CHILD CARE ASSISTANCE PROGRAM REVIEW

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

SFN 841 (10-2016)

Clear Fields

For Office Use Only

Date Received

Read review carefully and answer each question completely. Attach all required verification.

Attach another sheet if you need more space to answer questions.

Failure to complete the review process will result in your Child Care Assistance Program case closing.

Tell us about you

First Name	Middle Initial	Last Name		
Residential Address		City	State	ZIP Code
Mailing Address		City	State	ZIP Code
Telephone Number	Cell Phone Number		Work Telephone Number	
If you do not speak English, what is your preferred spoken or written language?				

Tell us who is in your household - List all persons in your household starting with you.

Name	Social Security No. (optional)*	Association/ Relationship to You	Date of Birth	Name	Social Security No. (optional)*	Association/ Relationship to You	Date of Birth
		SELF					

Are both parents in the home? ☐ Yes ☐ No

Is a parent currently active duty in the U.S. Military? ☐ Yes ☐ No

Is a parent currently a member of the National Guard or a military unit? ☐ Yes ☐ No

Is your household currently homeless? ☐ Yes ☐ No

Name of Any Person Temporarily Out of the Home	Association to Child Receiving Assistance

Reason for Absence	Date Expected to Return

Has anyone moved out of your household? ☐ Yes ☐ No	If Yes, Who?	When?
Has anyone moved into your household? ☐ Yes ☐ No		

If Yes, Who?	When?	Social Security Number (optional) *	Date of Birth

If this person needs child care, you must provide verification of association to caretaker, citizenship, age, social security number (optional), income, school status, and child care provider.

If this person is a parent/caretaker, you will need to provide verification of identity, activity, hours per week in activity, earned and unearned income, and child/spousal support paid. If this person is a student, they must complete a Postsecondary Education Information form (SFN 113) and provide a copy of current class schedule.

If this person is a child under the age of 19, you must provide verification of their unearned income.

* The Privacy Act of 1974 requires the following information to be provided when individuals are requested to disclose their social security numbers: Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Tell us about school status

List all names and current status for any adult household member in school or training:

Name	Course of Education/ Anticipated Degree	Credit Hours	Start Date	End Date

Does any adult in the household anticipate a change in school status? ☐ Yes ☐ No

If Yes, Who?

If Yes, Explain

If any adult household member has changed or has started in education, you must complete a Postsecondary Education Information form (SFN 113) and provide a copy of their current class schedule.

Tell us about your household's assets

Total Estimated Value of Your Household's Assets

Tell us about the earned income your household receives

Complete this section listing last month's income for each person that is employed (excluding children). List information about full-time, part-time, seasonal, or temporary employment for all household members.

Provide proof of last month's income. Provide an employer statement for all new jobs or any changes in anticipated income. If self employed, provide most recent tax return including all schedules.

Household Members Name	Employer	Gross Amount	Hours Worked Per Week	Salary/ Hourly Wage	Bonuses Amount of Tips/ Commission	How Often Paid	Day(s) of Week/Month Paid	Date of Next Paycheck

Do you or anyone in your household anticipate a change in earned or self-employment income this month or next month? ☐ Yes ☐ No

If Yes, Who?

Explain the change (provide verification of the anticipated change)

Tell us about the unearned income your household receives

Complete this section for each household member including children. Provide proof of last month's income. If you expect a change in unearned income you must provide verification.

Received	Yes	No	Received By	LAST MONTH Amount	LAST MONTH Date Received
Alaska Dividend					
BIA/Tribal General Assistance					
Child Support					
Contract or Contracts for Deed					
CRP (Conservation Reserve Payment)					

Continued on next page

Tell us about the unearned income your household receives (continued)

				LAST MONTH	
Received	**Yes**	**No**	**Received By**	**Amount**	**Dates**
Dividends or Interest					
Fund Raising Received Directly by Family					
Income from Roomer/Boarder					
Individual Indian Monies Account					
Insurance/Lawsuit Settlement					
Private Insurance or Disability Income					
Mineral Lease					
Money from Friends, Relatives, or Others					
Oil/Mineral Rights/Royalties					
Railroad Benefits					
Rental Income					
Social Security Benefits					
Spousal Support					
SSI (Supplemental Security Income)					
Tribal Gaming Distribution					
Tribal Spirit Lake Social Impact Payment					
Trust Income					
Unemployment Benefits					
Veteran's Benefits					
Workforce Safety Insurance					
Other					

