Clear

At-Risk Child Care Application and Authorization

Authorization: ☐ INITIAL AUTHORIZATION ☐ REDETERMINATION ☐ UPDATE

If update, change in: ☐ Hours ☐ Children ☐ Address ☐ Custody ☐ Eligibility Extension ☐ Termination of Care ☐ Worker/Unit

TO:	FROM: (Print Worker Name)	EMAIL ADDRESS:
	Unit, Number & Address	
	City, Zip Code	

SECTION A: CLIENT/FAMILY INFORMATION **If address for parent/guardian is a P.O. Box, enter street address in "Comments" below.**

Social Security No.	Last Name First Name MI (Print)	Date of Birth	Gender	Race
Social Security No.	Spouse or Other Parent (if applicable) (Print): Last Name First Name MI	Date of Birth	Gender	Race

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

If there is NO spouse: enter the Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Parent/ (if different from above): Last Name First Name MI (Print)	Social Security No.	Date of Birth	Gender	Race

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

SECTION B: ELIGIBILITY

I. Status: ☐ **Assistance** ☐ **Non-Assistance** **Rilya Wilson Act:** ☐ **Yes** ☐ **No**

☐ **At Risk:** ○ PI ○ PS ○ FC ○ Diversion

☐ **Placement Location:** ○ In Home ○ Out of Home: Relative/Non-Relative ○ Foster Care

Custody: ☐ DCF Placement & Care/Custody **Medicaid Eligible:** ☐ **Yes** ☐ **No**

☐ Not Under DCF Placement & Care/Custody

II. FOR COALITION USE ONLY

☐ Income Eligible <100% ☐ Income Eligible 150% - 200% ☐ TANF "Child Only"

☐ Income Eligible 100% <=150% ☐ OTHER ☐ TANF (Relative Caregiver)

III. Primary Purpose of Care: ☑ **PROTECTION**

Secondary Purpose of Care: ☐ Emergency ☐ Therapeutic Plan ☐ TANF At Risk (RCG)

☐ Employment ☐ Work Activity ☐ Education Activity (TED)

SECTION C: AUTHORIZATION

Child care services are authorized for this client for approved activity(ies). The minimum hours of care per child includes ☐ hours per week for reasonable transportation time. ***Children authorized to receive care:***

						FOR COALITION USE ONLY		
Name	SSN	(mm/dd/yy) Birth Date	Race/ Gender	Minimum Hours of Care/week	FAHIS Investigation Intake #	Center/Home Placed	Date Enrolled	Assessed Fee

Gross Monthly Family Income:_____ (Attach Income Documentation, if available)

Care Authorization from _____ through _____ (Not to exceed a 6 month period)

Comments:_____

SECTION D: AUTHORIZING SIGNATURE(S): I hereby certify that the information provided above is correct.

Applicant Signature:_____ Date:_____

Authorizing Worker:_____ Date:_____

If applicable, enter "ext." and extension number

Supervisory Approval:_____ Tel.:_____ Date:_____

Coalition:_____ Date:_____

THIS FORM IS *VOID* AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE