CHILD CARE APPLICATION

Department of Public Health and Social Services * Divison of Public Welare * Bureau of Management Support
130 University Drive, Castle Mall Rm. 15, Mangilao, Guam 96913 * Telephone 671-735-7344 * Fax 671-735-7165

Applicant ☐ Foster ☐ Homeless					**Employer or Training/Education Program**	**Office Use Only**	
Name					**Name:**	**Case Number:**	
Mailing Address					**Work/Program Start Date:**	New ☐ Reopen ☐ Reinstatement ☐ Renewal ☐ FOSTER ☐	CCDF ☐ GETP ☐ JOBS ☐ TCC ☐
Home Address					Currently Receiving: ☐ TANF ☐ SNAP ☐ Medicaid ☐ MIP ☐ Other Federal Programs (Specify) _____		
Contact Number(s)	(H)	(W)	(Cell)	(O)			

****** Members of the Household ******

	1. Applicant	2. Co-Applicant / Spouse	3. Household Member	4. Household Member	5. Household Member	6. Household Member
Social Security Number	_ _ _ - _ _ - _ _ _ _	_ _ _ - _ _ - _ _ _ _	_ _ _ - _ _ - _ _ _ _	_ _ _ - _ _ - _ _ _ _	_ _ _ - _ _ - _ _ _ _	_ _ _ - _ _ - _ _ _ _
Name						
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _
Ethnicity / Race						
Relationship to 1	Self					
Income						
US Citizen	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Needs Childcare?	Children needing Child Care must be U.S. Citizens.		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Disabled?			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I certify that I have been informed of my rights and responsibilities. I understand the questions on this application and the penalty for hiding or giving false information. My answers are complete to the best of my knowledge.

Applicant Signature: _____ Date: _____ email address: _____

I certify that the applicant/recipient has been informed of his/her rights and responsibilities and the possibility of criminal charges for misrepresenting or concealing facts that determine eligibility.

STAFF Signature: _____ Date: _____

MY RIGHTS

I have the right to:

* Discuss any action regarding my case with my worker or his/her supervisor if I am dissatisfied.
* Be notified at least 15 calendar days in advance before my benefits is discontinued.
* Ask for a fair hearing if I am dissatisfied with any action of the Division of Public Welfare, Department of Public Health and Social Services and to ask anyone I want to help me get a fair hearing. Any person I choose may represent my case at the hearing.
* Have my records kept confidential.

MY RESONSIBILITIES

I am responsible to report any of the following changes in my household within 10 calendar days from the time I learn of the change:

* My new address if I move or change my mailing address.
* Changes in employment, education, or training status.
* Changes in the cost of child/dependent care or child care arrangement(s)/provider(s).
* Changes in my household composition.

IF I DO NOT REPORT, AND I RECEIVE MORE ASSISTANCE THAN I SHOULD HAVE, I MAY HAVE TO PAY BACK TO THE GOVERNMENT. IF I FAIL TO REPORT ANY OF THE ABOVE CHANGES ON PURPOSE, THIS IS CONSIDERED FRAUD UNDER STATE AND LOCAL LAWS. IF I AM FOUND GUILTY OF INTENTIONAL PROGRAM VIOLATION, I WILL BE INELIGIBLE TO PARTICIPATE IN THE PROGRAM FOR ONE YEAR FOR THE FIRST VIOLATION, TWO YEARS FOR THE SECOND VIOLATION, AND PERMANENTLY FOR THE THIRD VIOLATION.

MY AUTHORIZATION

1. I permit the Department to check any information on this application to verify that I am eligible for assistance.
2. I agree to provide the necessary documents (papers) to verify the statements on this application. If documents are not available, I agree to give the name of person(s) or organization(s) (such as doctor, employer, State or Federal Agency) whom the Department may contact for information about me and member(s) of my household that may be needed to show that we are eligible for help.
3. I agree to cooperate with the Department if our case is selected for an audit or Quality Control review.

