

INFORMATION COLLECTION SHEET FOR CHILD CARE ASSISTANCE

List below the names of ALL children for whom you are requesting child care assistance, their ages, days and times in care, and total hours per week that they are in care.

Child's name	Age	Day(s) in care	Times (inc. drive time)	Total hours per day (inc. drive time)	Total hours per week (inc. drive time)

For all employed household members applying:

Parent 1 – Weekly work schedule for _____

Name of your employer: _____

Hours worked per day: _____

Shift worked: 1st 2nd 3rd

Lunch: 1 hour 1/2 hour None

Paid: Weekly Biweekly Monthly

Your weekly work schedule: (please complete with your actual schedule or a sample week)

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Start Time							
End Time							

What is your scheduled work week (i.e. Wed-Tues): _____

Do you anticipate any change or fluctuation in your work schedule? No Yes If yes, please explain in detail: _____

Parent 2 (only if in household)

Weekly work schedule for: _____ Name of Employer: _____

(please complete with your actual schedule or a sample week)

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Start Time							
End Time							

What is your scheduled work week (i.e. Wed-Tues): _____

Do you anticipate any change or fluctuation in your work schedule? No Yes If yes, please explain in detail: _____

Child Care Provider(s) Information: YOU MUST LIST ALL PROVIDERS EVERY TIME YOU SUBMIT THIS FORM

Provider No 1:

Name: _____

Phone: _____

Address: _____

Is this provider registered with the New York State Office of Children and Family Services?

Yes _____ No _____

If no, then your provider must complete an enrollment form once a year and submit to Family Enrichment Network.

Provider No 2:

Name: _____

Phone: _____

Address: _____

Is this provider registered with the New York State Office of Children and Family Services?

Yes _____ No _____

If no, then your provider must complete an enrollment form once a year and submit to Family Enrichment Network.

I give permission for Tioga County DSS to communicate with my listed provider(s)

I give permission for Tioga County DSS to communicate with me via electronic mail at the following email address: _____

I certify that the statements made above are accurate and true to the best of my knowledge. I acknowledge that any changes in work schedule and/or hours, household composition or income information shall be provided to the Department of Social Services within 10 business days of said change. I understand that providing false information may result in the suspension or termination of payment by the Department of Social Services.

Parent/Guardian Signature

Date