Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING

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POLICY DIRECTIVE #17-02-ELI

(This Policy Directive Replaces PD #16-04-ELI)

CHILD CARE IN LIEU OF CASH ASSISTANCE (CILOCA)

Date:	Subtopic(s):
January 18, 2017	Cash Assistance, Child Care

AUDIENCE

The instructions in this policy directive are for staff in the Job Centers, the Child Care Review Team (CCRT) and are informational for all other staff.

REVISION TO THE ORIGINAL DIRECTIVE

This policy directive has been revised to:

- inform staff at the Job Centers and the Child Care Review Team (CCRT) that child care enrollment must be in place prior to forwarding the case information to the CCRT unit.
- update the income amounts required for CILOCA eligibility due to the increase in minimum wage effective December 31, 2016.
- include the CILOCA Minimum Wage Requirements (**Attachment E**). This attachment gives a breakdown of the different minimum wage amounts that must be used to determine eligibility for CILOCA. The minimum wage differs depending on the place of employment and the number of employees a business has.
- include a new checklist. The CILOCA Eligibility Checklist (**FIA-1185**) must be completed by the CILOCA Liaisons at the Job Centers to ensure correct determination of Cash Assistance (CA) eligibility before forwarding the case to CCRT and by the CCRT to ensure correct determination of CILOCA eligibility.
- inform the JOS/Child Care Specialist that a predetermination of CILOCA eligibility after the applicant or participant is determined eligible for CA and prior to sending the case to CCRT is no longer required.
- update the budgeting instructions.
- remind the JOS/Worker to process any required changes on a participant's case before submitting an action for CILOCA request.
- add instructions on actions taken by CCRT when a CILOCA recipient has a change in household composition (child added or removed from household) or a change of provider.

- update the use of the Denial of Your Application of Child Care Benefits (**OCFS-LDSS-4780**). The **OCFS-LDSS-4780** must be sent by the JOS/Worker or CCRT to every applicant or participant that requests CILOCA and is denied.
- update the CILOCA Ineligible Language For Use With **OCFS-LDSS-4780** (**Attachment C**) and CILOCA Snippets For Use With **OCFS-LDSS-4782** (**Attachment D**) to add a new snippet for applicants/participants that are ineligible due to excess resources.
- add instructions on the use of Action Code **M55** when an applicant/participant is ineligible due to excess resources.
- update the **FIA-1100b** language to include CILOCA.
- update the following forms to reflect the correct income amounts for CILOCA eligibility:

    - Child Care Guarantee Informational (**M-528m**)
    - Child Care in Lieu of Cash Assistance (CILOCA) Discussion Guide (**M-528p**)
    - Appointment Notice Child Care in Lieu of Cash Assistance (CILOCA) (**FIA-1026b**)
    - Notice of Rescheduled Appointment for Child Care in Lieu of Cash Assistance (**FIA-1026c**)

POLICY

Applicants deemed eligible for or participants in receipt of Cash Assistance (CA) may choose to receive Child Care Assistance instead of CA under a provision in the Child Care Block Grant that guarantees child care services to households that meet the CA income and resources criteria as well as the program eligibility requirements for 'Child Care in Lieu of Cash Assistance' (CILOCA).

Parents/guardians must work a minimum number of hours or earn a minimum dollar amount per week to be eligible for CILOCA.

There is no time limit on receiving CILOCA if the household's income and resources remain within CA limits and the minimum hours/income requirements for CILOCA are met.

BACKGROUND

CILOCA will assist eligible low-income families in achieving self-sufficiency by providing the child care subsidies needed to maintain their employment without requiring them to receive CA benefits and comply with certain CA requirements.

To be eligible for CILOCA, an individual must apply for CILOCA and be deemed eligible for or be in receipt of CA, be employed, and meet the State's minimum wage and/or minimum hours required for CILOCA.

Families in receipt of CILOCA must pay directly to the child care provider a fifteen dollar per week family fee for full-time (or twelve dollars per week for part-time) child care assistance regardless of how many of their children require care.

Refer to PB #16-59-OPE for the maximum market rate.

If an applicant's/participant's child care provider charges more than the maximum market rate set by the New York State Office of Children and Family Services (OCFS), the applicant/participant will need to pay to the provider the difference between the OCFS market rate and the rate charged by the provider or he/she will have to find a different provider. For CILOCA recipients, this is in addition to the fifteen (or twelve) dollar per week family fee.

If a CILOCA case is subsequently denied or closed due to an excess or increase in earned income, increased hours of employment, increase in child support or the CILOCA recipient voluntarily closed his/her CILOCA case while the household is still eligible for CA, the household may receive Transitional Child Care (TCC) benefits for a maximum of 12 months, if eligible.

If a household receiving CILOCA moves to a county outside of New York City, the Human Resources Administration (HRA) is responsible for the child care benefits during the month of the move and through the end of the following month.

CILOCA Eligibility Requirements

Child-only cases are not eligible for CILOCA

To qualify for CILOCA, at least one parent/guardian applying for or in receipt of CA must have or have applied for a Social Security number.

In addition, when determining eligibility for CILOCA, the income and resources of all mandatory household members of the CA filing unit must be counted, unless the income or resource is otherwise exempt.

To be eligible for CILOCA, the parent/guardian must:

- apply for and be deemed eligible for CA or be in receipt of CA and elect to close the CA case;
- be in need of child care for at least one child under the age of 13;
- use an eligible child care provider; and
- meet the minimum income/hours worked requirement as follows:

CILOCA cannot be provided for a child over age 13 even if the child has special needs

Updated information

Single-parent households:

- The parent/guardian is employed or self-employed earning at least the State minimum wage (See **Attachment E** for required amounts); **OR**
- The parent/guardian is employed at least 17.5 hours per week in a job exempt from minimum wage rules that is paying less than minimum wage. (See note below for examples of exempt jobs).

Updated information

Two-parent households:

- A two-parent household in which both parents are employed or self-employed earning at least the State's minimum wage (See **Attachment E** for required amounts); **OR**
- A two-parent household in which both parents are employed for a combined total of at least 25 hours per week in jobs exempt from minimum wage rules that pay less than minimum wage; **OR**
- A two-parent household in which one parent is employed or self-employed who is earning at least the State minimum wage and the other parent is employed in a job exempt from minimum wage rules that is paying less than minimum wage. The parent working in a job earning less than minimum wage must be working a minimum of 7.5 hours per week.

Note: Some minimum wage exempt jobs include but are not limited to:

- Taxicab drivers
- Part-time babysitters (parent employed as a PT babysitter)
- Ministers and members of religious orders
- Tipped employees (Tips must be counted along with the earnings to determine minimum wage)
- Piece rate workers (Employee paid a certain amount for each piece produced)
- Independent contractors
- Newspaper delivery persons
- Food service workers
- Hairdressers or aestheticians
- Valet parking attendants
- Doorpersons

Most minimum wage exempt jobs rely on tips to bring the earnings up to the minimum wage standard. Tips must be reported and counted as earned income. If the tips are collected and distributed by the employer, the amount of tips earned should be reflected in the paystub or employer letter. Otherwise, tips may be reflected in the previous year's income taxes filed or under special circumstances can be attested to in writing by the applicant/participant and budgeted accordingly. However, these individuals must meet the hours/week requirement for single parent or two parent households.

The Child Care Guarantee Informational (**M-528m**), which explains the CILOCA eligibility requirements, is included in the CA application/recertification kits.

Since July 24, 2009 households requesting or in receipt of CILOCA are not required to pursue child support as a condition of eligibility.

Pursuing child support is not an eligibility requirement for CILOCA or TCC. However, staff should encourage individuals to pursue child support on their own behalf as a means of increasing self-sufficiency.

Any CILOCA recipient who intentionally reduces his/her income or the number of hours he/she works in order to maintain CILOCA eligibility will lose the child care assistance guarantee.

Benefits of Choosing CILOCA

- The child care assistance subsidy does not count against the CA time limits. Therefore, the remaining months of eligibility for CA can be saved for a time when greater financial assistance is needed.
- There are no time limit restrictions attached to CILOCA. A family may continue to receive the child care subsidy as long as it meets the eligibility criteria for CILOCA and cash assistance.

