State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Please complete all information below and return to:	**Parent/Guardian Name:**

PLEASE TYPE OR PRINT CLEARLY IN BLUE OR BLACK INK. (Este formulario está disponible en español. For the Spanish version go to http://www.dhs.state.il.us/onenetlibrary/27897/documents/forms/IL444-3455S.pdf)

- With your application, you must **include documents that confirm your reason for needing child care.** Please see Section 12 for a list of required documents to submit with your application.
- **Do not leave anything blank**. Please write "N/A" instead. Fields left blank will be assumed not applicable, but applications may be returned or delayed if critical information or attachments are missing.
- **If you have questions**, please contact your local Child Care Resource and Referral Agency (CCR&R) or Child Care Provider. To find your CCR&R, visit: https://www.inccrra.org/about/sdasearch or call 1-877-202-4453 (toll-free). FAQs are also available at: https://www.dhs.state.il.us/page.aspx?item=30355.

SECTION 1 - PARENT/GUARDIAN: TELL US ABOUT YOU

Please note: demographic information is used to understand how well CCAP is supporting all of the diverse populations in Illinois. It does not affect your eligibility for child care. See FAQs for more information.

First Name:	Last Name:	Social Security Number (Optional)*

Home Address:	Apt#:	City:	State:	Zip Code:
Mailing address, if different than above:	**Apt#:**	**City:**	**State:**	**Zip Code:**

County:

primary language spoken at home:
☐ English ☐ Spanish ☐ Other Specify:

Date of Birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to respond

Do you identify as transgender?
☐ Yes ☐ No ☐ Prefer not to disclose

Race and Ethnicity (check all that apply):

☐ African-American/Black ☐ Hispanic or Latina/o/x ☐ Other Specify:
☐ Arab American ☐ Native American/American Indian ☐ Not Identified
☐ Asian American and Pacific Islander ☐ White/Caucasian ☐ Prefer not to disclose

Are you Active Duty Military? ☐ Yes ☐ No

Are you Member of National Guard or Military Reserve? ☐ Yes ☐ No

Do you have a disability?
☐ Yes ☐ No ☐ Prefer not to disclose

Telephone Number:	Type:	E-mail Address
	☐ Cell ☐ Home ☐ Work	

May we send text notifications to your cell phone? ☐ Yes ☐ No

May we use email as an alternative method of communication? ☐ Yes ☐ No

Why do you need child care (check all that apply)?

☐ Work ☐ **Experiencing Homelessness ☐ Transfer from DCFS/Intact Family
☐ School/Training/TANF ☐ Searching for work/school
☐ *Other (please explain):

**Other response may not be a qualifying event; all activities are subject to approval.*
***Homelessness includes lacking a fixed, regular, and adequate nighttime residence. See FAQs for more detail.*

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name: _____

SECTION 2 - FAMILY MEMBERS: WHO LIVES IN YOUR HOME?

List all family members **living in your home**. This includes:

- Second parent, guardian, or stepparent if they live in your home
- Your biological or adoptive children under the age of 21
- Adults related to you by blood or law whom you provide more than 50% of their support - e.g., elderly family member or person(s) with physical and/or developmental/intellectual disabilities

*Note: If you are a teen parent (less than 20 years old), do not include your parents.

This is **used to calculate family size** which, along with income, determines eligibility and copay amount.
*Social Security Numbers are not used to determine eligibility but help us process your application faster.

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER (Optional)

SECTION 3 - SECOND PARENT/GUARDIAN

This section must be completed if the other parent/guardian is living in the same home as the applicant and child(ren).

Does the **other parent, guardian, or stepparent** of any child living in your home also live in your home? ☐ Yes ☐ No

Other Parent/Guardian/Stepparent First Name	Last Name	Date of Birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to respond

Are they Active Duty Military? ☐ Yes ☐ No

Are they a Member of National Guard or Military Reserve? ☐ Yes ☐ No

Telephone Number:	Type:			E-mail Address
	☐ Cell	☐ Home	☐ Work	

Why can't the second parent/guardian watch the child(ren) (check all that apply)?

☐ Work ☐ Medical Need ☐ *Other (please explain):

☐ School/Training/TANF ☐ Searching for work/school

Other response may not be a qualifying event; all activities are subject to approval.

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name: _____

SECTION 4 - CHILDREN IN CHILD CARE

Please share more information on the child(ren) that you need child care assistance for.

