

MISSOURI DEPARTMENT OF SOCIAL SERVICES

acessary to determine your eligibility for Child Care assistance. You must answer each question accurately and c	APPLICATION/ELIGIBILITY STATEMENT	AT DIVISION	
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SIGNATURE OR MARK OF APPLICANT	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.	CERTIFICATION SECTION:			CHILD CARE PROVIDER	IF YOU EXPECT ANY CHANGES IN HOUSEHOLD MEMBERS, INCOME OR HEALTH INSURANCE COSTS, PLEASE EXPLAIN	IF YOU PAY FOR HEALTH/DENTAL/HOSPITAL INSURANCE, HOW MUCH IS YOUR PREMIUM? .	DEDUCTIONS .					NAME OF PERSON WITH INCOME	any other source of income.	received from child support, SSA, SSI, food stamps, Temporary Assistance, housing assistance, state/federal	T AMOUNT OF INCOME AND SOIL					ºNAME	HOUSEHOLD MEMBERS (LIST YOUR NAME FIRST)	COMPLETE MAILING ADDRESS INCLUDING ZIP CODE	APPLICANT NAME	- Commission of the Commission	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:	CHILD CARE APPLICATION/ELIGIBILITY STATEMENT	FAMILY SUPPORT DIVISION
	on or verify many or	-				RS, INCOME	, НОМ МИСН								od stamp	BCE OF					BIRTH	VAME FIR				determin e this forr	ATION/I	2
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	ed to determine mymbers, health insumbers, health insumbers assistance benefication. I under or failing to report or given is true and				RESS	COSTS, PLEASE EXPLAIN				-		THE PERSONNEL PROPERTY OF THE PERSON NAMED IN	HOW OFTEN RECEIVED		istance, housing a	HOUSEHOUD					NUMBER				Phone:	r Child Care assisted help with this for	TATEMENT	
	y family's eligib rance premium rance premium its to be paid this to be that Misrstand that Misriformation recomplete.				COUNTY		HOW OFTE					***************************************			Δ.			- Control of the Cont			RELATIONSHIP				2 6	tance. You mus m, please cont	-h-15*	001
DATE	illity for Child Care assins, and need for child cas, and need for child cas, and need for child cas, and need for the souri laws provide for the cas, and the ca				TELEPHONE		HOW OFTEN DO YOU PAY THIS AMOUNT? _						SOURCE OF INCOME	A STATE OF THE PROPERTY OF THE		ist person and amount		- Line State of the State of th		Y/N HOURS DAY/EVE	CARE NEEDED	מיני איני איני איני איני איני איני איני			1717-907	at answer each question acc tact your local FSD office at:		
WITNESS TO MARK	hild Care assistance within fifteen days of eed for child care. I understand that my ceed for fine and/or imprisonment for determine eligibility for public assistance.				RELATIONSHIP TO CHILD				PARENT	medical evidence.)	Mental Health,	in foster care,	(My child receiv][PARENT PAR		EXPLANATION	DO ALL HOUSEHOLD MEMB	HOME TELEPHONE NUMBER	Worker:	n accurately and one at:		
	en days of this application. I that my child's caregiver musonment for persons who recassistance.			LIC/CON/REG	O CHILD PROVIDER STATUS				SCHOOL/COLLEGE/TRNG	ce.)	Mental Health, or is functionally challenged according to	in foster care, receives services through Department of	(My child receives SSI, is under court ordered supervision,	I/WE HAVE A CHILD WITH A SPECIAL NEED.	AND/OR EMPLOYMENT	AM BEING EVALUATED E	AM DISABLED	AM IN TOR TRAINING	ATTEND SCHOOL	PARENT	NEED(S) CARE BECAUSE I:	EXPLANATION OF NEED FOR CARE	DO ALL HOUSEHOLD MEMBERS INTEND TO REMAIN IN MISSOURI?	SER WORK TELEPHONE NUMBER		completely. You may be requ		
	ust comply with			DVN	TATUS				GRADE LEVEL		d according to	Department of	ed supervision,	NEED.		OB TRAINING					יירט(ייריא)	AII D/BEN)		NUMBER	ALL CALLED TO SERVICE	iired to provide		

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MO 886-2845 (3-04)

MO 886-2845 (3-04)	COUNTY WORKER NO.	APPROVED [5. EMPLOYMENT PLAN:	☐ IM-92 dated ☐ IM-93 dated ☐ SHP-159 dated _	☐ REIMBURSEMENT ☐ RELATIVE ☐ NON-RELATIVE	☐ REGISTERED ☐ IM-91 dated	FACILITY TYPE: HOME (D LICENSED CONTRACTED EXEMPT FROM LICENSURE	4. PROVIDER QUALIFICATIONS:	 □ EMPLOYMENT INCLUDING SELF EMPLOYMENT □ HOUSING VOUCHER OR CASH ASSISTANCE □ OTHER FEDERAL/STATE CASH INCOME PROGR □ OTHER INCOME 	TYPES OF INCOME	PREMIUM:	3. INCOME GUIDELINES MONTHLY INCOME: MEDICAL INSURANCE	1	2. HOUSEHOLD ELIGIBILITY	JOB SEARCH (WOR	SPECIAL NEEDS CHILD	☐ JOB TRAINING ☐ SCHOOL ATTENDANCE	EMPLOYMENT
	LOAD NO. CASEWORKER/CASE MANAGER SIGNATURE	☐ WAITING LIST ☐ REJECTED				☐ REGISTERED/REGULATED ☐ IM-91 dated	HOME (DH) ☐ GROUP (GH) ☐ CENTER (DC) ENSURE		NT [GRAMS ((if applicable)	SPECIAL NEEDS CHILD Functional Age	FAMILY UNIT SIZE MET NOT MET SLIDING FEE WAIVED	ion: Temporary Assistance Sect. ☐ shold C. ☐ DCSE Referral n	AINING/EMPLOYABILITY	ORI (PAREN		☐ JOB READINESS ICE ☐ 21ST CENT. WAGE SUPP.	☐ CWEP/AWEP
		CTED DATE OF REQUEST			NT .	ATED	ER (DC)		☐ TEMPORARY ASSISTANCE ☐ FOOD STAMPS SUCH AS SSI)		6		CC Sect.	O'HER	FAIR SHARE)			
	DATE OF DETERMINATION T	ELIGIBILITY B DATES ►																VERIF
	TYPE OF REQUEST APPROVED:	BEGIN END																VERIFICATION
	OTHER																	