Dear Customer,
In order to process your application for Child Care Assistance in the most efficient and timely manner possible, we will need to verify certain items. We have also included some FAQ's to help you determine if you are potentially eligible for Child Care Assistance.

Required documents:

- Completed three page application for Child Care Assistance.
- Proof of qualifying activity. This can be current wage stubs (30 days worth) and/or a current school schedule.

Frequently asked questions:

Q: Do I need to choose an ICCP provider before I apply for Child Care Assistance?
A: No. To determine if you are eligible, ICCP requires a Child Care Assistance application and the required documents mentioned above.

Q: Does ICCP pay the entire cost of child care?
A: No, the percentage of childcare expense paid for depends on the size of the family, the family's income, the market rate and the number of hours participating in a qualifying activity,. Payments are made directly to the providers.

Q: I'm not working right now, but I am looking for work, would I be eligible for child care assistance for my children?
A: No. In order to be eligible for Child Care Assistance, you need to be engaged in a qualifying activity.

Q: What is a qualifying activity?
A: Working, attending under graduate school, TAFI participation, and in some cases court ordered services.

Q: I am pregnant, can I apply for Child Care Assistance so that when the baby is born I already have it in place?
A: No. In order to be eligible for child care, you must have a child needing child care right now.

Q: Can I have anyone I want be my provider?
A: Yes but the provider must be approved through IdahoSTARS. If your chosen provider is not yet an ICCP eligible provider, have the provider contact 2-1-1 to enroll.

Q: Will I have to pay anything?
A: Yes. There is normally an out-of-pocket cost for co-pay and/or above the amounts allowable by the program.

Proof of	Examples of Documents
Income (most recent 30 days)	Wage Stubs (from most recent 30 days) Employer statement verifying income Self Employment documents such as tax returns or DHW Self Employment form. Child Support Income (if not paid through state of Idaho.)
Child support expenses withheld from income	Written statement from person receiving the payment. Wage stubs (from most recent 30 days) Showing support payment withheld (if not paid through Idaho). For children not in household.
Child Care Expenses due to Work, TAFI Participation, or school attendance.	Complete Monthly Dependent Care Charge form.
Qualifying Activity	School schedule, most recent 30 days of wages.

IDAHO DEPARTMENT OF HEALTH & WELFARE

CHILD CARE ASSISTANCE

APPLICATION FOR CHILD CARE ASSISTANCE

IMPORTANT NOTICE: If you need any of the following assistance, please ask. These services are free:

- Language Interpreter. (Nosotros proveemos los servicios de un interprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
- Help filling out this form.
- Accommodation for a disability.

INSTRUCTIONS: Read all questions and instructions carefully. The instructions include tips to help you fill out the application quickly and easily. Read the back side of each page for more information. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken_____ Written_____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐ No ☐ Yes

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted. ☐ No ☐ Sí

Tell Us Who You Are

First Name	Middle Initial	Last Name	Date of Birth	Former Names, if any
Home Address	City	State	Zip Code	County
Mailing Address (if different)	City	State	Zip Code	County
Daytime Phone Number (work, home, or cell)		If none, where can we leave a message? Phone:		E-Mail Address

List all household members living in your home. Even if a person does NOT want assistance, list them below. Social Security numbers and citizenship status are required for those applying for services. Use the code key on the back of page 1 to indicate your Marital Status and Race. Your responses to the Race and Hispanic/Latino boxes are optional.

Name: (First) (Middle) (Last)					Date of Birth:	Social security #:	Relationship to Self:
Immunized? ☐ YES ☐ NO	Sex: ☐ M ☐ F	Marital Status:	Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	Birth State (if born in US):	Birth Country:
Name: (First) (Middle) (Last)					Date of Birth:	Social security #:	Relationship to Self:
Immunized? ☐ YES ☐ NO	Sex: ☐ M ☐ F	Marital Status:	Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	Birth State (if born in US):	Birth Country:
Name: (First) (Middle) (Last)					Date of Birth:	Social security #:	Relationship to Self:
Immunized? ☐ YES ☐ NO	Sex: ☐ M ☐ F	Marital Status:	Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	Birth State (if born in US):	Birth Country:

CHILD CARE ASSISTANCE is provided by the Idaho Child Care Program (ICCP) to help parents and caretakers pay part of the costs of child care while they are working, attending school or training, or participating with the Department's Enhanced Work Services contractor.

TO APPLY for Child Care Assistance, complete and sign an application and return it to the ICCP Consolidated Unit :

REGION IV MSC4355
SELF RELIANCE
IDAHO DEPARTMENT OF HEALTH AND WELFARE
PO BOX 83720
BOISE ID 83707-9815

Email: ICCPUnit@dhw.idaho.gov

You may need to provide the following proof:

- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Child care costs.
- Immunization records for any children not yet in school. (If you do not immunize due to medical or religious reasons, please provide a written statement stating your reason.)
- Name of childcare provider.
- Current school schedule (if attending school) for parents/caretakers - this must include days and times in class.
- Child support paid for a child not living with you. Your child care benefit amount may increase if you provide this proof.