Individuals in need of other services such as emergency housing, DV or substance abuse may not benefit from choosing CILOCA until those needs are addressed.

- An individual in receipt of CILOCA who is employed for less than 35 hours a week is not required to participate in additional work activities because he/she is not in receipt of CA.
  Participants who choose CILOCA instead of CA will receive all court-ordered child support money paid by the noncustodial parent.
- Individuals choosing CILOCA are not subject to substance abuse or domestic violence screening requirements, are not required to sign a property lien, and are not required to pursue court ordered child support. However, he/she must still comply with all other eligibility requirements such as compliance with the Bureau of Eligibility Verification (BEV), finger imaging, etc.

- Applicants/participants receiving Supplemental Nutrition Assistance Program (SNAP) benefits (or who wish to apply for SNAP) may be eligible for a higher amount of SNAP benefits than if they were in receipt of CA because the household's budgeted income would be lower without the CA benefits.
- Applicants/participants may still be eligible for other benefits and services, if needed, such as Medicaid, Home Energy Assistance Program (HEAP), SNAP and child support enforcement services.

Child Care Review Team

The CCRT located at 109 E. 16 Street, NY, NY 10003 is responsible for:

- processing CILOCA denials on all CILOCA application cases that meet the CA eligibility criteria but do not meet the CILOCA criteria;
- processing all CILOCA approvals;
- processing the final approval for CILOCA on all CILOCA related Fair Hearing Compliance activity;
- completing the eligibility process in the Paperless Office System (POS) to close the case using the CILOCA eligibility code **F98**; and
- handling all further child care activity including the CILOCA recertification.

CILOCA Rejection Codes

M55 and **G46** can only be used by the CCRT.

Codes **M55** (Ineligible for Child Care in Lieu of Temporary Assistance) and **G46** (Ineligible for Child Care in Lieu of Temporary Assistance [Excess Income]) are used only by the CCRT when an applicant applied for and is determined ineligible for CILOCA because he/she failed to meet a CILOCA eligibility requirement.

M55 and **G46** cannot be used at the individual level.

Both codes **M55** and **G46** are used to reject the entire case for CILOCA. These codes do not apply to MA and SNAP eligibility; therefore if the applicant applied for all program areas (CA/MA/SNAP) a separate MA and SNAP determination will be made.

The CA rejection code **M55** will have multiple denial reasons in the Client Notice System (CNS) and the CCRT must select the appropriate reasons for denial. Refer to **Attachment A** for a list of the denial reasons associated with the use of rejection code **M55**.

Added Information

Note: If the applicant is ineligible because of excess resources, CCRT must select "other" and fill in the text to indicate that the ineligibility is because of excess resources.

Multiple denial reasons can be selected with rejection code **M55**; however, not all denial reasons are compatible with each other. **Attachment A** also includes a list of the denial reasons that can be used at the same time. If the CCRT selects denial reasons that cannot be used together, the system will display an error message.

CILOCA recipients do not have an active CA case in WMS and are placed in AP status when recertifying for CILOCA.

The CA rejection code **G46** is used during the CILOCA recertification process when the applicant has excess income that makes him/her ineligible for CILOCA. This code will require an excess income ineligible budget. Refer to **Attachment B** for a sample of the language that will be displayed with the use of rejection code **G46**. Cases rejected with **G46** may be eligible for Transitional Child Care based on whether the household has a recent CA/CILOCA history.

Note: The JOS/Worker must use rejection code **E30** (Excess Earned Income (No Transitional Medicaid Assistance [TMA]), Ineligible Budget Required) for applicants or closing code **E30** (Excess Income [No TMA]) or **E31** (Increased Employment Earnings [TMA Eligible]) for participants that do not meet the CA eligibility requirements because of excess income.

REQUIRED ACTION

JOS/Workers must discuss the option of CILOCA with all eligible applicants/participants who are employed. When an individual reports that he/she is employed and in need of child care, he/she might not be aware of the availability of CILOCA. It is the JOS/Worker's responsibility to inform him/her of this program. Under no circumstance is an individual required to accept CILOCA.

Note: It is critical to inform all applicants/participants that if they choose to receive CA, child care assistance may still be provided if they are in compliance with all engagement/work-related activity requirements.

<u>Processing the CILOCA Request</u>

The Job Centers are responsible for conducting the initial CILOCA interview and collecting **all** of the required documentation to make a determination of CILOCA eligibility.

Applicants

When interviewing an applicant who is already employed, the JOS/Worker must:

- verify that there is a child under the age of 13 years in need of child care.

- verify that the applicant requires child care assistance in order for him/her to continue working.
- inform the applicant of form **M-528m** which is included in the CA application kit. Inform the applicant that they must first meet the CA eligibility requirements to be potentially eligible for CILOCA.
- discuss the availability of the CILOCA subsidy (see the attached Child Care in Lieu of Cash Assistance (CILOCA) Discussion Guide [**M-528p**]).
- inform the applicant that if he/she chooses to apply for CILOCA, he/she is not required to pursue child support but there are financial and other benefits of child support such as inheritance rights, tuition assistance, medical support, parent participation, etc. Encourage him/her to seek child support on his/her own as a means to self-sufficiency.

Applicant chooses CILOCA

When an applicant informs the JOS/Worker that he/she wants only child care assistance and does not want CA, the JOS/Worker must:

The JOS/Worker must register the case as per applicant's request

Refer to PB #13-59-SYS

- indicate in POS that the applicant has requested CILOCA;
  - Select the "Child Care in Lieu of CA" in the **Site Determination** screen if the applicant states at the Application Intake Interview that he/she wants CILOCA; or
  - Check the "Case is a Child Care In Lieu of Public Assistance (PA)" box on the top of the **Disposition/Withdrawal Screen** if the applicant states that he/she wants CILOCA once the Application Interview has started.

    Note: The **Disposition/Withdrawal Screen** can be accessed at any time, allowing the JOS/Worker to indicate an applicant's choice or change of mind about CILOCA at any point until the CA denial/closing code **F98** (CA Denied/Closed Because of Request for Child Care in Lieu of CA) posts in WMS.
    POS will indicate to NYCWAY that the applicant is choosing CILOCA, and NYCWAY will post Action Code **918L** (Request for CC in Lieu of CA – Applicant). Action Code **918L** will trigger the Employability Plan (EP) to display only the language and child care sections required for CILOCA.

  - Obtain information regarding the availability of resources, other income, household composition, filing unit requirements, alien/citizenship requirements, and the Social Security number requirements.

Refer to PB #16-102 for information on the work schedule forms **FIA-1100** and **FIA-1100a**.

- Review the employment documents submitted to ensure that the criteria for CILOCA have been met. Employment information must include: wages (e.g.: $140 per week), hours worked (e.g.: 35 hours per week), tips (if any), and work schedule (e.g.: Mon – Fri. 10am to 4pm). The employment information must also include the work location and if working in NYC, the number of employees. The work schedule is necessary to support the hours of child care requested. The Work Schedule For Child Care (**FIA-1100**) and the Employer's Verification (**FIA-1100a**) must be given to the applicant to complete and submit at the child care return appointment.

  Note: Individuals who provide a letter from the employer on the employer's stationery with contact information that includes the daily work schedule (i.e., M – F 9am – 5pm), place of employment and number of employees are not required to complete the **FIA-1100** or to have the employer complete the **FIA-1100a**.

See PB #14-97-OPE for CILOCA BEV indicator

- Make a referral to the Finger Imaging Unit, and BEV. Although some Family Assistance (FA) applicants are not required to go to BEV, all applicants requesting CILOCA must go to BEV.
- Print the Request for Child Care Assistance or Request to Close My Cash Assistance (CA) Case (**M-528n**) and capture the applicant's electronic signature. (Only the casehead can request CILOCA and sign the **M-528n**).

Refer to PD #15-27-ELI Budgeting Earned Income on CA Cases and PD #16-10-ELI for information on earned income disregard.

- If all necessary employment information has been submitted, calculate and save a budget. When calculating the budget, the case status must remain in applying (AP) status and Employment Code **04** must be used so that the standard deduction will be applied; do not use Employment Code **13** to suppress the disregards. Do not do a Scratch Pad budget.

