State of Montana
Department of Public Health and Human Services
Early Childhood and Family Support Division
Early Childhood Services Bureau
www.childcare.mt.gov

Healthcare Sector
CHILD CARE SCHOLARSHIP PROGRAM
Application and Attachment Information

Application

Child Care Scholarship Application

- Includes *frequently asked questions and an application checklist*

Attachments Included in Packet

The following attachments are included with the application packet and may be needed to complete the process to receive a Child Care Scholarship to help you cover the cost of your child care expenses. Please refer to the application checklist for further information regarding each attachment.

ATTACHMENT A: Adult Household Member Information *(2 copies enclosed)*
ATTACHMENT B: Child Household Member Information *(2 copies enclosed)*
ATTACHMENT C: Child Care Service Plan

Attachments Not Included in Packet

The following attachments are not included with the application packet, but may be needed to complete the process to receive a Child Care Scholarship to help you cover the cost of your child care expenses. Each attachment is available through your Child CareResource and Referral Agency.

ATTACHMENT D: Work Verification
ATTACHMENT E: School / Training Verification
- *ONLY need for student applicants*

ATTACHMENT F: Self-Employment Income Verification
- *ONLY need if self-employed*

ATTACHMENT G: Child Support Compliance Verification
- *ONLY need if there is an absent parent*

ATTACHMENT H: Good Cause Exemption
- *ONLY need if claiming good cause*

Supplemental Information Included in Packet

The following is additional information regarding the Scholarship Program thatis important for you to know.

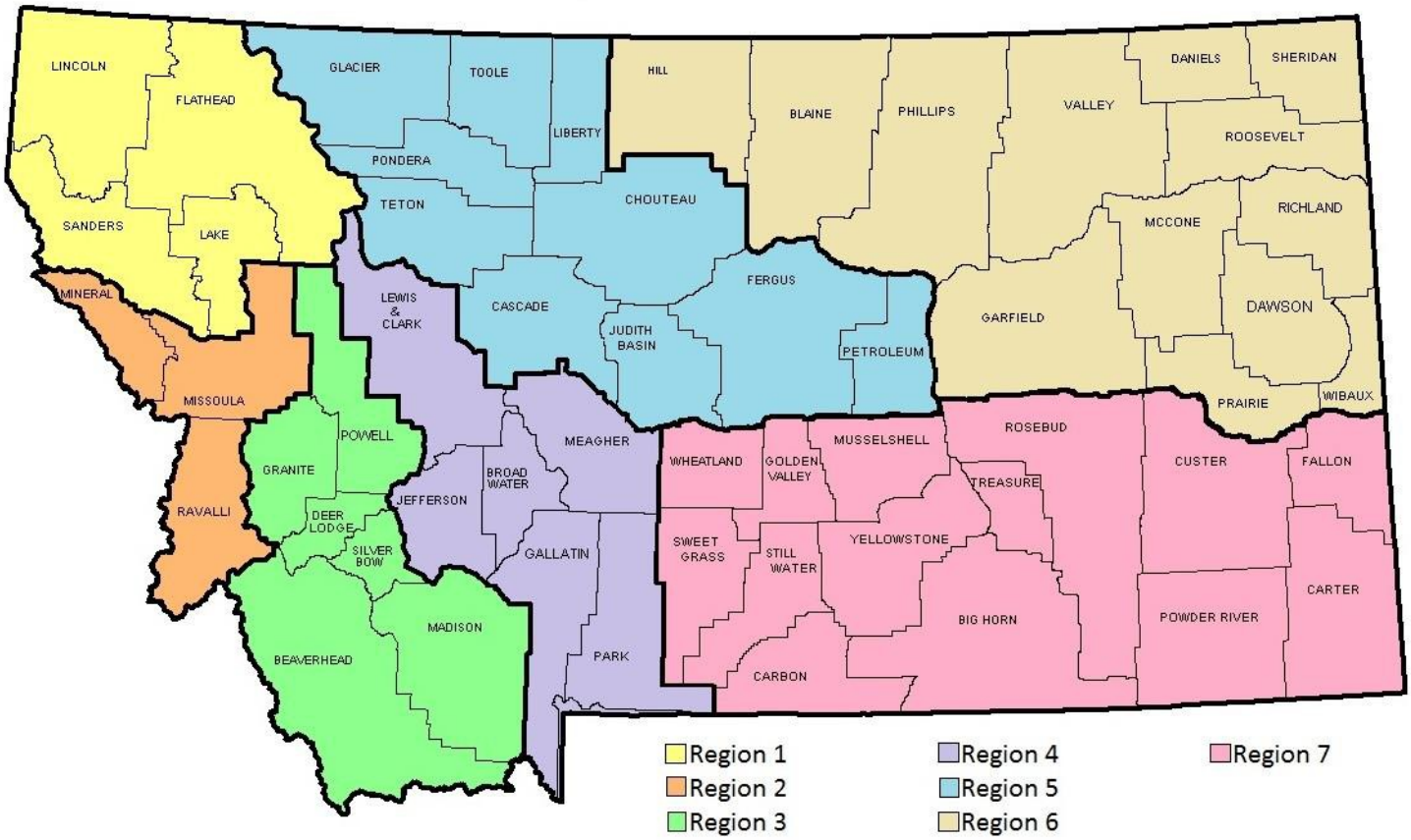
SUPPLEMENT 1: Reporting Requirements
SUPPLEMENT 2: Right to Appeal (Fair Hearings) Procedures

