Missouri Department of SOCIAL SERVICES

Your Potential. Our Support.

IMPORTANT INFORMATION REGARDING YOUR APPLICATION FOR CHILD CARE SUBSIDY

Including the following documents when mailing or dropping off a child care application can assist in processing the application in a timely manner:

Citizenship/Relationship

- Citizenship or Immigration Status – if not a United States Citizen, documentation that verifies your legal status in the United States.
- Birth Certificates – if children are born out of state, original birth certificate from the state/country child was born in.

Income

Both earned and unearned income must be verified for all household members included in the eligibility unit.

- Pay check stubs (at least last 30 days and continuous pay periods)
- If new employment, a letter on company letterhead, from the employer stating the number of hours you will be working during a pay period and how often you will be paid. Should also include the date of your first paycheck
- Social Security/Supplemental Security Income – award letter or other verification from the Social Security Administration.
- Child Support income – can usually be verified through the state computer system; however, if you receive child support from a different state, verification will be needed.
- Self-employment – current tax return along with any supporting schedules that were filed.
- Education – documentation for all grants/scholarships/loans you have received to attend school.

If you are uncertain if something is needed to verify income, it is better to submit all documentation/verification you have.

Need for Child Care

To be eligible for child care, there must be a need for all adults in the household or a documented special need for a child. The following are considered valid needs for child care and the verification needed:

- Employment – a copy of your work schedule from your employer, or a letter from the employer on company letterhead, stating the days and hours each day that you work.
- School – A copy of a class schedule to include times and days of week attended. When a class schedule changes, a new one must be submitted.
- Training – if you are enrolled in a training through a local agency/program, a copy of the training schedule with days and hours of attendance
- Incapacitated Care Taker – a physician's statement explaining you are unable to care for your child due to a mental or physical disability
- Child with a Special Need for Care – if you do not have a traditional need for care (employment, school, etc.) but have a child that has been classified as having a special need and that child has a special need for care, a medical professional must submit a statement regarding the reason care is needed and the duration of the need for care.

Child Care Provider Name – If you have chosen the child care provider or facility your child will be attending, please provide the name, address, phone number and/or DVN of that provider.

If you need assistance finding a child care provider, you may contact Child Care Aware ® of Missouri at (866) 892-3228 or visit the website at http://mo.childcareaware.org/. You may also visit the Department of Health and Senior Services' Show Me Child Care Provider search at http://health.mo.gov/safety/childcare/.

Social Security Numbers (SSN)

A SSN is NOT required as a condition of eligibility for Child Care Subsidy. Disclosure of SSN is strictly voluntary and will not affect your eligibility for Child Care Subsidy. Child Care Subsidy cannot be denied because you decide that you do not want to disclose your SSN or the SSN for any household member, including children whom benefits are requested. However, if you are applying for other benefits, along with Child Care Subsidy, your SSN may be required.

CHILD CARE APPLICATION

Date

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY user can call 1-800-735-2966. If you are blind or visually impaired and would like information regarding Rehabilitation Services for the Blind, please call 1-800-592-6004.

INSTRUCTIONS: List your address and any phone numbers where you may be reached.

Street Address	City	State	Zip

Primary phone number	What kind of phone is this? ☐ cell ☐ home ☐ work ☐ other
Alternate phone number	What kind of phone is this? ☐ cell ☐ home ☐ work ☐ other
Email Address	Preferred method of contact? ☐ *call ☐ text ☐ email ☐ mail *We will call your primary phone unless you note otherwise

INSTRUCTIONS: List all persons who live at your address including yourself. List yourself first. Answer all questions about each person.

Full Legal Name (First, Middle, Last)	Date of Birth	Race	Gender	Marital Status	SSN (Optional for Child Care)	Relationship to Head of EU
						Head of Eligibility Unit

Are the above household members Missouri residents and do they intend to remain in Missouri? ☐ Yes ☐ No

If no please explain:

INSTRUCTIONS: List all persons who have earned or unearned income in your household.

Name	Source	Monthly Gross Income	Hourly Pay Rate	Tips Per Pay Period	Pay Frequency

Are you receiving other State or Federal assistance?	☐ Yes ☐ No If yes, explain:___________________________ amount:____________
Are any changes in income expected?	☐ Yes ☐ No If yes, explain:___________________________ amount:____________
Do you pay a health insurance premium?	☐ Yes ☐ No If yes, premium frequency: _______________ amount:____________
Do you pay a dental insurance premium?	☐ Yes ☐ No If yes, premium frequency: _______________ amount:____________
Do you pay a hospital insurance premium?	☐ Yes ☐ No If yes, premium frequency: _______________ amount:____________
Do you have more than $1,000,000 in assets?	☐ Yes ☐ No

Please provide information concerning your child care provider(s) in the areas provided. Under each provider you list, include the information for each child under that provider's care. Please ensure you list the provider's relationship to each child you list with that particular provider (i.e. grandmother, no relation).

Name of Provider 1	DVN	Phone Number	
Street Address	City	State	Zip
Name of Provider 2	DVN	Phone Number	
Street Address	City	State	Zip

Is your child(ren) enrolled in Early Head Start or Head Start? ☐ Yes ☐ No

Please list the number of days per month each child is in care for each category listed below:

Child's Name (first, middle, last)		5 or more hours		3 to 5 hours		Less than 3 hours	
	Relationship To Provider	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)	Daytime (6am-6:59pm)	Evening/Weekend (7pm-5:59am) (Saturday/Sunday)
1.							
2.							
3.							
4.							
5.							

THE NEED FOR CHILD CARE IS BECAUSE YOU OR A HOUSEHOLD MEMBER IS: (CHECK **ALL** BOXES THAT APPLY)

☐ employed? Where ________________________ Phone Number _______________ Name ________________

☐ in job training? Where ________________________ Phone Number _______________ Name ________________

☐ attending school? Where ________________________ Phone Number _______________ Name ________________

☐ disabled? Physician _____________________ Phone Number _______________ Name ________________

☐ being evaluated for training and/or employability?

Where ________________________ Phone Number _______________ Name ________________

☐ Your child has a "special need" for child care? (i.e. child is classified as having a special need, there is no traditional need for care, but a medical or mental health professional has determined the child needs to be in child care.)

☐ I am homeless (Defined as individuals who lack a fixed, regular, and adequate nighttime residence.)

- My signature below certifies under penalty of perjury that all information given is true, correct and complete to the best of my knowledge.
- I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.
- I agree to provide any additional information or verification that is requested to determine my eligibility within 15 days of application date.
- I agree to report changes in my income if it exceeds 85% of the State Median income.
- I understand that the statements I have made are subject to investigation and verification.
- I also understand that the laws of Missouri provide for fine or imprisonment or both for persons who knowingly receive or attempt to receive public assistance they are not entitled to or who knowingly fail to report information required to determine eligibility for public assistance.

By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on Page 2. You do not have to consent to this as part of your application. If you want to opt out of getting these calls, check here: ☐

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