Do you or anyone in your household anticipate a change in unearned income this month or next month? ☐ Yes ☐ No

If Yes, Who?	Explain the Change (provide verification of the anticipated change)

Tell us about Court-Ordered Child Support and Court-Ordered Spousal Support

Do you or anyone in your houshold pay court-ordered child support and/or court-ordered spousal support? ☐ Yes ☐ No

If Yes, Who?	Court-Ordered Amount	Amount Paid Last Month (provide verification)

Has anyone in your houshold had a change in court-ordered child support and/or court-ordered spousal support? ☐ Yes ☐ No

If Yes, Who?	Explain the Change (provide verification of the anticipated change)

Tell us what activities/programs you participate in

For which of the following activities/programs do you continue to need child care?

☐ Work ☐ Activity Search ☐ High School ☐ Postsecondary Education or Training ☐ TANF Assistance or Diversion ☐ Crossroads

Tell us about your child care needs

ACTIVITY SCHEDULE

Name of Parent Participating in Activity

Allowable Activity

☐ Employment ☐ High School/GED ☐ Education or Training ☐ Activity Search ☐ Applied/Receiving TANF
☐ Applied/Receiving Crossroads ☐ Applied/Receiving Diversion
☐ Other - Specify: _____

Provide a schedule of when you participate in each activity - if additional space is needed, attach a separate sheet

If attending postsecondary education, is child care needed for study time? ☐ Yes ☐ No

If yes, list the day(s) of the week and the time of the day(s) child care is needed for study time.

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider (use codes below)
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

ACTIVITY SCHEDULE - complete this section if participating in more than one activity or for a second parent if both parents are in the home

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Allowable Activity

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☐ Other - Specify: _____

ACTIVITY SCHEDULE - complete this section if participating in more than one activity or for a second parent if both parents are in the home

Provide a schedule of when you participate in each activity - if additional space is needed, attach a separate sheet

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	Dropped off at Provider	Picked up from Provider				
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

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RIGHTS AND RESPONSIBILITIES:

Please read each bullet and sign at the bottom of the page.

- I declare under the penalties of perjury that the information on this review is true and correct.
- I understand that it is my responsibility to provide proof of income and other requested information needed to determine eligibility for this program and that failure to do so can result in my case being closed.
- I understand that it is my responsibility to notify my County Social Service Office of mandatory changes within 10 days from the date the event occurred.
- I understand that I am responsible for payment of any child care expenses not covered by the Child Care Assistance Program.
- I understand that if I receive assistance to which I am not entitled as a result of providing false information, I must repay the costs of that assistance.
- I understand that I have the right to appeal any decision made by the Child Care Assistance Program and that the request must be made within 30 days from the print date of my denial or benefits notification.

I understand that the amount of Child Care Assistance I receive will be based on the information I have provided on this form. I also understand that the amount of Child Care Assistance may be changed without advance notice. I understand that the County Social Service Office will verify the information I have provided, and that federal and state laws provide for fines and/or imprisonment of any person who fraudulently receives, or attempts to receive public assistance to which he or she is not entitled. I understand that I must report all mandatory reportable changes. I understand that I am responsible for paying my Family Monthly Co-Pay and any additional costs over the allowable maximum not covered by the program.

Please read and sign the authorization to furnish or release information for verification of wages, student status, and child care costs. This authorization must be signed in order to process your review.

TO WHOM IT MAY CONCERN:

I hereby authorize any person, agency, or institution to supply information, other than protected health information, concerning me or my family requested by the County Social Service Office and to allow inspection and reproduction of records in their possession by any duly authorized representative of County Social Service Office. I further authorize the County Social Service Office to release such information, other than protected health information, to cooperating state or federal agencies. I authorize the County Social Service Office to inform my provider(s) of my eligibility or ineligibility of payment for child care.

I release any person, agency, or institution from any and all liability to me or my family for supplying such information, other than protected health information.

This authorization is given only in connection with its use by the County Social Service Office in its administration of the Child Care Assistance Program and for no other purpose.

Parent/Caretaker Signature	Date