PLEASE SUBMIT ALL SCHOLARSHIP APPLICATION MATERIALS TO:
Addresses for Child Care Resource and Referral Agencies are located on the next page

Families seeking child care assistance must complete the Child Care Scholarship Application. These applications must be obtained from and submitted to a Child Care Resource and Referral Agency.

Child Care Resource and Referral Regional

The following map shown by county indicates the CCR&R for your county.



Region 1	**The Nurturing Center** 322 2nd Ave W, Suite C Kalispell, MT 59901	Office: (406) 756-1414 Toll Free: (800) 204-0644 Fax: (406) 756-1410
Region 2	**Child Care Resources** 500 N. Higgins, Suite 202 Missoula, MT 59807-7038	Office: (406) 728-6446 Toll Free: (800) 728-6446 Fax: (406) 549-1189
Region 3	**Butte 4 C's** 101 N. Main Butte, MT 59701	Office: (406) 723-4019 Toll Free: (800) 794-4061 Fax: (406) 723-6982
Region 4	**Child Care Connections** 1143 Stoneridge Drive, Suite 1 Bozeman, Montana 59718	Office: (406) 587-7786 Toll Free: (800) 962-0418 Fax: (406) 587-1682
Region 5	**Family Connections MT Great Falls** 202 2nd Ave S, Suite 201 Great Falls, MT 59405	Office: (406) 761-6010 Toll Free: (800) 696-4503 Fax: (406) 453-8976
Region 6	**Family Connections MT Havre** 2229 5th Ave. Havre, MT 59501-5217	Office: (406) 265-6743 Toll Free: (800) 696-4503 Fax: (406) 265-1312
Region 7	**HRDC District 7** 7 North 31st Street Billings, MT 59103-2016	Office: (406) 247-4732 Toll Free: (800) 443-1411 Fax: (406) 869-2585

For more information, visit https://dphhs.mt.gov/ecfsd/ChildCare/ChildCareResourceandReferral

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Healthcare Sector
CHILD CARE SCHOLARSHIP PROGRAM
Application Frequently Asked Questions

ARPA Healthcare Sector Child Care Scholarship: *Montana's Child Care Assistance Program to help Montana families in the healthcare sector pay for their child care costs.*

How do I apply?
Fill out the application, sign it and turn it in to your local Child Care Resource and Referral Agency. Supply any supporting documentation and attachments. If you need help completing the application the Child Care Resource and Referral Agency can help you complete it. A list of the Child Care Resource and Referral Agencies is available on the on page 2 of the application packet.

To qualify, what must my family and I do?
The Healthcare Sector Child Care Scholarship Program is available to families who meet the following eligibility requirements

Be Income Eligible

- Your family's income must be below 250% of the federal poverty guidelines.

Meet employment and training requirements

- At least one parent must provide direct care services to patients or clients in one of the following health care sector categories:
  - Health care,
  - Behavioral health,
  - Disability services, or
  - Long-term care settings.
- A two-parent household shall work a minimum of 120 hours each month.
  - Example: The work hours may be divided between the two parents. One parent may meet the work requirement while the other parent attends school full time.
- A single parent household shall work a minimum of 60 hours each month.
- A single parent, who is attending school part-time, shall work a minimum of 40 hours each month.