Once applicant is deemed income eligible

- complete an **FIA-3A Information Only** that will result in the automatic posting of Action Code **16FI** (**FIA-3A Information Only** Data Entry Completed).

  If the employed applicant does not have proof of employment or income:

  - the **FIA-3A information Only** must still be completed; and
  - Action Code **910R** (FA Job Center Return Appointment – Other) must be entered to schedule a return appointment for the applicant to provide proof of employment.

- initiate an EP. The CILOCA EP will require the entry of the language and child care information only.

  Note: If an EP is attempted before the **FIA-3A Information Only** is completed on a case that has CILOCA Action Code **918L**, NYCWAY will prompt the JOS/Worker to complete the **FIA-3A Information Only** first. This is critical to ensure that the individual is employed before the CILOCA specific EP is launched.

- discuss child care options with the applicant.

Child care not in place at time of application.

  - Enter the appropriate child care type code for each child on the case. For most applicants, child care will not be in place at the time of application. In this case, the JOS/Worker must:

    - indicate Child Care Type **3** (No Child Care in Place – Arrangement Required) and transmit.

      This will generate the following Action Code **933S** (CC Provider needed and documentation is required). This code is for the initial child care return appointment even if the applicant/participant only needs to return with child care documentation.

  - Give the applicant the following forms:

    - Enrollment Form for Provider of Legally-Exempt Family Child Care and Legally-Exempt In-Home Child Care (**OCFS-LDSS-4699**).
    - Enrollment Form for Provider of Legally-Exempt Group Child Care (**OCFS-LDSS-4700**).
    - Child Care Provider Enrollment Supplement (**CS-274W**).
    - Proof of ID & Residency for your Child Care Provider (**CS-574FF**).
    - Child Care Fact Sheet and Planner (**CS-574EE**). The **CS-574EE** is also included in the application/recertification kits.

See PD #16-05-EMP for information on the informal child care provider enrollment process

  - Inform the parent/guardian that, if he/she chooses an informal child care provider, he/she must:

    - complete the appropriate enrollment form (**OCFS-LDSS-4699** or **OCFS-LDSS-4700**) with the child care provider.
    - ensure that the provider's TIN is entered in the **CS-274W** and that the number is accurate and the name of the provider matches the name associated with the TIN provided.

- bring the forms mentioned above as well as the provider's identification and proof of provider's residence to the Women's Housing and Economic Development Corporation (WHEDCo), which is the citywide Enrollment Agency, for approval of the informal child care provider.

- Inform the parent/guardian that if a regulated child care provider is selected, only Form **CS-274W** needs to be completed and does not require WHEDCo's involvement.
- Give the parent/guardian the Child Care Return Appointment form **W-273NN** to return within 15 business days with required child care documentation.

Referrals to Child Care Providers or Programs

Refer to PD #14-27-EMP for instructions on using the OCFS Child Care search link.

If the applicant is in need of referrals to child care providers or programs, the JOS/Worker can locate ACS contracted child care centers/Early Learn programs and family child care network providers by accessing the OCFS Child Care search link http://ocfs.ny.gov/main/childcare/ccfs_template.asp.

Refer to PD #14-27-EMP for information on enrollment in ACS contracted center/Early Learn program.

It is important to call the contract center/Early Learn program or network to confirm the available slots before making a referral. The information for the referral must be entered on the Child Care Appointment Confirmation and Contact List **W-273J** and the form must be given to the applicant after it has been scanned and indexed into the electronic case record.

Return Appointment Needed

If the applicant needs to return with employment or other required eligibility documentation, issue the Documentation Requirements and/or Assessment Follow-up (**W-113K**) with a ten-day return appointment. The JOS/Worker must check the "Must see Worker upon return" box on the **W-113K**.

Child Care Return Appointment – Applicant

Fails to keep child care return appointment

If the applicant fails to keep the child care return appointment, the case will fall on the ISAR Worklist. The JOS/Worker will:

- enter Action Code **918I** (CILOCA Ineligible) in NYCWAY, which completes Action Code **918L**, to close out the request for CILOCA in NYCWAY and remove the case from the CLPAR worklist.
- reject the case with the appropriate CA case denial code in WMS.

Child care return appointment kept

When the applicant returns with completed child care provider forms, the JOS/Child Care Specialist must:

- review the child care forms to determine if the informal provider has been approved by the enrollment agency. If the applicant is using an informal provider that has not yet been approved, refer the applicant to WHEDCo and ensure that the TIN for the provider has been submitted.
- verify in the Automated Child Care Information System (ACCIS) that there is no existing child care case under ACS. If an ACS child care case exists, take the necessary action to transfer the child care case from ACS to HRA.
- a case comment must be entered in NYCWAY if there is an active ACS child care case in ACCIS. The comment must state that a request of transfer was initiated and the date the request was made.

Updated
Must enroll child (ren) with provider/program in ACCIS.

- if necessary and once the child care is successfully transferred from ACS to HRA, ensure that the provider information is correct and update the information.
- enroll the child/children with the provider in ACCIS using reason for care code **03**.
- print the Notice of Temporary Child Care Assistance (**FIA-1100b**) in ACCIS and give to the applicant.
- scan and index the child care forms, provider documentation and employment information, including the **FIA-1100** and/or the **FIA-1100a**.
- update the EP in NYCWAY with either child care type **1** or **2** and Action Code **933T** (Childcare in Place – Applicant) is posted in NYCWAY. When the EP is completed, Action Code **119U** (EP assessment completed – participant exemption) will post.

Note: In order for the system to accept an applicant's request for CILOCA, there must be at least one child in the household requiring either Child Care Type **1** or Child Care Type **2**. If the child care is at no cost to the agency (free program or informal provider is not charging a fee), the household is ineligible for CILOCA.

<u>CA Eligibility Document Return Appointment – Applicant</u>

When the applicant returns to the Center to see the JOS/Worker (**W-113K**), the JOS/Worker will:

- ensure that the applicant has complied with all CA eligibility requirements including BEV and Finger Imaging.

- search MAPPER for BEV Recommendation. (A BEV Recommendation must be received prior to making the eligibility determination.)
- review the submitted employment documentation to ensure that the criteria for CILOCA have been met. Employment information must include; wages, hours worked, tips (if any), and work schedule.
- calculate and save a budget. When calculating the budget, the case status must remain in applying (AP) status and Employment Code **04** must be used so that the standard deduction will be applied; do not use Employment Code **13** to suppress the disregards. Do not do a Scratch Pad budget.
- enter an appropriate case comment in POS. The comment must include the saved budget number.
- ensure that the completed **CS-274W**, and **LDSS-4699/4700** have been scanned and indexed.
- update the **FIA-3A Information Only** if Action Code **910R** was posted for applicant to return with proof of employment.
- ensure that the EP in NYCWAY was updated with either child care type **1** or **2** and Action Code **933T** (Childcare in Place – Applicant) is posted in NYCWAY.
- make a CA eligibility determination.

Refer to PD #15-27-ELI Budgeting Earned Income on CA Cases and PD #16-10-ELI for information on earned income disregard.

CA Eligibility Determination – Applicant

The JOS/Worker must complete the initial application interview activity in POS including the TALX clearance. The JOS/Worker must also resolve any Resources File Integration (RFI) hits. The JOS/Worker must ensure that the applicant has complied with all the required cash assistance eligibility factors. These eligibility factors include compliance with the Bureau of Eligibility Verification (BEV) and verification of the following:

Identity	Martial Status
Relationship	Residence
Household Composition/Size	Age
Absence/Death of Parent(s)	Absent Parent Information
Resources	Social Security Number
Citizenship/Current Alien Status	Earned Income
Unearned Income	Shelter Expenses
Medical Expenses	Health Insurance
Disability/Pregnant	Unpaid bills
Referral	Dependent Care Cost
Other Expenses	School Attendance

Applicant Ineligible for CA

If the applicant is ineligible for CA, the JOS/Worker must complete the actions mentioned above and process the denial using the appropriate CA denial code. Examples: If the applicant failed to comply with BEV the JOS/Worker must use CA denial code **W10** (Fail to Keep Investigatory Appointment). If the applicant failed to comply with finger imagining, the JOS/Worker must use the CA denial code **M88** (Failure to Comply with Automated Finger Imaging Requirement).