NAME	Gender (Man/Woman/ Non-binary/ Other)	Do they identify as transgender? (Yes/No/ Prefer not to respond)	Disability or Delay? (Yes/No)	US Citizen* (Yes/No)	Ethnic Origin* (see key below)	DCFS / Foster Child or Active Intact Family (Yes/No)

*Ethnicity and US Citizenship of children in child care is required for reporting on how funding is distributed, summarized for all Illinois CCAP families. Your answer will not affect your eligibility for CCAP. Use the following numbers for Ethnic Origin (enter all that apply).

1 = African-American/Black
2 = Arab American
3 = Asian American
4 = Hispanic or Latina/o/x
5 = Native American/American Indian
6 = Native Hawaiian or Pacific Islander
7 = White/Caucasian
8 = Other/Not Identified

SECTION 5 - OTHER SERVICES AND INFORMATION

*In addition to assistance with child care, IDHS offers a variety of services that support families with young children. Below is a list of IDHS funded programs that you may be currently receiving, or you can be connected to through the CCR&R. Participation in these services **does not** affect your eligibility for child care.*

Does anyone in your household participate in any of the following? *(check yes or no for each. **1-3 in bold are required** for reporting but do not affect eligibility)*		Would you like more information?	
1.Food Assistance (SNAP)	☐ Yes ☐ No	☐ Yes	☐ No
2.Homeless Shelter and/or Prevention Programs	☐ Yes ☐ No	☐ Yes	☐ No
3.Housing voucher or cash assistance	☐ Yes ☐ No	☐ Yes	☐ No
4.Domestic & Sexual Violence Intervention	☐ Yes ☐ No	☐ Yes	☐ No
5.Women, Infants and Children (WIC) Program	☐ Yes ☐ No	☐ Yes	☐ No
6.Healthy Families Illinois	☐ Yes ☐ No	☐ Yes	☐ No
7.Parents Too Soon	☐ Yes ☐ No	☐ Yes	☐ No
8.Early Intervention (EI) Services	☐ Yes ☐ No	☐ Yes	☐ No
9.Head Start/Early Head Start	☐ Yes ☐ No	☐ Yes	☐ No
10.Low-Income Home Energy Assistance (LIHEAP)	☐ Yes ☐ No	☐ Yes	☐ No
11.Medicaid/Children's Health Insurance Assistance	☐ Yes ☐ No	☐ Yes	☐ No
12.Refugee Medical Assistance	☐ Yes ☐ No	☐ Yes	☐ No
13.Individuals with Disabilities	☐ Yes ☐ No	☐ Yes	☐ No
14.Mental Health Services	☐ Yes ☐ No	☐ Yes	☐ No
15.Substance Use Prevention & Recovery	☐ Yes ☐ No	☐ Yes	☐ No
16.Rehabilitation Services	☐ Yes ☐ No	☐ Yes	☐ No

**Additional information is also available at https://www.dhs.state.il.us*

CHILD CARE ASSISTANCE PROGRAM APPLICATION

	Parent/Guardian Name:

SECTION 6 - WORK INFORMATION

Complete this section if you or second parent/guardian are working.

Applicant	**Second Parent/Guardian or 2nd job if single-parent** *(please circle to indicate which one)*
Number of jobs currently working: ☐ One ☐ Two* ☐ None *(*copy this page and attach for additional jobs)*	Number of jobs currently working: ☐ One ☐ Two* ☐ None *(*copy this page and attach for additional jobs)*
Employer/Company Name:	Employer/Company Name:
Address:	Address:
City/State/Zip Code:	City/State/Zip Code:
Work Telephone Number/Extension:	Work Telephone Number/Extension:
When did you start this job (mm/dd/yyyy)?	When did you start this job (mm/dd/yyyy)?

Please give a normal work schedule

DAY	START	END
SUNDAY	☐ AM ☐ PM	☐ AM ☐ PM
MONDAY	☐ AM ☐ PM	☐ AM ☐ PM
TUESDAY	☐ AM ☐ PM	☐ AM ☐ PM
WEDNESDAY	☐ AM ☐ PM	☐ AM ☐ PM
THURSDAY	☐ AM ☐ PM	☐ AM ☐ PM
FRIDAY	☐ AM ☐ PM	☐ AM ☐ PM
SATURDAY	☐ AM ☐ PM	☐ AM ☐ PM

Travel time from the child care provider to work:

_____(hours) _____(minutes)

Do you use public transportation? ☐ Yes ☐ No

Please give a normal work schedule

DAY	START	END
SUNDAY	☐ AM ☐ PM	☐ AM ☐ PM
MONDAY	☐ AM ☐ PM	☐ AM ☐ PM
TUESDAY	☐ AM ☐ PM	☐ AM ☐ PM
WEDNESDAY	☐ AM ☐ PM	☐ AM ☐ PM
THURSDAY	☐ AM ☐ PM	☐ AM ☐ PM
FRIDAY	☐ AM ☐ PM	☐ AM ☐ PM
SATURDAY	☐ AM ☐ PM	☐ AM ☐ PM

Travel time from the child care provider to work:

_____(hours) _____(minutes)

Do you use public transportation? ☐ Yes ☐ No

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name:

SECTION 7 - SCHOOL/TRAINING INFORMATION

Complete this section if you or second parent/guardian are enrolled in school/training/TANF program.

Applicant	Second Parent/Guardian
Do you have a Bachelor's degree? ☐ Yes ☐ No	Do you have a Bachelor's degree? ☐ Yes ☐ No
Type of education/training attending/enrolled in: ☐ Below Post-Secondary (e.g., ABE or ESL) ☐ High School or GED ☐ Occupational/Vocational Certificate Program ☐ 2/4-Year College Degree ☐ Work experience (TANF only)	Type of education/training attending/enrolled in: ☐ Below Post-Secondary (e.g., ABE or ESL) ☐ High School or GED ☐ Occupational/Vocational Certificate Program ☐ 2/4-Year College Degree ☐ Work experience (TANF only)
School/Training Program Name:	School/Training Program Name:
Address:	Address:
City/State/Zip Code:	City/State/Zip Code:
School Telephone Number:	School Telephone Number:
Term Begin Date: (mm/dd/yyyy) / Term End Date: (mm/dd/yyyy)	Term Begin Date: (mm/dd/yyyy) / Term End Date: (mm/dd/yyyy)

Please give a normal school schedule

DAY	START	END
SUNDAY	☐ AM ☐ PM	☐ AM ☐ PM
MONDAY	☐ AM ☐ PM	☐ AM ☐ PM
TUESDAY	☐ AM ☐ PM	☐ AM ☐ PM
WEDNESDAY	☐ AM ☐ PM	☐ AM ☐ PM
THURSDAY	☐ AM ☐ PM	☐ AM ☐ PM
FRIDAY	☐ AM ☐ PM	☐ AM ☐ PM
SATURDAY	☐ AM ☐ PM	☐ AM ☐ PM

Travel time from the school to the child care provider:

_____(hours) _____(minutes)

Do you use public transportation? ☐ Yes ☐ No

Please give a normal school schedule

DAY	START	END
SUNDAY	☐ AM ☐ PM	☐ AM ☐ PM
MONDAY	☐ AM ☐ PM	☐ AM ☐ PM
TUESDAY	☐ AM ☐ PM	☐ AM ☐ PM
WEDNESDAY	☐ AM ☐ PM	☐ AM ☐ PM
THURSDAY	☐ AM ☐ PM	☐ AM ☐ PM
FRIDAY	☐ AM ☐ PM	☐ AM ☐ PM
SATURDAY	☐ AM ☐ PM	☐ AM ☐ PM

Travel time from the school to the child care provider:

_____(hours) _____(minutes)

Do you use public transportation? ☐ Yes ☐ No

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name:

SECTION 8 - EMPLOYMENT/SELF EMPLOYMENT INCOME

This helps us determine your income eligibility and copayment amount. List each job that a working family member has on a separate row. ***Please do not leave any blanks*** *- write "N/A" if not applicable.*

Working family members in household (name, employer name)	**Rate of pay** (gross wages*; include overtime, bonuses)	**How often are you paid?**	**Other earned income** (e.g., tips, cash jobs, freelance)
	$ ☐ per hour ☐ per day ☐ other	☐ every day ☐ every two weeks ☐ every week ☐ once per month ☐ other explain	$ ☐ per week ☐ per month ☐ per hour
	$ ☐ per hour ☐ per day ☐ other	☐ every day ☐ every two weeks ☐ every week ☐ once per month ☐ other explain	$ ☐ per week ☐ per month ☐ per hour
	$ ☐ per hour ☐ per day ☐ other	☐ every day ☐ every two weeks ☐ every week ☐ once per month ☐ other explain	$ ☐ per week ☐ per month ☐ per hour
	$ ☐ per hour ☐ per day ☐ other	☐ every day ☐ every two weeks ☐ every week ☐ once per month ☐ other explain	$ ☐ per week ☐ per month ☐ per hour
	$ ☐ per hour ☐ per day ☐ other	☐ every day ☐ every two weeks ☐ every week ☐ once per month ☐ other explain	$ ☐ per week ☐ per month ☐ per hour
	$ ☐ per hour ☐ per day ☐ other	☐ every day ☐ every two weeks ☐ every week ☐ once per month ☐ other explain	$ ☐ per week ☐ per month ☐ per hour