Cooperate with Child Support Enforcement

- Families with a parent absent from the household must comply with the Child Support Enforcement Division, must have a parenting plan signed by a judge and filed with the court, or request a good cause exemption.

How long will it take?
It may take up to 30 days to process your application. If household is eligible, benefits may begin the date you submitted you signed application as long as required documentation is received within 30 days. Benefits cannot be backdated. Avoid possible delays or lapses in service by submitting all the required documentation with your application.

Is an interview required?
No. An interview may be needed if there is not sufficient information to determine your eligibility for assistance. Your interview may be in person or by telephone.

Will I have to pay anything?
Yes, you will pay a monthly co-payment of $100 to your child care provider.

CHILD CARE SCHOLARSHIP

Application and Supporting Documentation Checklist and Instructions

✓ **Check to be sure you have submitted the following documents**

APPLICATION

☐ **APPLICATION**
- *Completed and signed*
- *Signed by both adults in the family, If two parent household*
- *Release of Information must be completed*

ATTACHMENTS

☐ **ATTACHMENT A:**
ADULT HOUSEHOLD MEMBER INFORMATION
- *One per Adult household member*
- *Detail your work and/or school schedule*
- *Request additional copies if needed*

☐ **ATTACHMENT B:**
CHILD HOUSEHOLD MEMBER INFORMATION
- *One per Child household member*
- *Detail your children's school schedule*
- *Request additional copies if needed*

☐ **ATTACHMENT C:**
CHILD CARE SERVICE PLAN
- *To be completed with your child care provider*
- *A separate form is required for each child care provider*
- *Only hours that child care is needed for each child is to be documented, including the start and end time of care*

☐ **ATTACHMENT D:**
WORK VERIFICATION RELEASE
- *To be completed by your employer*
- *Complete the applicant release portion*
- *Send to your employer for completion*

☐ **ATTACHMENT E:**
SCHOOL / TRAINING VERIFICATION RELEASE
- *To be completed by a school official*
- *Complete the Applicant Release portion*
- *Send to your school for completion*

☐ **ATTACHMENT F:**
SELF-EMPLOYMENT INCOME VERIFICATION

☐ **ATTACHMENT G:**
CHILD SUPPORT COMPLIANCE VERIFICATION

☐ **ATTACHMENT H:**
GOOD CAUSE EXEMPTION

SUPPORTING DOCUMENTATION

☐ **PHOTO IDENTIFICATION** (for all adults)
Provide one of the following:
- *Government Issued Identification*
- *Passport*
- *MT Driver's License*
- *School identification card*

☐ **RESIDENCY VERIFICATION**
Provide one of the following:
- *Utility Bill*
- *Rental / Lease Agreement*
- *Mortgage Agreement*
- *MT Driver's License*

☐ **BIRTH CERTIFICATES**
- *Copies of proof of age for each child who will be receiving child care assistance*

☐ **US CITIZENSHIP**
- *Social Security Card (optional)*

☐ **SCHOOL SCHEDULE**
- For all individuals enrolled in and attending school

☐ **INCOME**
- *Proof of all earned income received by you and any other adult in your family*
- *Proof of unearned income received by you and any other adult in your family*
- *Unearned income includes but is not limited to: dividends and interest, Social Security, Supplemental Security Income (SSI) and Child Support*

☐ **SELF-EMPLOYED INDIVIDUALS**
- *A copy of your business license*
- *Your most recently completed and filed Federal tax return*
- *Income and expenses records or other documentation of adjusted gross income and allowable costs of doing business*

SUPPLEMENTAL INFORMATION (Keep for your Records)

☐ **SUPPLEMENT 1:**
REPORTING REQUIREMENTS

☐ **SUPPLEMENT 2:**
RIGHTS TO APPEAL PROCEDURES

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Healthcare Sector Child Care
SCHOLARSHIP APPLICATION

