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| HI RES-GEORGE_NEW  STATE OF WASHINGTON  **DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES**  CHILD CARE SUBSIDY PROGRAMS (CCSP) | |
| PARENT’S NAME AND ADDRESS | CASE NUMBER    DATE |
| FOLD  **CCSP Child Care Reapplication**  **Your** **Child Care Subsidy Program (CCSP) eligibility will end** **.** You must contact the department by to reapply. WAC 110-15-0109.    You can reapply by either calling us at (844) 626-8687 or by completing and returning the enclosed CCSP Reapplication form (DCYF 14-430). You may also reapply at [www.washingtonconnection.org](http://www.washingtonconnection.org).  If you return the form, be sure to read and sign the statement declaring all information on the form is true and correct. The form can be returned in the enclosed envelope or you can fax it to 1-877-309-9747. Provide proof of any income your household received for the last three months. Examples are wage stubs, earnings statements showing your current total monthly hours and gross income, child support payments, approval letters or monthly statements.  We also need to know if your schedule or provider has changed.  **If you don’t reapply by      , your child care benefits will end on** **and your provider will no longer receive payments from DCYF.**  **Report Changes**  Call: 1-844-626-8687; Fax: 1-877-309-9747 (with your Client ID on each page); or www.washingtonconnection.org | |

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|  | | | | | | CHILD CARE SUBSIDY PROGRAMS (CCSP)  **CCSP Reapplication** | | | | | | | | | | | | | | | | |
| APPLICANT’S NAME | | | | | | | | | | | | | CLIENT ID NUMBER | | | | | | | DATE | | |
| APPLICANT’S ADDRESS (Physical) | | | | | | | | | | | | | BIRTHDATE | | | | | | | | | |
| CITY STATE ZIP CODE | | | | | | | | | | | | | EMAIL ADDRESS (optional) | | | | | | | | | |
| APPLICANT’S ADDRESS (Mailing if different) | | | | | | | | | | | | | SSN (OPTIONAL) | | | | | | | TELEPHONE NUMBER | | |
| CITY STATE ZIP CODE | | | | | | | | | | | | | APPLICANT’S ETHNICITY RACE | | | | | | | APPLICANT’S GENDER  Male  Female | | |
| Is your family experiencing homelessness?  Yes  No *(Examples include: living in a motel, shelter, transitional housing, car, public space, or doubled-up with others due to loss of housing or economic hardship.)*  Are you a parent or legal guardian who has received child welfare services in Washington State in the last six (6) months and been referred for child care as part of your case plan?  Yes  No (***If you answer yes, please call 1-844-626-8687 to see if you qualify for expedited application processing.)*** | | | | | | | | | | | | | | | | | | | | | | |
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| **Children for Whom You Are Responsible Living In The Household** | | | | | | | | | | | | | | | | | | | | | | |
| If You Do Not Have Enough Space To Complete, Please Use A Separate Piece Of Paper To Submit Additional Information | | | | | | | | | | | | | | | | | | | | | | |
| NAME (LAST, FIRST, MIDDLE INITIAL) | | | | BIRTHDATE | MALE/ FEMALE | | | ETHNICITY (OPTIONAL) | | | | | SSN (OPTIONAL) | | | U.S. CITIZEN OR LEGAL RESIDENT | | | | | RELATIONSHIP TO APPLICANT | |
|  | | | |  |  | | |  | | | | |  | | | Yes  No | | | | |  | |
|  | | | |  |  | | |  | | | | |  | | | Yes  No | | | | |  | |
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| **Determining Whether You Are A Single 0r Two-Parent Household - Required** | | | | | | | | | | | | | | | | | | | | | | |
| You are:  Single  Married  Divorced  Separated  Married Living Apart  Widowed  Registered Domestic Partnership  Do you live with a spouse or another parent / guardian of any of your children?  Yes  No *If no, complete the* [*Single Parent Declaration form, DCYF 27-164*](http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/forms?field_form_number_value=27-164&title=)*, and submit with your application. If yes, complete the information below.* | | | | | | | | | | | | | | | | | | | | | | |
| SPOUSE OR OTHER PARENT’S NAME | | | BIRTHDATE | | | | SSN (OPTIONAL) | | | | | | | | RELATIONSHIP TO APPLICANT | | | | RELATIONSHIP TO ABOVE CHILDREN | | | |
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| **If you do not have enough space to complete, please use a separate piece of paper to submit additional information** | | | | | | | | | | | | | | | | | | | | | | |
| **Applicant** | | | | | | | | | | **Spouse or Second Parent / Guardian** | | | | | | | | | | | | |
| NAME OF EMPLOYER, WORKFIRST ACTIVITY, OR SCHOOL    ADDRESS (EMPLOYMENT, WORKFIRST ACTIVITY, OR SCHOOL)    TELEPHONE NUMBER DATE STARTED    IF YOU ARE EMPLOYED, HOW OFTEN ARE YOU PAID **AND** YOUR GROSS WAGE PER PAY PERIOD (BEFORE TAXES, INCLUDE TIPS)?  Weekly  Every two weeks  Twice a month  Monthly $  **Is this work** farm-based employment which includes cultivation, production, harvesting or processing of fruit trees or crops.  Yes  No | | | | | | | | | | NAME OF EMPLOYER, WORKFIRST ACTIVITY, OR SCHOOL    ADDRESS (EMPLOYMENT, WORKFIRST ACTIVITY, OR SCHOOL)    TELEPHONE NUMBER DATE STARTED    IF YOU ARE EMPLOYED, HOW OFTEN ARE YOU PAID **AND** YOUR GROSS WAGE PER PAY PERIOD (BEFORE TAXES, INCLUDE TIPS)?  Weekly  Every two weeks  Twice a month  Monthly $  **Is this work** farm-based employment which includes cultivation, production, harvesting or processing of fruit trees or crops.  Yes  No | | | | | | | | | | | | |
| **Other Monthly Sources of Earned / Unearned Income For All Family Members** | | | | | | | | | | | | | | | | | | | | | | |
| ***(Examples include: Self-Employment, Public Assistance such as TANF, Child Support, Social Security or VA Benefits)*** | | | | | | | | | | | | | | | | | | | | | | |
| **Income Type**  Include copies (for the last three months) | | | | | | | | NAME  **SELF** | | | | | | NAME | | | NAME | | | | | NAME |
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| Do you pay court ordered child support?  Yes  No Monthly amount: $ | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | **Barcode label** | | | | | | | | | 14417 | | | | |
| **Available Resources** | | | | | | | | | | | | | | | | | | | | | | |
| Do you have available assets valued at $1,000,000.00 or more?  Yes  No  Examples of available assets are: cash, bank accounts, stocks / bonds, investment accounts, investment real estate. | | | | | | | | | | | | | | | | | | | | | | |
| **Parent / Guardian’s Activity Schedule** | | | | | | | | | | | | | | | | | | | | | | |
| APPLICANT | | | | | | | | | | | SPOUSE OR SECOND PARENT/GUARDIAN | | | | | | | | | | | |
| ACTIVITY (EMPLOYMENT, SCHOOL, WORFIRST ACTIVITY) INDICATE TIME WITH A.M./ P.M. | | | | | | | | | | | ACTIVITY (EMPLOYMENT, SCHOOL, WORFIRST ACTIVITY) INDICATE TIME WITH A.M./ P.M. | | | | | | | | | | | |
| Monday | WHAT IS YOUR SCHEDULE FOR EMPLOYMENT,  SCHOOL, WORKFIRST ACTIVITY? | | | | | | | | | | WHAT IS YOUR SCHEDULE FOR EMPLOYMENT,  SCHOOL, WORKFIRST ACTIVITY? | | | | | | | | | | | |
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| Tuesday |  | | | | | | | | | |  | | | | | | | | | | | |
| Wednesday |  | | | | | | | | | |  | | | | | | | | | | | |
| Thursday |  | | | | | | | | | |  | | | | | | | | | | | |
| Friday |  | | | | | | | | | |  | | | | | | | | | | | |
| Saturday |  | | | | | | | | | |  | | | | | | | | | | | |
| Sunday |  | | | | | | | | | |  | | | | | | | | | | | |
| Do you have a Child Care Provider?  Yes  No  Child Care Provider Name:  Phone Number/Address:  Social Service Payment System (SSPS) Identification number:  **If you would like to use a Family Friend Neighbor Provider, please contact Child Care Subsidy**  What is the child care begin date:  **Applicant:** If known, how long does it take you to travel from your child care provider to your activity (work, school, etc.)?    **Other parent/guardian**: If known, how long does it take you to travel from your child care provider to your activity (work, school, etc.)? | | | | | | | | | | | | | | | | | | | | | | |
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| **Children’s Activity Schedule** | | | | | | | | | | | | | | | | | | | | | | |
| ***For additional children, attach a separate piece of paper with their information.*** | | | | | | | | | | | | | | | | | | | | | | |
| CHILDREN’S NAMES | | SCHOOL SCHEDULE  (EXACT DAYS AND TIMES) | | | | | | | | | | CHILD CARE SCHEDULE  (EXACT DAYS AND TIMES) | | | | | | | | | | |
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| Will your school age children need care during school and summer breaks?  Yes  No | | | | | | | | | | | | | | | | | | | | | | |
| Do you have a child with Special Needs?  Yes  No  **If yes, please contact Child Care Subsidy for information about special needs payment rates at 844-626-8687** | | | | | | | | | | | | | | | | | | | | | | |