To receive Child Care Assistance, you must meet the following program requirements:

- If both parents are in the household, each parent must be working, attending school or training or participating with the Department's Enhanced Work Services contractor in order for the family to be approved for Child Care Assistance.
- You must be working, attending school/training, or participating with the Department's Enhanced Work Services contactor to receive Child Care Assistance.
- ICCP only covers a part of your child care costs while you are actually at work or attending school or training or participating in Enhanced Work Services. You must pay the remaining costs not covered by the Child Care program. ICCP will never pay 100% of your child care costs.
- ICCP will cover part of your child care costs only when care is provided by an ICCP registered child care provider.

If you receive Child Care Assistance, you must report changes such as:

- When your work or education hours change from part-time (24 hours per week or less) to full-time (25 or more hours per week).
- When your work or education hours change from full-time (25 or more hours per week) to part-time (24 hours per week or less).
- When you are no longer participating in work or education activities.
- When you switch child care providers or stop using child care services.
- When your living address changes.
- When your income exceeds the gross income limit for your household size (see www.benefitprograms.dhw.idaho.gov for income limits).

If you have questions about applying for Child Care Assistance, please call 1-866-343-2027 or by emailing ICCPUnit@dhw.idaho.gov. For information on how a child care provider can become registered with ICCP please contact the Idaho CareLine by dialing 2-1-1 or 1-800-926-2588.

Example of how to complete page 1

Name: (First)	(Middle)	(Last)	Date of Birth:	Social security #:	Relationship to Self:
Jon	Nathan	Doe	01-02-1957	012-34-5678	Self

Immunized?	Sex:	Marital Status:	Race:	Hispanic or Latino? (Optional)	U.S. Citizen?	Birth State (if born in US):	Birth Country:
☒ YES ☐ NO	☒ M ☐ F	WI	WH	☐ YES ☒ NO	☒ YES ☐ NO Alien ID #:	Kansas	US

Marital Status Codes:

Married -	MA
Never Married -	NM
Divorced -	DI
Separated -	SE
Widowed -	WI

Race Codes:

White - WH
Black - BL
Asian - AS
American Indian/Alaska Native - AL
Native Hawaiian/Pacific Island - HP

Tell Us Who You Are (continued)

List all household members living in your home.

Name: (First) (Middle) (Last)					Date of Birth:	Social security #:	Relationship to Self:
Immunized? ☐ YES ☐ NO	Sex: ☐ M ☐ F	Marital Status:	Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	Birth State (if born in US):	Birth Country:
Name: (First) (Middle) (Last)					Date of Birth:	Social security #:	Relationship to Self:
Immunized? ☐ YES ☐ NO	Sex: ☐ M ☐ F	Marital Status:	Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	Birth State (if born in US):	Birth Country:
Name: (First) (Middle) (Last)					Date of Birth:	Social security #:	Relationship to Self:
Immunized? ☐ YES ☐ NO	Sex: ☐ M ☐ F	Marital Status:	Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	Birth State (if born in US):	Birth Country:

Do you have any students In your home? List any household member age 16 or older who is a student or planning to attend school.

STUDENT NAME	WHERE ATTENDING SCHOOL	HOURS PER WEEK	EXPECTED GRADUATION DATE

Tell Us About Your Household Income

* If you need to provide more information, please attach extra sheets

Please list all money received and/or expected by all household members. Include all income from wages, Social Security, Child Support, unemployment, tips, gifts or loans of cash, etc.

TYPE OF MONEY RECEIVED	WHO EARNED / RECEIVED MONEY	NAME OF EMPLOYER	EMPLOYER PHONE	HOW OFTEN PAID	$ PER HOUR	HOURS PER WEEK	TOTAL MONTHLY AMOUNT
				☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			
				☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			
				☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			

Is anyone in the household self-employed? ☐ No ☐ Yes Who? _____

Name of business: _____

Years in business:_____ Hours per week: _____

List all household members paying court-ordered child support expenses

NAME OF PERSON PAYING CHILD SUPPORT	AMOUNT PAYED PER MONTH	LAST DATE PAID	NAME OF PERSON RECEIVING PAYMENT

DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including Medicaid, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a green card, becoming a U.S. citizen, or sponsoring relatives in the future.

DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Medicaid only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSN's will not be given to the U.S. Citizen and Immigration Services.

IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS:

U.S. Department of Health & Human Services
Room 506 F, 200 Independence Ave. SW
Washington, D.C. 20201
ocrcomplain@hhs.gov
(202) 619.0403 (Voice)
(202) 619.3257 (TTY)

HHS are equal opportunity providers and employers.

Rights and Responsibilities

By initialing the following provisions, I understand that . . .

_____ I could be sanctioned and required to return any benefits I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

_____ I consent to the gathering, use, and disclosure of my information by the Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.

_____ I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

_____ My signature indicates I have received a copy of the Department Privacy Practices.

_____ My signature certifies that the citizenship / immigration status marked on page 1 is correct for each person applying.

Under penalty of perjury, I swear or affirm that the information I provide is true and complete.

_____ _____

Signature of Applicant Date