1. *Primary Reason that you are applying for Child Care Assistance?*

What is your household makeup? ☐ Single parent household ☐ Two parent household	Are you a teen parent? ☐ Yes ☐ No
Do you ☐ Own ☐ Rent ☐ Live with relatives ☐ Live with someone else ☐ Other _____	
Do you live in an… ☐ Apartment ☐ House ☐ Mobile Home ☐ Other_____ If other please specify, for example, hotel, motel, camp ground, shelter	
What is the primary reason that you need child care assistance? ☐ Work hours ☐ School hours ☐ Other:	
Have you ever requested or received child care assistance before? ☐ Yes ☐ No If yes, when? Where? (city/county/state)	
Have you ever been disqualified from receiving child care assistance? ☐ Yes ☐ No If yes, when? Where? (city/county/state)	
Are you a SNAP participant? ☐ Yes ☐ No	

2. *Who is the Responsible Party?*

This is the applicant who is requesting child care assistance and assumes responsibility for following the program rules and requirements, including penalties and repayment of any overpaid benefits.

- Include ***proof of identity***, such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate
- Include ***proof of your residence***, such as one of the items listed above or a copy of a recent utility bill, rental lease, or mortgage agreement

LAST NAME	FIRST NAME			MIDDLE NAME
OTHER NAMES YOU MIGHT BE KNOWN AS OR HAVE USED IN THE PAST			E-MAIL ADDRESS	
ADDRESS (physical)				
CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION
MAILING ADDRESS (if different)				
CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION
PRIMARY PHONE Cell Home Work Other			SECONDARY PHONE Cell Home Work Other	
What is your primary spoken language?			Do you need an interpreter? Yes No	
MILITARY STATUS Not in the Military Active Duty US Military National Guard / Military Reserve				

CCR&R OFFICE USE ONLY	**CS** _____ **CE**_____		**HoH Name**		**Date Received**
	Begin Date	**End Date**	**Reason**	**Determination Date**	**Determined By**

3a. FAMILY MEMBERS – Adult Household Members

List all <u>required</u> Adult Household Members (Age 18 and up) as related to the child(ren) for whom a scholarship is requested:

- *Biological, adoptive parent or stepparent of an intact family, regardless of living arrangements. This would include incarcerated parents or parents working and living out of town.*
- *Parent by common law marriage*
- *Parent joined by a common child*
- *Adult acting in loco parentis*

List <u>optional</u> Adult Household Members (Age 18 and up), only if you want them included in eligibility determination

- *Adult sibling, age 18 and over [no Child Support Enforcement Division [CSED] requirement]*
- *Aunt or Uncle*
- *Grandparent or Great Grandparent*
- *Parent's Significant Other*

One or more of the Adult Household Members must provide direct care services to patients or clients in the health care, behavioral health, disability services, or long-term care settings.

ATTACHMENT A: Adult Household Member Information must be completed for all adults listed below

Relationship to you, the applicant	Name (First, Middle, Last)	Working	Hours per Month	Attending School	Hours per Month
SELF		☐ Yes ☐ No		☐ Yes ☐ No	
		☐ Yes ☐ No		☐ Yes ☐ No	
		☐ Yes ☐ No		☐ Yes ☐ No	

3b. FAMILY MEMBERS - Child Household Members, Living in the Home

Minor Household Members (Age 17 and under)

Minor sibling(s), age 17 and under, including stepbrother, stepsister, half-brother and half-sister;

- *Child receiving Temporary Assistance for Needy Families [TANF] Cash benefits, or other subsidy, as a member of the household*

ATTACHMENT B: Child Household Member Information must be completed for all children listed below.

- *Include proof of each child's relationship to you, such as birth certificate, adoption record, legal guardianship statement*
- *Include proof of each child's age, such as their birth certificate*
- *Include proof of citizenship or immigration status for each child in need of child care assistance, such as birth certificate, an adoption record, or an INS Card*

Please check "Child has Disability" below

- If you have a child with an IEP or 504 in school, enrolled or referred to Part C (Montana Milestones) or Part B (IDEA)?

Relationship to you, the applicant	Name (First, Middle, Last)	Attending School	Receiving Child Support	Need Child Care	Child has Disability?
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		Yes No	Yes No	Yes No	Yes No

4. *PROVIDER INFORMATION*

List the provider where your children attend child care.
If the provider is a relative: Please indicate and describe the relationship.
Days / Times of child care: Please indicate the days and times that care is needed.
Child Name: If you have multiple providers and more than one child, please indicate which child attends which provider.