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| **Hearing Rights WAC 110-15-0280**  If you disagree with DCYF’s decisions, you may request a hearing by contacting this office or write to Office of Administrative Hearings, P O Box 42489, Olympia, WA 98507-2489. You must request your hearing:   * On or before the effective date of this action or no more than 10 days after we send you notice of this action, IF you receive benefits now and you want them to continue, or * Within 90 days of the date you receive this letter.   At the hearing, you have the right to represent yourself, be represented by an attorney or by any other person you choose. You may be able to get free legal advice or representation by contacting an office of legal services. | | | |
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| **I declare under penalty of perjury that the information given by me in this declaration is true, correct and complete to the best of my knowledge and realize that willful falsification of this information by me may subject me to penalties as provided in Washington State Law.**  **I understand that it is a crime to make a false statement on purpose or not report information I know should be reported. I understand if I report information I know is incorrect I could be criminally prosecuted, be required to repay benefits I was not eligible to receive and possibly lose the ability to receive child care benefits for five years.**  **(RCW 74.08.055)** | | | |
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| APPLICANT SIGNATURE | DATE | SECOND PARENT/LEGAL GUARDIAN’S SIGNATURE | DATE |

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| **Discrimination is prohibited in all programs and activities: No one shall be excluded on the basis of race, color, religion, creed, national origin, gender, age, marital status, disabled veteran or Vietnam-era veteran status, or disability.** |
| **CCSP APPLICATION**  **DCYF 14-430 (REV. 08/2022)** |