The JOS/Worker must also do the following:

- Send the applicant the appropriate prefilled **OCFS-LDSS-4780**.
- Enter action code **918i** (CILOCA Ineligible) in NYCWAY to close out Action Code **918L**.

Note: If the CA eligibility criteria are not met, the JOS/Worker must not process denials based on the CILOCA criteria.

Applicant Eligible for CA

If the applicant is eligible for CA, the JOS/Worker must complete the actions mentioned above and must ensure that all eligibility related documents are scanned and indexed. The JOS/Worker must also notify the Center's CILOCA Liaison that the case has requested CILOCA. See page 23 for the Center's CILOCA Liaison responsibilities.

Applicant decides he/she does not want CILOCA

At any time until code **F98** is posted in WMS an applicant may change his/her mind as to whether he/she wants CILOCA. If an applicant changes his/her mind before code **F98** is posted, the JOS/Worker must:

- print Form **M-528n,** check the "Withdrawal from Child Care subsidy guarantee in lieu of CA" box, capture the applicant's electronic signature and scan and index the form into POS.
- check the "Child Care In Lieu of PA" box in the **Other Programs to Withdraw From:** section of the POS **Disposition/Withdrawal Screen**.

    - Enter a case comment in POS to reflect that the applicant has withdrawn their application for CILOCA and engagement activity will be initiated via the EP.

- POS will indicate to NYCWAY that the applicant has withdrawn his/her request for CILOCA; and
- NYCWAY will post Action Code **918D** (Withdrawal Request for CC in Lieu of CA – Applicant) to close out the **918L.** Action Code **918D** will also close out the existing EP with Action Code **119T**.

- initiate a <u>new</u> EP. The new EP will allow the JOS/Worker to address all barriers, initiate required referrals, and complete the regular application process as per current procedure.

Participants

When a participant reports that he/she is now employed or when interviewing a participant who is already employed, the JOS/Worker must:

- verify that the participant requires child care assistance for a child under 13 years of age in order for him/her to work.
- discuss the availability of the guaranteed CILOCA subsidy (see the attached Child Care in Lieu of Cash Assistance (CILOCA) Discussion Guide [**M-528p**]).
- give the participant Form **M-528m** and inform the participant that he/she must meet the CA eligibility requirements to be eligible for CILOCA.

See Form **M-528m** for an explanation of the requirements for CILOCA.

Participant chooses CILOCA

When a participant informs the JOS/Worker that he/she wants to receive child care assistance only (<u>no longer wants CA</u> and <u>wants to close his/her CA case in order to receive CILOCA</u>), the JOS/Worker must:

If the CILOCA request is made at the time of a recertification interview, follow these steps in the recertification interview activity.

Refer to PB #16-102-OPE for information on the work schedule forms **FIA-1100** and **FIA-1100a**.

- begin a Change Case Data activity in POS and:
  - ensure that the participant is still eligible for CA and has complied with all eligibility requirements for all household members such as Finger Imaging or household composition verification, if questionable.
  - review the submitted employment documentation to ensure that the criteria for CILOCA have been met. Employment information should include; wages (e.g.: $140 per week), hours worked (e.g.: 35 hours per week), tips (if any), and work schedule (e.g.: Mon. – Fri. 10am to 4pm). The Work Schedule For Child Care (**FIA-1100**) and the Employer's Verification (**FIA-1100a**) must be given to the participant to complete and return.

Note: Individuals who provide a letter from the employer on the employer's stationery with contact information that includes the daily work schedule (i.e., M – F 9am – 5pm), place of employment and number of employees are not required to complete the **FIA-1100** or to have the employer complete the **FIA-1100a**.

- calculate and save a budget. When calculating the budget, Employment Code **04** must be used so that the income disregards will be applied; do not use Employment Code **13** to suppress the disregards. Do not do a Scratch Pad budget. Enter an appropriate case comment. The comment must include the budget number used to determine financial eligibility for CA.
- print the Request for Child Care Assistance or Request to Close My Cash Assistance (CA) Case (**M-528n**) and electronically capture the participant's signature.

  Note: Prior to printing the **M-528n** or processing any action to start the CILOCA process, the JOS/Worker must complete all CA required actions on the case. Some examples are:

  - Emergency need request, such as rent arrears, utility shut off, furniture request, etc.
  - Add or remove an individual (Adult or child) from the CA household.
  - Missed benefits.

- scan and index either pay stub(s) documenting all income from the last 30 days, or a letter from the employer on official stationery listing salary, hours worked, and work schedule (documentation cannot be more than 30 days old) to verify that the participant's employment information or income has not changed and is current/correct. A return appointment may be required to provide current verification.
- if a return appointment is required to provide documentation, give the participant the **W-113K** with a ten day return appointment. The JOS/Worker must check the "Must see Worker upon return" box on the **W-113K** and suspend the activity.

- enter Action Code **118L** in NYCWAY to indicate that this participant is requesting CILOCA. Action Code **118L** will trigger the Employability Plan (EP) to display only the language and child care sections required for CILOCA.

- start a new **FIA-3A** (auto-budget) if:

  - the participant's employment information/income has changed.
  - the participant is newly employed.
  - no **FIA-3A** currently exists or the current **FIA-3A** is more than six months old.
  - the income is not being reported during the CA recertification process (if at recertification, do **FIA 3A information Only**).

- create an information-only **FIA-3A** if:

  - the existing **FIA-3A** is more than six months old but recent documentation verifies that the information has not changed. This will show that the information used to determine eligibility for CA is the same as the income currently budgeted; or
  - the new earned income is being reported during the CA recertification process. In this instance the budget must be calculated and authorized as part of the recertification/CED information/change.

- initiate a new EP, which will require only the language and child care information.

  Note: If an EP is attempted before a current (within the last six months) **FIA-3A** is completed on a case with CILOCA Action Code **118L**, NYCWAY will prompt the JOS/Worker to complete the **FIA-3A** first.

  - If no child care is in place, indicate Child Care Type **3** (No Child Care in Place – Arrangement Required) on the EP in NYCWAY, transmit, and schedule a child care return appointment via Action Code **133S** (CC Provider needed and documentation is required).
  - Give the parent/guardian the Child Care Return Appointment form **W-273NN** to return within 15 business days with the required child care documentation.

Because of engagement requirements, most participants will already have childcare in place.

Participants with Child Care in Place

If child care is in place, the JOS/Worker must search the electronic document file for the most recent child care forms submitted. The dates on child care forms on file cannot be a year or older. If the forms are dated a year or older, the JOS/Worker must give the participant new child care forms to be filled by the parent and the child care provider. At the return appointment, the JOS/Worker must scan and index the updated child care forms.

Participants with No Child Care in Place

For those participants who do not have child care in place, the JOS/Worker must:

- discuss all child care options with the participant.
- give the participant the following forms:
    - Child Care Fact Sheet and Planner (**CS-574EE**).
    - Enrollment Form for Provider of Legally-Exempt Family Child Care and Legally-Exempt In-Home Child Care (**OCFS-LDSS-4699**)
    - Enrollment Form for Provider of Legally-Exempt Group Child Care (**OCFS-LDSS-4700**)
    - Child Care Provider Enrollment Supplement (**CS-274W**)
    - Proof of ID & Residency for your Child Care Provider (**CS-574FF**).
- inform the parent/guardian that, if he/she chooses an informal child care provider, he/she must:
    - complete the appropriate enrollment form (**OCFS-LDSS-4699** or **OCFS-LDSS-4700**) with the child care provider.
    - ensure that the provider's TIN is entered in the **CS-274W** and that the number is accurate and the name of the provider matches the name associated with the TIN provided.
    - bring the forms mentioned above as well as the provider's identification and proof of provider's residence to the Women's Housing and Economic Development Corporation (WHEDCo).
- inform the parent/guardian that if a regulated child care provider is selected, only Form **CS-274W** needs to be completed and does not require WHEDCo's involvement.