**Gross wages are before any deductions are taken out (e.g., before taxes, insurance, benefits, garnishments are subtracted).*

SECTION 9 - OTHER HOUSEHOLD INCOME

Please share additional income your household receives. This is also used to determine income eligibility and copay. ***Please do not leave any blanks*** *- mark "No" or write "N/A" if not applicable.*

Please check yes or no for each type of income your household receives and write the total monthly amount.

- Include all family members living in the home: yourself, second parent/guardian (if living in the home), and all others listed in Section 3.
- Do not leave any blanks in this section - select "No" and write "N/A" for amount

			Monthly Amount (total for household)
1. Child Support Received for any family member?	☐ Yes	☐ No	$
2. Child Support Paid by you or other family member (subtracted)	☐ Yes	☐ No	- $
3. IDHS TANF Cash Assistance?	☐ Yes	☐ No	$

4. Other Monthly Income - Check yes or no for each and enter total to right: *Including, but not limited to (CCAP Policy 01.02.02 Non-exempt Income; see FAQs for more details):*

Unemployment Compensation	☐ Yes	☐ No	Alimony	☐ Yes	☐ No	$
Social Security (SSI, SSA)	☐ Yes	☐ No	DCFS Adoption assistance	☐ Yes	☐ No	
Workers Compensation	☐ Yes	☐ No	Interest Annuities	☐ Yes	☐ No	
Other	☐ Yes	☐ No	Royalties/Pension	☐ Yes	☐ No	

SECTION 10 - OTHER RESOURCES

Does your family currently have **assets/resources that exceed $1,000,000** in value? ☐ Yes ☐ No
Assets include, but are not limited to: homes, real estate, cars, campers, stocks, bonds, and cash.

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name:

SECTION 11 - CHILD CARE ARRANGEMENT

**If your provider does not have a 15-digit CCMS Provider ID, please have them fill in sections A - E (at the end of this document) to submit with your application, in addition to filling in this section.*

Provider First Name	Provider Last Name	*15-digit CCMS Provider ID

If you are a Day Care Center, Corporate Name

Home Address:	Apt#:	City:	State:	Zip Code:

Provider's relationship to child(ren) (please write "N/A" if none):

Child Care Schedule - Usual hours your child(ren) is in the care of this provider

	MON	TUE	WED	THURS	FRI	SAT	SUN
FROM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
TO	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

Child's first and last name	Does the child care schedule above vary for this child? (Yes*/No); If yes, explain below	Does this child attend school? (Yes/No)	If yes, what hours is the child in school?	Date child care will begin for this child (mm/dd/yyyy)

*Please explain how the Child Care Schedule above varies for any of the children listed:

Provider Name (please print): _____

Provider Signature: _____ **Date:** _____

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name: _____

SECTION 12 - PARENT/GUARDIAN REQUIREMENTS

I understand and agree to the following:

Eligibility Verification: I need to provide documentation on the following reasons for needing child care to verify eligibility for assistance. Please check all that are submitting with this application:

- ☐ **Work:** 2 most recent and consecutive pay stubs for each family member employed in the household or an income verification letter from employer if you/they haven't been paid yet.
- ☐ **Self-employment:** Documentation of gross earnings and expenses for the past month or the most recent Federal Tax Return.
- ☐ **School:** Official school schedule and most recent report card showing grade point average (GPA).
- ☐ **TANF Activity:** Current Responsibility and Service Plan (RSP)
- ☐ **Experiencing Homelessness:** Certification of Temporary Living Arrangement Questionnaire.
- ☐ **Intact Family Transfer:** Intact Family Services Case-IDCFS/IDHS Child Care Services Referral Form 2000A.

Provider and Fees: I am responsible for the selection of the child care provider(s) for my child(ren), and:

1. **I will need to pay a monthly copayment to the provider** that is based on family income and size as determined by IDHS.
2. Child care **providers may charge other fees** that IDHS will not pay and I will be responsible for (e.g., registration, field trip, difference between their rate and the maximin CCAP daily rate, late fees). Refer to the provider's program manual or financial agreement to determine which additional fees you need to pay for.
3. I must also pay the provider for care not approved by CCAP, including while eligibility is being determined.
4. CCAP will make payments to all types of legal, qualified care providers, licensed and license-exempt centers and homes and license-exempt relatives and non-related in the home of the provider or the home of the child.