Applicant Signature: _____ Date: _____

Co-Applicant Signature: _____ Date: _____

CHILD CARE PROVIDER DATA FORM

Case Name:	Case/Social Security Number:

CHILD CARE PROVIDER DATA

Provider Name:	Social Security Number:	
Mailing Address:	EIN/Tax Payer ID#:	
Residence Address:	Vendor #:	☐ Police Clearance ☐ Criminal Court Clearance
Business Address (if other than above): ☐ GHURA/Section 8	Phone #: (H) (W) (Cell/Pager)	

Other Adult Member(s) in place of business: Indicate name(s) and check if clearances are attached	
☐ Police ☐ Criminal Court	☐ Police ☐ Criminal Court
☐ Police ☐ Criminal Court	☐ Police ☐ Criminal Court
☐ Police ☐ Criminal Court	☐ Police ☐ Criminal Court
☐ Police ☐ Criminal Court	☐ Police ☐ Criminal Court

Check the appropriate box.

- ☐ Licensed, Center Based
- ☐ Licensed, Family Day Care
- ☐ Licensed, Group Day Care
- ☐ License-Exempt, Family Day Care: ☐ Relative ☐ Non-Relative
- ☐ License-Exempt, In-home Care: ☐ Relative ☐ Non-Relative
- ☐ Legally Operating Center-Based (Public/Private Schools, Before-/After-School Programs)

Total number of children in provider's care, including provider's children: _____

CHILD CARE SERVICES

Effective Date:

CHARGES	REGISTRATION FEE	MONTHLY RATE	WEEKLY RATE	DAILY RATE	HOURLY RATE
Full-time	$	$	$	$	$
Part-time	$	$	$	$	$
CHILD'S NAME	**CHILD CARE COST**	Check if **SPECIAL NEEDS Child**	**DAYS CHILD CARE NEEDED**	**TIME CHILD CARE NEEDED**	**TOTAL HOURS MONTHLY**
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				
	$				

Applicant's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

PROVIDER'S ASSURANCES/CERTIFICATION

Public Law 101-508 of the Omnibus Budget Reconciliation Act of 1990, Section 5082, established the Child Care and Development Block Grant (CCDBG) program. Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 amended the requirements of the CCDBG Act effective October 1, 1996. CCDBG is now referred to as the Child Care and Development Funds (CCDF). The purpose of CCDF is to increase the availability, affordability, and quality of child care. To accomplish this purpose, CCDF brings to Guam funds for purchase of child care services to eligible families, enhance the quality and increase the supply of child care for all families, and increase the availability of early childhood development, and school-age programs.

I certify that I, the child care provider, will comply with the requirements of the Department of Public Health and Social Services (DPHSS) with regard to the priority rules for the receipt of CCDF funds by providers. These include but not limited to:

a) Compliance with all licensing and regulatory requirements applicable under federal and local law.

b) Registration with DPHSS (for license-exempt providers);

c) Compliance with health and safety requirements, including:

1) **obtaining a health certificate, sanitary permit, business license, and vendor number;**
2) **submission of police and criminal court clearances, to include on all other adult member(s) in the household or child care center;**
3) **prevention and control of infectious disease; and**
4) **building and physical premises safety.**

d) Compliance with Public Law 103-227, Part C, Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994, which requires that smoking is not permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18;

e) Providing equal access for CCDF children to comparable child care services that are provided to children whose parents are not eligible to receive assistance under this program or under any other federal or local programs;

f) Affording parents unlimited access to their children and to the provider caring for their children, during the normal hours of operations or whenever such children are in the care of such provider;

g) Mandatory attendance in at least fifteen hours of training and technical assistance (workshops, seminars, conference, etc.) annually; and

h) Acceptance of program reimbursement rates, payment procedures and timelines.

I understand that I am required to comply with above requirements within 30 calendar days, except that I have a year to complete the 15 hours training and technical assistance requirement.

I understand that payments for child care services shall only be authorized upon completion of all requirements and upon meeting all conditions setforth.

I certify that I have read and agreed to the requirements.

Provider's Signature: _____ Date: _____

OFFICE USE ONLY

Verification: [ ] Complete [ ] Incomplete
Disposition: [ ] Approved [ ] Disapproved

Comments:

_____

BMS/BES Staff Signature: _____ Date: _____