If the participant needs a referral to a child care provider or program, refer to the instructions on page 11 of this procedure.

Child Care Return Appointment - Participant

When the participant returns with the completed child care provider forms, the JOS/Child Care Specialist must:

- review the child care forms to determine type of provider. If the participant is using an informal provider take the following actions:

  - Verify that the informal provider was evaluated by WHEDCo. If the informal provider has not yet been approved or evaluated by the enrollment agency, refer the applicant to WHEDCo.
  - Informal providers must have the TIN verified prior to the enrollment. The JOS/Child Care Specialist must contact CCRT for TIN verification.

Refer to PD #16-05-EMP for legally-exempt child care process and TIN information.

- scan and index the child care forms, provider documentation and employment information, including the **FIA-1100** and/or the **FIA-1100a**.
- verify in ACCIS that there is no existing child care case being paid by ACS. If an ACS child care case exists, take the necessary action to transfer the child care case from ACS to HRA.
- enter a case comment in NYCWAY if there is an active ACS child care case in ACCIS. The comment must state that a request of transfer was initiated and the date the request was made.
- if necessary, once the child care case is successfully transferred from ACS to HRA, ensure that the provider information is correct and update the information.

updated

- enroll the child/children with the provider in ACCIS.
- update the EP in NYCWAY with either Child Care Type **1** or **2**. When the EP is completed, Action Code **119U** (EP assessment completed – participant exemption) will post.

Note: In order for the system to accept a participant's request for CILOCA, there must be at least one child under 13 in the household requiring child care.

CA Eligibility Document Return Appointment - Participant

When the participant returns the documents requested on the **W-113K**, the JOS/Worker must:

If a recertification interview was initiated, return to the Recertification Interview Activity in POS.

- return to the Change Case Data activity in POS and:
  - verify that the participant is still eligible for CA and has complied with all of the eligibility requirements such as Finger Imaging for all household members 18 years of age or older.
  - review the submitted employment documentation to ensure that the criteria for CILOCA have been met. Employment information must include; the wages, hours worked, tips (if any), and work schedule.
  - verify that all documents submitted at the return appointment were scanned and indexed.

Refer to PD #15-27-ELI Budgeting Earned Income on CA Cases and PD #16-10-ELI for information on earned income disregard.

- ensure that a budget using Employment Code **04** was calculated; and that Employment Code **13** to suppress the disregards was not used. A Scratch Pad budget must not be used.
- enter appropriate case comments and include the saved budget number.
- ensure that the **CS-274W**, **LDSS-4699/4700** and the **CS-574FF**, if applicable, have been scanned and indexed.
- make a CA determination.

- ensure that the EP in NYCWAY was updated with either child care type **1** or **2** and Action Code **133T** (Child Care in Place – Participant) is posted in NYCWAY.

CA Eligibility Determination – Participants

The JOS/Worker must ensure that:

- all the necessary questions are answered in the Change Case Data activity in POS.
- all required documentation is scanned and indexed.

Participant Ineligible for CA

Participant determined ineligible CA

If a participant is ineligible for CA and, therefore, ineligible for CILOCA, the JOS/Worker must:

- close the CA case with the appropriate CA closing code. **Note**: If the case is closed due to excess income, though ineligible for CILOCA, the household may be eligible for transitional child care (TCC) for up to 12 months. The CA case must be closed using closing code **E31**.
- send the participant the appropriate prefilled **OCFS-LDSS-4780**. Do not suppress the CA CNS closing notice. In this instance, the participant must receive both a CA discontinuance notice and a CILOCA denial notice.
- enter Action Code **118i** in NYCWAY to complete Action Code **118L**.

Participant eligible for CA

If a participant is still eligible for CA, the JOS/Worker must scan and index all eligibility related documents and notify the Center's CILOCA Liaison that the case has requested CILOCA. See page 23 for the Center's CILOCA Liaison responsibilities.

Participant decides he/she does not want CILOCA

At any time before code **F98** is posted in WMS a participant may change his/her mind as to whether he/she wants CILOCA. If a participant changes his/her mind before code **F98** is posted, the JOS/Worker must:

- access the POS **Disposition/Withdrawal** screen.
- select the withdrawal from "Child Care in Lieu of CA" button.
- print Form **M-528n**, have the participant check the box under "Withdrawal from the child care subsidy guarantee 'in lieu of CA,'" and capture the participant's electronic signature.
- manually enter Action Code **118D** in NYCWAY to indicate that this participant has withdrawn his/her request for CILOCA.
- initiate a new EP as per current instructions.

If the participant changes his/her mind and an **F98** closing is pending in WMS, the JOS/Worker must do a Settle In Conference (SIC) to stop the pending transaction.

If the **F98** has not yet posted in WMS, but the JOS/Worker cannot SIC the transaction in time to prevent the case from closing (**F98** to post the next business day), once the case is actually closed, it must be reopened using Closed in Error code **Y42**.

Case is closed **F98** in WMS

If a participant changes his/her mind after code **F98** is posted in WMS, he/she must reapply for CA. Upon reapplication, the assigned JOS/Child Care Specialist in CSIC Child Care must update ACCIS to reflect the new reason for child care. A new child care case must not be established in ACCIS. If child care is no longer required, the JOS/Child Care Specialist must manually discontinue the child care case in ACCIS for all children.

Instructions for prefilled OCFS-LDSS-4780

Revised

The **OCFS-LDSS-4780** that is now available on HRA eDocs has a drop down box in the upper right hand corner that contains a list of 23 numbers with a heading. Each number corresponds with a criterion or reason for a CILOCA denial. When the appropriate reason is selected, a snippet with the language required for the selected CILOCA criterion will populate the form. **Attachment C** can be used to assist in identifying which criterion corresponds to each number and heading used in the **OCFS-LDSS-4780**.

When rejecting an applicant's/participant's request for CILOCA, the CCRT or JOS/Worker will open the form on HRA eDocs and do the following:

- Click on the drop down arrow and select the appropriate snippet number.
- Once snippet is displayed, all text boxes in fields that require entry of information will become enabled and information can be entered by clicking in the text boxes.
- For snippets that require additional information such as documents not submitted and date appointment missed, click in the text box next to snippets and enter the information.
- Once all fields have been entered, print the form.
- Scan and index the form into the POS electronic folder.

If denied for CA eligibility reasons, the case must be rejected with the appropriate CA reason code. The **OCFS-LDSS-4780** must be used along with the CA denial reason code to inform applicant/participant of CILOCA determination.

Center's CILOCA Liaison Responsibilities

New Information

The CILOCA Liaison must review the POS case action completed by the JOS/Worker and complete the **FIA-1185.**

Note: Refer to the FIA Child Care Review Team sections starting on page 24 for actions taken by the CCRT to process the CILOCA applications.

The CILOCA Liaison must notify the FIA Child Care Review Team (CCRT) via email to the "*FIA Child Care Review Team*" mailbox of the cases that have been determined eligible for CA and that CCRT must determine CILOCA eligibility. The email must include Job Center's name and number (e.g. DeKalb Job Center #64), case name, case number, the date of application for CILOCA or the date the participant requested CILOCA and signed the **M-528n** and the **FIA-1185**.

Refer to PB #14-130-SYS for information regarding CILOCA Processing queue.

The CILOCA Liaison is also responsible for transferring the case that is being referred to the CCRT from the JOS/Worker's queue to the CILOCA Processing queue in POS. This transfer must take place immediately following the email.

Cases with open Action Codes **918L**/**118L** will post on the **CLPAR** Worklist. Each Job Center must review and monitor this worklist to ensure that:

- all initial CILOCA requests for their center have been forwarded to the CCRT for final determination by prescribed deadlines.

- action code **918i/118i** is posted on cases that appear on the worklist but were determined ineligible for CA reasons so that these cases can be removed from the worklist.
- the acceptance or denial for CILOCA has been processed.

For participants, once the CA case is closed and the household is receiving CILOCA, all further child care activities are handled by the CCRT including CILOCA recertification.