Provider Name	Provider Address	Phone Number	Relative	Relationship	Days / Times of Child Care	Child Name
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

5. *ASSETS*

Does your household have family assets over one million ($1,000,000)? ☐ Yes ☐ No

6. *EARNED INCOME*

List all EARNED income received by you, the applicant, and all members of your family.

- Include income received by family members temporarily absent from your home
- Include proof of earned income:
  - **ATTACHMENT D: Work Verification**

If you or someone in your family is self-employed:

- Complete **ATTACHMENT F: Self-Employment Income Verification**.

Name ○ of individual earning income	Source of Income ○ Including employer name	Gross Monthly Amount (before deductions)

7. *UNEARNED INCOME*

List all *UNEARNED* income received by you, the applicant, and all members of your family.

- Include income received by family members temporarily absent from your home
- Include proof of unearned income, such as a check stub, signed letter from Employer, or income tax records
- Examples of unearned income to include:
  - Child Support
  - Unemployment Insurance
  - Insurance Benefits
  - Veteran's Benefits
  - Social Security
  - SSI
  - Student Loans
  - Interest / Dividends
  - Tribal Payments

Name ○ of individual earning income	Source of Income	Gross Monthly Amount (before deductions)

8. *DEDUCTIONS*

- **Child Support** - Paid out, for children not living in the home
- Include proof of child support payments.

Type of Expense (deduction)	Name of Individual Being Paid	Gross Monthly Amount

9. *HERE ARE YOUR RIGHTS AND RESPONSIBILITIES*

	a. I have the right to choose my child care provider. The scholarship will only pay a child care provider that is licensed, registered, or certified.
	b. I will pay a monthly co-payment to the child care provider. If I have an unpaid co-payment, I will be ineligible when I re-apply for the scholarship until receipts of unpaid copayments are received.
	c. I understand that child care providers may set their own rates. Providers may charge in addition to the child care program co-payment obligation. I am responsible for any amount over and above the state reimbursement rates and any registration and activity fees not paid by the Child Care Scholarship.
	d. I have the right to appeal any loss of scholarship. I will submit a request for a fair hearing within 90 days of receiving the notice regarding the loss of scholarship.
	e. I have a right to receive a monthly EOB (Explanation of Benefits), which shows the care that has been paid for by the state.
	f. I understand that my Child Care Scholarship will be terminated if my family becomes ineligible or if program funds become unavailable.
	g. I understand my child must be living with me for child care to be paid for under the Child Care Scholarship.
	h. I will be notified of changes that reduce my child care scholarship. A letter will be mailed 15 days before any loss of benefits.
	i. I understand that the Health Sector Worker program is subject to available federal ARPA funds. One or more of the Adult Household Members must provide direct care services to patients or clients in the health care, behavioral health, disability services, or long-term care settings to remain eligible for this program.
	j. **Reporting Change in Provider:** I will report a change in child care provider to my regional Child Care Resource and Referral agency within one business day. *Failure to report may mean that the provider will not receive a payment under the scholarship.* The payment start date for the new provider will be the date the change is reported.
	k. **Reporting a Change in Activity Requirements:** I must report a job loss to my regional Child Care Resource and Referral agency within 10 calendar days. *Failure to report within the required 10 calendar may mean that you don't receive a full grace period.*
	l. **Reporting a Change in Address:** I will report a change in address to my regional Child Care Resource and Referral agency within 10 calendar days. *Failure to report may mean that you don't receive timely notice on changes to eligibility.*
	m. **Repayment**: Anyone who causes an improper payment to a provider by withholding information about any of the above changes will be required to repay the amount of the improper payment. Repayment must be current with the Business and Fiscal Services Division.
Instructions: Please initial all above requirements.	

10. *Authorization to Release Information / Request for Verification*

Certain information is needed to determine eligibility. This includes residency, relationship of applicant to children, school attendance, household composition, income, and other circumstances relevant to the need for child care. The Department or this Child Care Resource & Referral agency may request information about any of the issues involved in the Child Care Eligibility Application Packet. You have the responsibility to provide any additional information necessary to determine eligibility. If you are not able to gather the requested information by yourself, your Department representative may be able to help you. Because this is your confidential information, you must give permission for your CCR&R representative to help you.

