Office Use Only

CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

FAMILY REPORT OF CHANGE

Printed Family's Parent First and Last Name:_____

ICCIS ID Number, if known:_____

To continue Child Care Assistance Program participation without penalty, you must report the following changes in your circumstance and provide the required verification listed within the timeframes prescribed.

CHANGE IN ELIGIBLE ACTIVITY: Report within 10 business days of the end of the 3rd month following a loss of employment, or ending attendance at a job training or educational program. Your child care benefit will continue for the following 3 months and you will be considered to be participating in job search activities. You must obtain employment or begin attendance at a job training or educational program, report it to this office, and provide verification before the end of this 3 month period, in order to continue program participation. You are not required to report if you are ending employment and beginning with a new employer.

EMPLOYMENT
Parent First and Last Name:_____

☐ **Employment Ended**
Employer Business Name:_____ Last Day Worked:_____
Submit verification including the name of the employer, the last day employed, the date of your last pay check and the gross wages on your last pay check.

☐ **Employment Beginning/Began. Verification of activity, wages, and earnings must be provided.**

Employer Business Name:_____ Employment Start Date:_____

Employer Name and Contact Number:_____
Schedule of work days and times:

Mon:_____Tues:_____Wed:_____ Thurs:_____

Fri:_____ Sat:_____ Sun:_____

Hourly Rate of Pay: $_____

Pay Frequency is: ☐ Weekly ☐ Monthly ☐ Every Two Weeks (same day of the week)
☐ Twice a Month (such as the 5th and the 20th)
Note: Every two weeks and twice a month are different. Please be certain of the pay frequency before checking the box.

JOB TRAINING/EDUCATIONAL PROGRAM ATTENDANCE

Parent First and Last Name:_____

☐ Attendance Ended

Program Name:_____ Last Day Attended:_____

☐ Attendance Beginning/Began. Verification of program enrollment, class schedule, cost of tuition and fees, and any financial aid received or to be received must be provided.

Program Name:_____ Program Start Date:_____

CHANGE IN INCOME: Report within 10 business days if your family's countable monthly income exceeds 85% of the State Median Income. See the *Family Income and Contribution Schedule.*

☐ **Increase in family countable income exceeding 85% of the State Median Income.** Attach verification.

Family Member Name:_____

Name/type of income source changing:_____

Date Received:_____ Amount Received:_____ New Amount to Continue: ☐ Yes ☐ No

☐ **Decrease in income, not due to employment change above.** Reporting is not required; however, may positively affect your benefit if the decreased amount is expected to continue. Attach Verification.

Family Member Name:_____

Name/type of income source changing:_____

Date Received:_____ Amount Received:_____ New Amount to Continue: ☐ Yes ☐ No

CHANGE IN CHILD CARE NEED: Report within 10 business days when an increase of child care coverage is needed due to a change in your eligible activity.

☐ Change in days/hours

Child Care Provider Name:_____

Child(ren) Name(s): _____

Days/Times Care Needed:

Mon:_____Tues:_____Wed:_____ Thurs:_____

Fri:_____ Sat:_____ Sun:_____

CHANGE OF CHILD CARE PROVIDER: At least 10 business days prior to ending care with your child care provider you must give your child care provider written notice. Within 10 business days of the change occurring you must also report the change and provide a copy of the written notice given to your child care provider to the child care assistance office.

Current Child Care Provider Name:_____

Date 10 day written notice was given to child care provider:_____ Last date of care:_____

New Child Care Provider Name:_____

Date care to begin or began:_____

Child(ren) Name(s):_____

Days/Times Care Needed:

Mon:_____Tues:_____Wed:_____ Thurs:_____

Fri:_____ Sat:_____ Sun:_____

Is full time care needed for school age children for in-service or school closures: ☐ Yes ☐ No

If yes, indicate the names of the children and dates full time care is needed:_____

_____

☐Secondary Provider Needed

Child Care Provider Name:_____

Date care to begin or began:_____

Child(ren) Name(s):_____

Days/Times Care Needed:

Mon:_____Tues:_____Wed:_____ Thurs:_____

Fri:_____ Sat:_____ Sun:_____

Is full time care needed for school age children for in-service or school closures: ☐ Yes ☐ No

If yes, indicate the names of the children and dates full time care is needed:_____

_____

CHANGE IN FAMILY ADDRESS/CONTACT INFORMATION: Report within 10 business days of the change occurring to ensure we have the most current information.

☐ Mailing Address Change

New Mailing Address:_____

☐ Physical Address Change

New Physical Address:_____

☐ Contact Phone Number Change

Home phone number:_____ Work Phone Number:_____

Cell Phone Number:_____ Other Contact Number:_____

_____ _____

Family's Parent Signature Date