When does payment begin

If the applicant was already using a provider at the time of application and the provider is approved, the child care subsidy is paid from the date of application. If child care was not in place at the time of application, the subsidy will be paid from the date the provider began caring for the child (ren). If the application is subsequently denied with any code other than **F98**, NYCWAY will send the information on a weekly basis to ACCIS and the child care will be terminated for each child on the case.

FIA Child Care Review Team CILOCA Application Process

The CCRT must check the "FIA Child Care Review Team" mailbox on a daily basis for cases that require CILOCA eligibility determination referred to the CCRT by the Center's CILOCA Liaison. The CCRT worker will use the **FIA-1185** when conducting a review of the case. The CCRT worker will:

- review each case in POS, WMS and NYCWAY to ensure that all actions were done correctly and that the applicant/participant has complied with all necessary referrals.
- review the saved budget number entered in the case comments by the JOS/Worker to determine if it was completed correctly and if the applicant/participant is financially CA eligible.
- review the HRA OneViewer to ensure that all required documentation is present and current.
- review the **W-113k** to ensure that all required documentation was requested.
- search MAPPER for the BEV recommendation.
- search in ACCIS to determine if an agency transfer request was processed, if applicable, and to ensure that child care is in place.

Cases eligible for CILOCA

After the review is complete, if all documentation and compliance with CA requirements have been verified and the case is deemed eligible for CILOCA, the CCRT will:

Note: Case Number reuse and CIN Number linking rules must be followed with all CILOCA cases

- complete the POS Activity (Application Interview, Change Case Data, Recertification Interview, etc.) and accept the case for CILOCA using the CA rejection code **F98**.
- complete the appropriate prefilled Approval of Your Application of Child Care Benefits (**OCFS-LDSS-4779**). (Approval is for a one year period).
- submit the case to the CCRT Supervisor for review and approval. (See supervisor action on page 26.)

CCRT deems cases predetermined eligible for CILOCA ineligible

If the CCRT determines that a case is ineligible due to an issue that can be addressed and resolved by the Center, such as lack of viewable documentation or verification, the CCRT must:

- enter a case comment in NYCWAY.
- send an email to the Center's CILOCA Liaison explaining the issue that is preventing them from making a determination and what documentation or verification is lacking.
- transfer the case from the CILOCA Processing queue to the worker's queue in POS.

The Center's CILOCA Liaison is responsible for advising the JOS/Worker and/or Supervisor of the issue and what documentation or verification, if any, must be submitted.

The JOS/Worker, if able, must immediately address or resolve the issue(s), scan and index the necessary documentation or verification of compliance and resubmit the information to the Liaison.

If the agency failed to ask for documentation which is critical to a decision and the information cannot be obtained through collateral contact, the applicant/participant must be afforded the opportunity to submit the document. The case cannot be denied based on the lack of documentation that the applicant/ participant never knew he/she needed to submit, even if the applicant/participant already had two (2) or more return appointments.

Once the action has been corrected, the Liaison must send an email to the CCRT and transfer the case from the worker's queue back to the CILOCA Processing queue in POS.

CCRT deems applicant ineligible for CILOCA

After the review is complete, if all documentation and compliance with CA requirements have been verified and the case is deemed ineligible for CILOCA, the CCRT will:

Do not use the code **F98** for CILOCA ineligible cases.

- reject the case for CILOCA in POS using Rejection Code **M55**.
- complete the appropriate prefilled Denial of Your Application For Child Care Benefits (**OCFS-LDSS-4780**).
- scan and index the **OCFS-LDSS-4780** in the HRA One Viewer.
- submit the case to the CCRT Supervisor for review and approval.

CCRT Supervisor Actions in the Application Process

If the case is determined ineligible for CILOCA, the CCRT Supervisor must take the following actions:

- Enter Action Code **918I** (CILOCA – Ineligible) and case note in NYCWAY.
- Verify that all corresponding documents are scanned and indexed into the viewer.
- Ensure that the completed **OCFS-LDSS-4780** is scanned and indexed and mail the form to the parent/guardian.
- Approve and transmit the **Approve Application Interview** activity in POS.

If the case is determined eligible for CILOCA, the CCRT Supervisor must take the following actions:

- Enter Action Code **918E** (CILOCA – Eligible) in NYCWAY to complete the Action Code **918L**.
- Ensure the correct care type, provider rate, hours of care and income is reflected in ACCIS so that the appropriate CILOCA parent fees are applied.
- Verify that all corresponding documents are scanned and indexed into the viewer.
- Ensure that the completed **OCFS-LDSS-4779** is scanned and indexed and mail the form to the CILOCA eligible parent/guardian.
- Approve and transmit the **Approve Application Interview** activity in POS.

After the case has been accepted for CILOCA in WMS with denial code **F98**, NYCWAY will post Action Code **918E**/**118E** with a 12-month future action date (FAD) on the case.This will place the case on the CILOCA Recertification worklist “CILPAR” in the eleventh month. ACCIS will check the data in NYCWAY to ensure that **F98** denial/closing code has not changed and will post a one year recertification date.

Processing Case Changes for CILOCA Recipients

The CCRT is responsible for actions that require change, when a CILOCA recipient reports changes to:

- add or remove an individual (Adult or child)
- change address
- change provider

For all changes required, CCRT must enter a case comment in POS, NYCWAY and ACCIS. All changes in information are made in ACCIS.

FIA Child Care Review Team CILOCA Recertification Process

The CCRT will conduct the CILOCA eligibility recertification one year after code **F98** posts in WMS.

On a monthly basis, CCRT will pull up the "CILPAR" Worklist. This is a Worklist of cases that are approaching the eleventh month and require recertification. The CCRT Worker must:

- verify address, number of children and number of providers in ACCIS for every case.
- enter Action Code **918F** (Recertification Call-in for CILOCA) with the date and time of the appointment in NYCWAY.
- mail the Appointment Notice for Child Care In Lieu of Cash Assistance (CILOCA) (**FIA-1026b**).
- mail the appropriate number of child care provider forms (**LDSS-4699/4700/CS-274W**) that are needed for the household.

Rescheduling a CILOCA Recertification

If a parent calls and requests to reschedule a recertification appointment, the CCRT Worker must:

- enter Action Code **918R** (Reschedule CILOCA Recertification) with the date and time of the new appointment and a comment in NYCWAY.
- mail the Notice of Rescheduled Appointment for Child Care in Lieu of Cash Assistance (CILOCA) (**FIA-1026c**).

CILOCA Recertification Kept

When the parent keeps the CILOCA Recertification, the CCRT Worker must:

- register the case in POS.
  - Select the "Child Care in Lieu of CA" in the Site Determination screen in the Application Intake Interview. POS will then register the case in WMS and indicate to NYCWAY that this is a CILOCA case, and NYCWAY will post Action Code **918L**.
- run all necessary clearances on the case.
- conduct the interview, and collect documentation to verify the following:
  - Household composition and the continued need for child care.
  - Shelter expense (rent or mortgage).
  - Employment income including hourly wage, how many hours worked per week, and work schedule. This information is required for both parents if it is a two parent household.
    Note: If the income fluctuates, the parent(s) must submit 3 to 6 months of paystubs.
  - Resources (savings or checking accounts, motor vehicle, etc.)

Note: To capture the new minimum wage requirements, all CILOCA recertification during 2017 will require the **FIA-1100** and the **FIA-1100a** to be completed and submitted.

- add or remove household members that have joined or left the household as appropriate.
- refer any adults that have joined the household or household member that has reached the age of 18 to AFIS for finger imaging.
- calculate and save a budget using Employment Code **04**; <u>do not use Employment Code **13** to suppress the disregards</u>. <u>Do not</u> do a Scratch Pad budget.

Any child support income redirected to a CILOCA participant becomes part of his/her household's countable income.

Added information

Note: For the recertification process the case and individual status in the WMS budget must be changed to active in order for the Earned Income Disregard to be applied.

- take the following actions in NYCWAY:
  - Complete the **FIA3A** Information Only.
  - Initiate and complete the EP.
  - Enter a case note.
- scan and index all submitted documents.
- manually refer the case to the on-site BEV for review and recommendation using the Notice To Report To BEV Interview (**BEV-229**).