***Please Note:** This release does not authorize CCR&R staff to obtain any HIPAA-protected information on the behalf of the child(ren), parent(s), or provider(s).

11. *Applicant & Spouse/Other Adult – Please initial option 1 or 2 and sign below*

OPTION 1: Applicant	**OPTION 2: Applicant**
___I give the Department and the Child Care Resource and Referral agency permission to gather information that is necessary to determine eligibility for my family and me. This authorization expires one year from the date this application is signed. I understand that I can revoke this consent in writing at any time.	___I **DO NOT** wish to sign an authorization to release information. I understand that because of confidentiality issues, the Department and the Child Care Resource and Referral agency will not be able to help in gathering information necessary to determine eligibility. I choose to provide the necessary documentation myself.
OPTION 1: Spouse/Other Adult	**OPTION 2: Spouse/Other Adult**
___I give the Department and the Child Care Resource and Referral agency permission to gather information that is necessary to determine eligibility for my family and me. This authorization expires one year from the date this application is signed. I understand that I can revoke this consent in writing at any time.	___I **DO NOT** wish to sign an authorization to release information. I understand that because of confidentiality issues, the Department and the Child Care Resource and Referral agency will not be able to help in gathering information necessary to determine eligibility. I choose to provide the necessary documentation myself.

I hereby affirm that the statements included in this application are accurate, complete, and true to the best of my knowledge. I understand that I must periodically re-apply for assistance and that my eligibility will be re-determined at that time.

_____ _____

Applicant (or Authorized Representative) Signature Date *Spouse/Other Adult (or Authorized Representative) Signature Date*

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Healthcare Sector Child Care Scholarship

ATTACHMENT A

ADULT HOUSEHOLD MEMBER INFORMATION

- ONE PER ADULT -

1. GENERAL PERSON INFORMATION

GENDER: ☐ Female ☐ Male	Ethnic Affinity? (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino		
LAST NAME	FIRST NAME	MIDDLE NAME	
BIRTH DATE	AGE	SOCIAL SECURITY NUMBER (optional)	Montana State Resident: ☐ Yes ☐ No
RACE: ☐ Asian ☐ Black or African American ☐ Caucasian/White ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Alaskan Native			Tribal Affiliation? ☐ Yes ☐ No Tribe _____
Applicant Name	Relationship to Applicant		
MARITAL STATUS: ☐ Married ☐ Divorced ☐ Separated ☐ Single (Not Married)			

2. CURRENT EMPLOYERS

- PLEASE list all current employers for this person
- Attach two months of consecutive wage stubs for all current employers, for the previous 60 days.
- An employer Verification Form needs to be completed for each current employer listed below.
- If you are self-employed you must complete the Self Employment Verification form.

EMPLOYER NAME			EMPLOYER PHONE #
EMPLOYER'S ADDRESS			HOURLY RATE
WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK	# OF HOURS PER MONTH
EMPLOYER NAME			EMPLOYER PHONE #
EMPLOYER'S ADDRESS			HOURLY RATE
WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK	# OF HOURS PER MONTH

CCR&R OFFICE USE ONLY	**CS_____CE_____**	**HoH Name**			**Date Received**
	Begin Date	**End Date**	**Reason**	**Determination Date**	**Determined By**

Adult Household Member Name	Applicant Name

3. SCHOOL

Are you attending school? ☐ Yes ☐ No	Highest Grade Completed?	Degree or Certificate Earned?
If Yes, - Please complete the below information. - Attach your school schedule - Additionally, a School / Training Verification form will need to be completed from your school.		

School Name	Current Grade	First day of School?	Last Day of School?

4. MONTHLY SCHEDULE *(When you need child care!)*

List the times that you require care for your children.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
m/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

If schedule varies, please explain:

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Healthcare Sector Child Care Scholarship

ATTACHMENT A
ADULT HOUSEHOLD MEMBER INFORMATION

- ONE PER ADULT -

1. GENERAL PERSON INFORMATION

GENDER: ☐ Female ☐ Male	Ethnic Affinity? (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino		
LAST NAME	FIRST NAME	MIDDLE NAME	
BIRTH DATE	AGE	SOCIAL SECURITY NUMBER (optional)	Montana State Resident: ☐ Yes ☐ No
RACE: ☐ Asian ☐ Black or African American ☐ Caucasian/White ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Alaskan Native			Tribal Affiliation? ☐ Yes ☐ No Tribe _____
Applicant Name	Relationship to Applicant		
MARITAL STATUS: ☐ Married ☐ Divorced ☐ Separated ☐ Single (Not Married)			