Change of Information: I need to report the following within 10 calendar days of becoming aware of the change:

1. Change in family income that exceeds 85% of the State Median Income (SMI);
2. Change in activity that is not temporary (e.g., loss of employment, graduate from school or training activity);
3. Request for change in child care provider;
4. Any change in child care arrangements (including child care provider's location, relationship of the provider and the child, cost, or need for care);
5. If there is no longer a need for child care assistance;
6. If the family moves out of Illinois;
7. If the child(ren) moves out of the home;
8. Change in contact information (e.g., phone number, email address, mailing address).

Parents/Guardians may need to repay IDHS if failure to report changes causes improper payments.

Applicants Initials: _____

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name: _____

SECTION 13 - PARENT/GUARDIAN AGREEMENT OF UNDERSTANDING

I understand and agree to the following:

Eligibility Determination

1. I understand the information provided will be checked using State and other databases, and if inconsistencies are discovered, the processing of my application may be delayed or denied.
2. I understand that eligibility shall terminate at the end of the twelfth month unless the redetermination is completed, and the family is determined eligible for on-going services.
3. I understand that if my family income exceeds 85% of the State Median Income (SMI), if the parent(s)/ guardian(s) experiences a non-temporary change in the work or educational status, if the child has left the home or the family has moved out of Illinois, then I will no longer be eligible for CCAP.
4. I understand that I have the right to appeal and to have a fair hearing concerning any decision.

Other Services

5. I'm aware that Temporary Assistance for Needy Families (TANF) recipients have the right to be exempted from TANF mandatory participation in employment services activities if appropriate when child care is not available, affordable or cannot be accessed.
6. I understand that child care assistance for foster children, and active participants in Intact Family Services, should be requested through the Illinois Department of Children and Family Services (IDCFS).

Applicants Initials: _____

SECTION 14 - PARENT/GUARDIAN AUTHORIZATION

1. I declare under penalty of perjury that I have read and agree with all statements on this form and the information I give is true, correct, and complete to the best of my knowledge.

2. I understand that giving false information or failing to provide correct information can also result in an overpayment which I will have to pay back and could result in my prosecution for fraud.

3. My signature is my consent and authorization for information to be released by or to the Illinois Department of Human Services (IDHS) or its agents that may establish my eligibility, or my continued eligibility for the Child Care Assistance Program (CCAP).

Applicants Signature: _____ **Date:** _____

Second Parent/Guardian Signature: _____ **Date:** _____
(if living in the home)

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name:

SECTION A - CHILD CARE PROVIDER INFORMATION

Complete sections A - E if provider does not have a 15-digit CCMS Provider ID listed in section 11.

Provider First Name	Provider Last Name	Birthdate: (mm/dd/yyyy)
Corporate/Business Name, if applicable:		County:

Service Address:	Apt#:	City:	State:	Zip Code:
Mailing Address: ☐ Same as above	Apt#:	City:	State:	Zip Code:

Primary Language: ☐ English ☐ Spanish ☐ Other Specify:

Telephone Number:	Type: ☐ Home ☐ Cell ☐ Work ☐ Other	E-mail Address

May we send text notifications to your cell phone? ☐ Yes ☐ No

May we use email as an alternative method of communication? ☐ Yes ☐ No

SECTION B - PROVIDER TYPE: PLEASE SELECT ONE

Centers and Licensed Providers	**Care by a Relative** (License not required)	**Care by a Non - Relative** (License not required)
☐ Licensed Day Care Center ☐ Licensed Day Care Home ☐ Day Care Center Exempt from Licensing ☐ Licensed Group Day Care Home	☐ In Child Care Provider's Home ☐ In Child's Home	☐ In Child Care Provider's Home ☐ In Child's Home

Daily Rate per child:	Under Age 2	Age 2	Age 3 and Older
Full - Day			
Part - Day			

Do you offer a multi-child/family discount? ☐ Yes ☐ No If yes, please explain:

SECTION C - FOR LICENSED PROVIDERS

Complete one of the following taxpayer identification numbers:

1. Social Security Number: (Individual or sole proprietor)	2. FEIN: (Corporation, partnership or sole proprietor)	3. Government Unit Code: (Public school or park district)
License Number:	**License Capacity: (day/night)**	**License Expiration: (mm/dd/yyyy)**

Hours of Operation: FROM		☐ A.M. ☐ P.M.	TO:	☐ A.M. ☐ P.M.	Date of last inspection: (mm/dd/yyyy)
and FROM		☐ A.M. ☐ P.M.	TO:	☐ A.M. ☐ P.M.	