- manually refer the CILOCA individual to WHEDCo if there is a change in provider or if the current provider is a legally-exempt provider.
- perform TIN evaluation on all legally-exempt child care providers that received an approval or temporary approval from WHEDCo.
- verify status of child care in ACCIS and update any information, if necessary.
- make an eligibility determination. (See pages 29 & 30 for eligibility determinations.)

Return Appointment documents required

If the parent does not have all of the necessary documents at the recertification appointment, the CCRT Worker must:

- enter Action Code **918M** (CILOCA Return Appointment) in NYCWAY.
- list the required missing documents on the Child Care in Lieu of Cash Assistance (CILOCA) Return Appointment and/or Documents Required for Recertification **FIA-1093**.
- scan and index the completed **FIA-1093** into the HRA One Viewer.
- give the completed **FIA-1093** to the parent/guardian.

Return appointment kept.

When the parent keeps the document return appointment, the CCRT Worker must:

- collect the necessary documents.
- calculate and save a budget using Employment Code **04**; <u>do not use Employment Code **13** to suppress the disregards</u>. <u>Do not</u> do a Scratch Pad budget.

Added information

Note: For the recertification process the case and individual status in the WMS budget must be changed to active in order for the Earned Income Disregard to be applied.

- take the following action in NYCWAY:
  - Update the **FIA3A** Information Only with the information verified by the submitted documentation.
  - Initiate and complete the EP.
  - Enter a case note, if applicable.
- scan and index submitted documents into the viewer.
- verify status of the child care for each child in ACCIS and update any information, if necessary.
- make an eligibility determination. (See below for eligibility determinations.)

Eligibility Determinations

Failure to keep CILOCA Recertification.

If the parent fails to keep the CILOCA Recertification appointment, the CCRT Worker must:

- enter Action Code **11FR** (Failure to Report to Interview) and a case comment in NYCWAY regarding the parent's failure to report.
- complete the Notice of Intent To Discontinue Child Care Benefits (**OCFS-LDSS-4782**). The end date entered on the **OCFS-LDSS-4782** is 15 days from the recertification appointment date.

Revised

The **OCFS-LDSS-4782** is available on HRA eDocs. It has a drop down box in the upper right hand corner that contains a list of 23 numbers with a heading. Each number corresponds with a criterion or reason for a CILOCA denial. When a number with its heading is selected, a snippet with the language required for the CILOCA criterion that was not met will populate the form. **Attachment D** can be used to assist in identifying which criterion corresponds to each number and heading used in the **OCFS-LDSS-4782**.

When closing a CILOCA participant, the CCRT or JOS/Worker will find the form on HRA eDocs, click on the drop down arrow and select the appropriate number and heading. Once the form is populated, the CCRT will fill in all of the fields that require entry and then print the form.

- scan and index the completed **OCFS-LDSS-4782**.
- submit the case to the CCRT Supervisor for review and approval of case action and to terminate child care in ACCIS.

Failure to keep document return appointment.

If the parent fails to keep the CILOCA document return appointment, the CCRT Worker must:

See above for information on completing the **OCSF-LDSS-4782**.

- ensure that all eligibility related documents or forms received are scanned and indexed into the viewer.
- enter the appropriate information into POS question sets with case comments and reject the case in POS using code **M55.**
- select and complete the **OCFS-LDSS-4782**. The end date entered on the **OCFS-LDSS-4782** is 15 days from the recertification return appointment date.
- scan and index the completed form.
- submit the case to the CCRT Supervisor for review and approval. (See page 31 for supervisor actions).

Financially ineligible

If the budget renders the household ineligible for CILOCA:

- do not refer the case to BEV.
- enter the appropriate information into POS question sets with case comments and reject the case in POS using code **G46** and the ineligible budget number.
- select and complete the **OCFS-LDSS-4782**. The end date entered on the **OCFS-LDSS-4782** is 15 days from the recertification appointment date.
- scan and index the completed form.
- submit the case to the CCRT Supervisor for review and approval. (See page 31 for supervisor action).

CILOCA Ineligible

If the household is deemed ineligible for CILOCA for reasons other than income, the CCRT Worker must:

- ensure that all eligibility related documents or forms received are scanned and indexed into the viewer.
- enter the appropriate information into POS question sets with case comments and reject the case in POS using code **M55.**
- select and complete the **OCFS-LDSS-4782**. The end date entered on the **OCFS-LDSS-4782** is 15 days from the recertification or return appointment date.
- scan and index the completed form.
- submit the case to the CCRT Supervisor for review and approval. (See below for supervisor actions).

CILOCA recipient remains income and resource-eligible for CA

If the household is still deemed income and resource-eligible for CA and still meets the CILOCA criteria, the CCRT Worker must:

Remember to use the Case Number reuse and CIN number linking rules with all CILOCA cases.

- accept the case for CILOCA in POS using the **F98** rejection code.
- select and complete the prefilled Approval of Your Redetermination for Child Care Benefits form (**OCFS-LDSS-4784**). The effective date entered on the **OCFS-LDSS-4784** is the date of compliance with required documentation.
- verify the status of the child care in ACCIS.
- Scan and index the completed **OCFS-LDSS-4784**.
- submit the case to the CCRT Supervisor for review and approval.

CCRT Supervisor Actions

Determined eligible

If the case is determined eligible for CILOCA, the supervisor must take the following actions:

- Verify that all corresponding documents are scanned and indexed into the viewer.
- Approve and transmit the **Application Interview** activity in POS.
- Check that the ACCIS history screen is appropriately updated and make system annotations/changes needed in ACCIS to guarantee one additional year of CILOCA.
- Ensure the correct care type and income rate is reflected in ACCIS so that the appropriate CILOCA parent fees are applied.
- Enter Action Code **918E** (CILOCA – Eligible) and case note in NYCWAY.
- Ensure that the completed **OCFS-LDSS-4784** is scanned and indexed and mail the form to the CILOCA eligible parent/guardian.

Does not keep recertification appointment

If the parent does not keep the CILOCA recertification appointment, the CCRT Supervisor must:

- terminate the Child Care in ACCIS by entering the end date and the drop date in the **Child Maintenance** screen.
- ensure that the completed **OCFS-LDSS-4782** is scanned and indexed and mail the form to the parent/guardian.

Fails to keep document return appointment

If the parent fails to keep the CILOCA document return appointment, the CCRT Supervisor must:

- ensure that all eligibility related documents or forms received are scanned and indexed into the viewer.
- review and approve the Application Interview activity in POS.
- enter Action Code **918I** in NYCWAY.
- terminate the child care in ACCIS by entering the end date and the drop date (FAD date) in the **Child Maintenance** screen.

Determined ineligible

If the case is determined ineligible for CILOCA, the supervisor must take the following actions:

- Verify that all corresponding documents are scanned and indexed into the viewer.
- Approve and transmit the **Application Interview** activity in POS.
- Enter Action Code **918I** (CILOCA – Ineligible) in NYCWAY to complete the action code **918L**.
- Terminate the Child Care in ACCIS by entering the end date and the drop date in the **Child Maintenance** screen.

- Ensure that the completed **OCFS-LDSS-4782** is scanned and indexed and mail the form to the parent/guardian.

CILOCA recipient becomes financially ineligible for CA

If the income renders the household ineligible for CA/CILOCA, the case will be systemically referred to the Administration for Children's Services Transitional Child Care Unit at 109 East 16th Street 3rd floor for evaluation of Transitional Child Care (TCC) benefits. The TCC Worker determines eligibility for up to 12 months of TCC benefits.

If eligible for TCC, the weekly fee will vary depending on the amount of the household income. The CILOCA recipient will be informed of the TCC eligibility and fee change by the TCC Unit.

If ineligible for TCC, the TCC Unit will notify the parent by mail via the Notice of Ineligibility for Transitional Child Care Benefits form (**CS-560DD**).

CILOCA recipient wants CA (no longer wants CILOCA)

A CILOCA recipient who wishes to discontinue CILOCA and return to CA is considered a new applicant. He/she must return to the Job Center to apply for and file a **new** CA application.

If upon application for CA child care is still required, **DO NOT** create a new child record in ACCIS for the child (ren) in care. The reason for care code will update based on the WMS case status and the engagement activity.