2. CURRENT EMPLOYERS

- PLEASE list all current employers for this person
- Attach two months of consecutive wage stubs for all current employers, for the previous 60 days.
- An employer Verification Form needs to be completed for each current employer listed below.
- If you are self employed you must complete the Self Employment Verification form.

a. EMPLOYER #1

EMPLOYER NAME			EMPLOYER PHONE #
EMPLOYER'S ADDRESS			HOURLY RATE
WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK	# OF HOURS PER MONTH

b. EMPLOYER #2

EMPLOYER NAME			EMPLOYER PHONE #
EMPLOYER'S ADDRESS			HOURLY RATE
WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK	# OF HOURS PER MONTH

CCR&R OFFICE USE ONLY	**CS_____CE_____**	**HoH Name**			**Date Received**
	Begin Date	**End Date**	**Reason**	**Determination Date**	**Determined By**

Adult Household Member Name	Applicant Name

3. SCHOOL

Are you attending school? ☐ Yes ☐ No	Highest Grade Completed?	Degree or Certificate Earned?
If Yes, - Please complete the below information. - Attach your school schedule - Additionally a School / Training Verification form will need to be completed from your school.		

School Name	Current Grade	First day of School?	Last Day of School?

4. MONTHLY SCHEDULE *(When you need child care!)*

List the times that you require care for your children.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
m/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

If schedule varies, please explain:

State of Montana
Department of Public Health and Human Services
Early Childhood and Family Support Division
Early Childhood Services Bureau
www.childcare.mt.gov

Healthcare Sector Child Care Scholarship

ATTACHMENT B

CHILD HOUSEHOLD MEMBER INFORMATION

- ONE PER CHILD -

1. GENERAL PERSON INFORMATION

GENDER: ☐ Female ☐ Male	Ethnic Affinity? (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino		
LAST NAME	FIRST NAME	MIDDLE NAME	
BIRTH DATE	AGE	SOCIAL SECURITY NUMBER (*optional*)	Montana State Resident: ☐ Yes ☐ No
US CITIZEN: If this is a child who needs care, is the child a US Citizen? ☐ Yes ☐ No			
RACE: ☐ Asian ☐ Black or African American ☐ Caucasian/White ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Alaskan Native			Tribal Affiliation? ☐ Yes ☐ No Tribe _____
Applicant (Head of Household) Name			Relationship to Applicant

2. SPECIAL NEEDS

Has a special need been identified for this child? ☐ Yes ☐ No
If Yes, please talk more with your caseworker regarding additional services for children with special needs.

3. SCHOOL

Does this child attend school (including preschool or kindergarten)? ☐ Yes ☐ No If Yes, please complete the below information		
This child: Is currently in the_____Grade or will be in the_____Grade (in the Fall).		
School Name	First day of school?	Last day of school?

DAYS AND TIMES STUDENT ATTENDS SCHOOL						
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

CCR&R OFFICE USE ONLY	CS_____CE_____	HoH Name		Date Received
Begin Date	End Date	Reason	Determination Date	Determined By

Child Household Member Name	Applicant Name

4. CHILD SUPPORT

Does this child have a parent who does not live in the home? ☐ Yes ☐ No			
-			
☐ Cooperation with CSED	CSED Case #	Who is child support received from?	Amount per month?
☐ Court Approved Parenting Plan		Who is child support received from?	Amount per month?
☐ Claim Good Cause (*please see good cause form*)			
Please indicate what state or tribe do you co-operate with?			