State of Illinois
Department of Human Services - Division of Early Childhood

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name:

SECTION D - FOR LICENSE EXEMPT PROVIDERS

Social Security Number:	Prior legal name(s) or "n/a":	Date of last health & safety visit: (mm/dd/yyyy)

Are you an employee of the Illinois Department of Human Services or any other State agency? ☐ Yes ☐ No

Do you have another job? ☐ Yes ☐ No | If yes, will you be working while children are in your care? ☐ Yes ☐ No

If care is being provided in the home of the provider, list all other people living in the provider's home.

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER (Optional)

SECTION E - CHILD CARE PROVIDER CERTIFICATIONS

Provider Registration: Providers new to CCAP will need to submit the following additional documents to the Child Care Resource and Referral agency (CCR&R) in order to complete this application. Please check all that you have included today (some counties may have additional requirements):

- ☐ **A W9 form for payment processing.**
- ☐ **License-exempt child care center must** submit a License-exempt Center Verification letter from IDCFS.
- ☐ **License-exempt home providers must** submit copies of their Social Security Card and current valid driver's license, State ID card, or military ID.

Additionally, child care centers, group homes and homes that are subject to licensing by the Illinois Department of Children and Family Services (IDCFS) must remain in "good standing."

Parent/Guardian Rights

1. Parents/Guardians will have unrestricted access to their child(ren) at all times.

Payments and Fees

2. I cannot be paid until I complete a W-9 form and I am certified by the Illinois Office of the Comptroller.
3. I will submit a billing form during the month following care only for the days on which I cared for the child(ren).
4. The family co-payment as listed on the Notice of Approval will be deducted from the payments.

CHILD CARE ASSISTANCE PROGRAM APPLICATION

Parent/Guardian Name: _____

5. The State is required to make payment deductions for home child care providers who are members of Service Employees International Union (SEIU).
6. The State is not liable for payment of child care services provided prior to or after the eligibility period as listed on the Notice of Approval.

Background Checks

7. I and all required members of my household and staff will comply with all background check requirements.
8. Payments will not be made if the provider or member of their household or staff fail any required background check.
9. Appeals of failed background checks must be filed with the agency that reported a disqualifying offense.
10. I will report any new staff or person(s) living in my household within ten (10) calendar days to determine if a background check is required.

Health and Safety

11. The children will be supervised (indoors and outdoors) at all times.
12. If I am a licensed child care provider, I will comply with all training requirements established by Illinois Department Children and Family Services (IDCFS).
13. As a non-relative provider exempt from licensing, I will complete all required Health, Safety and Child Development trainings including pre-service, orientation and annual requirements as required by CCAP Policy 05.05.01 https://www.dhs.state.il.us/page.aspx?item=85480.
14. As a provider exempt from licensing, either in my home or the home of the child(ren), I agree to a visit from a CCR&R Health and Safety Coach at least once a year to help ensure that all standards listed in CCAP Policy 05.01.03 https://ww.dhs.state.il.us/page.aspx?item=88036 are being met.
15. I and members of my staff/household are in compliance with all State and local health departments, and Fire Marshall health, safety and fire codes and standards including firearms and ammunition.
16. There will be no corporal punishment of any child(ren).

Records

17. I will maintain, for a minimum of five (5) years from the date of payment, daily attendance records and agree to make all attendance and payment records and supporting documentation available to any authorized Department representatives and Federal authorities.
18. Failure to maintain adequate records shall establish a presumption in favor of the State for any funds paid by the State for which adequate documentation is not available to support disbursement.

Authorization and Declaration

19. I understand that the information provided will be disclosed only for administrative purposes of the Child Care Assistance Program (CCAP) and for investigation of improper payments and may be subject to release under the Freedom of Information Act (FOIA).
20. I declare under penalty of perjury that I have read and agree with all statements on this form and the information I give is true, correct, and complete to the best of my knowledge.
21. I understand that giving false information or failing to provide correct information can result in being required to repay the State for any improper payments, and could result in my referral for prosecution of fraud or other sanctions.
22. My signature certifies that I have read and understand all the statements listed above.

Provider Name (please print): _____

Provider Signature: _____ **Date:** _____