSURANCE, HOW MUCH IS YOUR PREMIUM? _____
 HOW OFTEN DO YOU PAY THIS AMOUNT? _____
 IF YOU EXPECT ANY CHANGES IN HOUSEHOLD MEMBERS, INCOME OR HEALTH INSURANCE COSTS, PLEASE EXPLAIN _____

CHILD CARE PROVIDER	ADDRESS	COUNTY	TELEPHONE	RELATIONSHIP TO CHILD	PROVIDER STATUS

CERTIFICATION SECTION:

- I agree to provide additional information or verification as requested to determine my family's eligibility for Child Care assistance within fifteen days of this application.
- I agree to report changes in income, employment, household members, health insurance premiums, and need for child care. I understand that my child's caregiver must comply with all state and federal laws and requirements in order for Child Care assistance benefits to be paid by FSD.
- I understand that my statements are subject to investigation and verification. I understand that Missouri laws provide for fine and/or imprisonment for persons who receive or attempt to receive public assistance by knowingly giving false statements, or failing to report information required to determine eligibility for public assistance.
- My signature certifies, under penalty of perjury, that all information given is true and complete.

SIGNATURE OR MARK OF APPLICANT _____ DATE _____
 WITNESS TO MARK _____

FOR OFFICE USE ONLY - ELIGIBILITY DETERMINATION

VERIFICATION

1. NEED FOR CHILD CARE

EMPLOYMENT CWER/AWEP

JOB TRAINING JOB READINESS

SCHOOL ATTENDANCE 21ST CENT. WAGE SUPP.

SPECIAL NEEDS CHILD OUTSTATE WAGE SUPP.

INCAPACITATION PEER SUPPORT (PARENTS FAIR SHARE)

JOB SEARCH (WORK FIRST/DIRECT JOB PLACEMENT)

EVALUATION FOR TRAINING/EMPLOYABILITY OTHER _____

2. HOUSEHOLD ELIGIBILITY

A. Relationship/age verification:

IM-36 Temporary Assistance Sect. CC Sect.

B. Single parent household C. DCSE Referral made

3. INCOME GUIDELINES

MONTHLY INCOME: _____ FAMILY UNIT SIZE _____

MEDICAL INSURANCE _____ MET NOT MET

PREMIUM: _____ SPECIAL NEEDS CHILD

NET INCOME: _____ = _____ Functional Age _____

(if applicable)

TYPES OF INCOME

EMPLOYMENT INCLUDING SELF EMPLOYMENT TEMPORARY ASSISTANCE

HOUSING VOUCHER OR CASH ASSISTANCE FOOD STAMPS

OTHER FEDERAL/STATE CASH INCOME PROGRAMS (SUCH AS SSI)

OTHER INCOME

4. PROVIDER QUALIFICATIONS:

PROVIDER DVN: _____

FACILITY TYPE: HOME (DH) GROUP (GH) CENTER (DC)

LICENSED

CONTRACTED

EXEMPT FROM LICENSURE

REGISTERED REGISTERED/REGULATED

IM-91 dated _____ IM-91 dated _____

DIRECT PAY DIRECT PAY

REIMBURSEMENT REIMBURSEMENT

RELATIVE DOH COMPLIANT

NON-RELATIVE IM-93 dated _____

IM-92 dated _____

IM-93 dated _____

SHP-159 dated _____

5. EMPLOYMENT PLAN: _____

APPROVED WAITING LIST REJECTED

COUNTY _____ WORKER NO. _____ LOAD NO. _____ CASEWORKER/CASE MANAGER SIGNATURE _____

DATE OF REQUEST	ELIGIBILITY DATES	BEGIN	END
DATE OF DETERMINATION		TYPE OF REQUEST APPROVED: <input type="checkbox"/> BG <input type="checkbox"/> SF <input type="checkbox"/> FS <input type="checkbox"/> OTHER	