5. SHARED CUSTODY / VISITATION SCHEDULE

If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements, by indicating the time and day that the child is with you under either a shared custody or visitation agreement.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

If schedule varies please explain

6. CHILD CARE PROVIDERS

- PLEASE list all providers that you have for this child
- A Child Care Service Plan needs to be completed for each provider that your child has and must include the hours the child needs care.

a. PROVIDER #1	
PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER
PROVIDER'S ADDRESS	PROVIDER'S LICENSE NUMBER **PV#**
PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER
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State of Montana
Department of Public Health and Human Services
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CCR&R OFFICE USE ONLY	CS_____CE_____	HoH Name		Date Received
Begin Date	End Date	Reason	Determination Date	Determined By

Child Household Member Name	Applicant Name

4. CHILD SUPPORT

Does this child have a parent who does not live in the home? ☐ Yes ☐ No			
Families with a parent absent from the household must comply with the Child Support Enforcement Division or must receive child support under a court order. - Please mark below how you meet the requirements for Child Support Compliance!			
☐ Cooperation with CSED	CSED Case #	Who is child support received from?	Amount per month?
☐ Court Approved Parenting Plan		Who is child support received from?	Amount per month?
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Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

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PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER
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Healthcare Sector Child Care Scholarship

SUPPLEMENT 1

REPORTING REQUIREMENTS

Reporting Changes

You must report a change in child care provider to your Resource and Referral Agency within one business day. Failure to report may mean that the provider will not receive a payment under the scholarship. The payment start date for the new provider will be the date the change is reported.

Fraud

Child care fraud is larceny. Fraud involving more than $500 is a felony. In Montana, a person who purposely makes a false statement to get assistance or who knowingly fails to notify of a change in circumstances that could affect eligibility for assistance may be guilty of larceny. If you are convicted of child care fraud, you can be punished according to Montana law.

Payment Policies

Parents are responsible for paying their Scholarship co-payment, charges above the maximum reimbursable rate the Scholarship may pay to providers, and those registration and activity fees not paid by the Scholarship. Family, Friend, and Neighbor (FFN) and Relative Care Exempt (RCE) providers must pay all fees associated with background checks.

Repayment

Anyone who causes an improper payment to a provider by withholding information about any of the above changes will be required to repay the amount of the improper payment. Repayment will be in either a lump sum or according to a written repayment plan.

Healthcare Sector Child Care Scholarship

SUPPLEMENT 2

RIGHTS TO APPEAL PROCEDURES
ADMINISTRATIVE REVIEWS, (APPEALS) AND FAIR HEARINGS

Child Care Policy Manual

A. ACTIONS SUBJECT TO ADMINISTRATIVE REVIEW, (APPEAL):

Section 1-3 Page 1 of 9

1. A failure of the Department or of the CCR&R agency to provide a parent an opportunity to make an application or reapplication for a child care scholarship;
2. A failure of the Department or of the CCR&R agency to act with reasonable promptness on a parent's application for a child care scholarship [reasonable promptness is 30 calendar days from the date of application];
3. A failure of the Department or of the CCR&R agency to provide timely or adequate notice when an adverse action will be taken; and
4. An action by the Department or the CCR&R agency denying, suspending, reducing or terminating a scholarship of a parent or payment[s] to a provider, or an action by the Department demanding repayment of an overpayment.

B. PROCEDURES:

Section 1-11 Page 1 of 3

Actions taken by a Child Care Resource and Referral [CCR&R] agency must conform to applicable laws, regulations and policies. Parents and providers who are subject to any adverse action, [as defined in section 1-3 of this manual], by the CCR&R agency are entitled to a fair hearing. However, there is no right to a fair hearing if denial or termination of benefits is based solely on depletion of Child Care and Development Fund [CCDF] funding.

C. REPRESENTATION:

The State agency and the institution and its' responsible principals and individuals may retain legal counsel, or may be represented by another person.

D. TIMEFRAMES:

Section 1-11 Page 1 of 3

The request must be made within the time limits stated below, following the mailing date of the notice of the Department's adverse action:

- 90 calendar days – Parent, whose benefits are reduced or terminated; and
- 30 calendar days – Provider, who has been notified of overpayment.

E. BASIS FOR DECISION:

The administrative review official must make a determination based solely on the information provided by the State agency, the institution, the responsible principals and individuals, and based on Federal and State laws, regulations, policies, and procedures governing the Program.

THE WRITTEN REQUEST FOR AN ADMINISTRATIVE REVIEW, (APPEAL) MUST BE ADDRESSED TO EITHER THE REGIONAL CCR&R OFFICE OR TO:

Department of Public Health and Human Services

Office of Administrative Hearings

Mail: PO Box 202922, Helena MT 59620

Visit: 2401 Colonial Drive, Third Floor, Helena, MT

Fax: (406) 444-6565