The Recertification cases with open Action Codes **918L/118L** will post on the CLPAR Worklist. The CCRT will monitor this worklist to ensure that the appropriate action was taken on all Recertification cases.

Completing Fair Hearing Decisions on Initial CILOCA Case Actions

All fair hearing decisions on CILOCA application case actions must be evaluated to determine if the fair hearing is based on a decision made by the Job Center or by CCRT. If the fair hearing issue was based on a decision made by the Job Center, the fair hearing will be completed by the Job Center. If the fair hearing issue was based on a decision made by CCRT, the fair hearing will be completed by CCRT.

All fair hearing decisions on CILOCA recertification case actions must be sent to Center 97 to be completed by CCRT.

If the Fair Hearing decision is sent to the incorrect Center via the FHOUT Worklist, the receiving Center should ensure that the Fair Hearing decision is forwarded to the responsible Center and moved to the FHOUT/FH029n of the receiving/correct center.

Completing Aid-To-Continue (ATC) Actions

The Fair Hearing Tracking Monitoring and Review Unit (FHTMRU) is responsible for all ATC actions on CILOCA cases.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

POS implications are discussed in the body of this policy directive.

Model Center Implications

At the Model Centers, the Front Door Reception must forward all CILOCA child care return appointments to the Customer Service and Information Center's (CSIC) Child Care Specialist, who will:

- review all child care-related information in ACCIS;
- update the child care type in the EP to **1** or **2** as appropriate and close the EP with Action Code **119U**;
- close the Model Office Number Identification Queue (MONIQ) ticket; and
- issue a new MONIQ ticket in the "CA Other" queue to refer the applicant/participant back to the original CA JOS/Worker, who will complete the CILOCA process as appropriate.

Supplemental Nutrition Assistance Program Implications

The receipt of CILOCA has no effect on Supplemental Nutrition Assistance Program (SNAP) eligibility. If the applicant has also applied for SNAP benefits and withdraws the CA application or the participant closes the CA case, a separate determination is required for SNAP. The $12/$15 weekly fee is counted as a SNAP out-of-pocket dependent care expense. Additionally, if the CILOCA recipient is paying the difference between the State market rate for child care and the rate his/her child care provider charges, this difference is also an out-of-pocket expense and must also be counted as a child care deduction in the SNAP calculation.

Medicaid Implications	Receipt of CILOCA has no effect on Medicaid eligibility. If the applicant withdraws only his/her CA application or the participant closes his/her CA case, a separate determination is required for Medicaid.
LIMITED ENGLISH PROFICIENT IMPLICATIONS	For Limited English Proficient (LEP) and hearing-impaired applicants/participants, staff must make sure to obtain appropriate interpreter services in accordance with PD #16-14-OPE and PD #16-16-OPE.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution	Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants/participants must receive adequate or timely and adequate notification of all actions taken on their case.
Conferences	An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor. The AJOS/Supervisor I will explain to the applicant/participant the reason for the Agency's action(s). If the determination is that the applicant/participant has presented good cause for the infraction or that the outstanding Notice of Intent needs to be withdrawn for other reasons, the FH&C AJOS/ Supervisor I will SIC, enter detailed case notes in NYCWAY and forward all verifying documentation, submitted by the applicant/participant, to the appropriate JOS/Worker, for corrective action to be taken.

In addition, if the adverse case action still shows on the "Pending" (**08**) screen in WMS, the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS- 3722**), change the **02** to an **01** if the case has been granted Aid Continuing (ATC) or prepare and submit a PA Recoupment Data Entry Form (**LDSS-3573**), to delete a recoupment. The AJOS/Supervisor I must complete a Conference Report Form (**M-186a**).

If the determination is that the applicant/participant has not shown good cause for the infraction or that the Agency's action(s) should stand, the AJOS/Supervisor I will explain to the applicant/participant why he/she cannot SIC. The AJOS/Supervisor I must complete Form **M-186a**.

Should the applicant/participant elect to continue his/her appeal by requesting or proceeding to a Fair Hearing which has already been requested, the FH&C AJOS/Supervisor I is responsible for ensuring that a further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets

All Evidence Packets must contain a detailed history, copies of relevant WMS screen printouts, other documentation relevant to the action taken and copies of NYCWAY **Case Notes** screens. All evidence packets also require all relevant information regarding the application/recertification for CILOCA eligibility.

REFERENCES

04-OCFS-ADM-01
16-OCFS-INF-01
16-INF-14
18 NYCRR 387.12 (d);415.2(a)(i)(ii);350.3(c)
Temporary Assistance Source Book Chapter 28; Section A
GIS 07 TA/DC015
SSL 410-w(4)(a)

RELATED ITEM

PB #16-97-EMP
PB #16-102-OPE
PB #16-59-OPE
PB #14-69-OPE
PB #14-97-OPE
PD #14-27-EMP
PD #16-10-ELI
PD #16-05-EMP
PD #16-08-EMP
PD #15-27-ELI

ATTACHMENTS

Please use Print on Demand to obtain copies of forms.

Attachment A	CNS Text and Fill Options for WMS CILOCA Denial Code M55
Attachment B	CNS Text for WMS CILOCA Denial Code G46
Attachment C	CILOCA Ineligible Criteria for Use with **OCFS-LDSS-4780**
Attachment D	CILOCA Ineligible Criteria for Use with **OCFS-LDSS-4782**
Attachment E	CILOCA Minimum Wage Requirements as of 12/31/16
BEV-229 (E)	Notice To Report To BEV Interview (Rev.3/01/13)
CS-274W	Child Care Provider Enrollment Supplement (Rev.4/08)
CS-274W (S)	Child Care Provider Enrollment Supplement (Spanish) (Rev. 4/08)
CS-560DD	Notice of Ineligibility for Transitional Child Care Benefits (Rev. 5/07)
CS-560DD (S)	Notice of Ineligibility for Transitional Child Care Benefits (Spanish) (Rev. 8/07)
CS-574EE	Child Care Fact Sheet And Planner (Rev.8/08)
CS-574EE (S)	Child Care Fact Sheet And Planner (Spanish) (Rev.8/08)
CS-574FF	Proof of ID & Residency for your Child Care Provider
CS-574FF (S)	Proof of ID & Residency for your Child Care Provider (Spanish)
FIA-1026b	Appointment Notice Child Care In Lieu of Cash Assistance (CILOCA) (Rev.1/03/17)
FIA-1026b (S)	Appointment Notice Child Care In Lieu of Cash Assistance (CILOCA) (Spanish) (Rev.1/03/17)
FIA-1026c	Notice of Rescheduled Appointment for Child Care In Lieu of Cash Assistance (CILOCA) (Rev.1/03/17)
FIA-1026c (S)	Notice of Rescheduled Appointment for Child Care In Lieu of Cash Assistance (CILOCA) (Spanish) (Rev.1/03/17)
FIA-1093	Child Care in Lieu of Cash Assistance (CILOCA) Recertification Return Appointment (Rev. 1/18/17)
FIA-1093 (S)	Child Care in Lieu of Cash Assistance (CILOCA) Recertification Return Appointment (Spanish) (Rev. 1/18/17)
FIA-1100(E)	Work Schedule For Child Care (Rev.12/27/16)
FIA-1100(S)	Work Schedule For Child Care (Spanish)(Rev.12/27/16)
FIA-1100a(E)	Employer's Verification (Rev.12/27/16)

FIA-1100b	Notice of Temporary Child Care Assistance (Rev.11/09/16)
FIA-1100b (S)	Notice of Temporary Child Care Assistance (Spanish) (Rev.11/09/16)
FIA-1185(E)	CA/CILOCA Eligibility Checklist (Rev.1/18/17)
M-528m	Child Care Guarantee Informational (Rev.1/18/17)
M-528m (S)	Child Care Guarantee Informational (Spanish) (Rev.1/18/17)
M-528n	Request for Child Care Assistance or Request to Close My Cash Assistance (CA) Case (Rev. 2/20/13)
M-528n (S)	Request for Child Care Assistance or Request to Close My Cash Assistance (CA) Case (Spanish) (Rev. 2/20/13)
M-528p	Child Care in Lieu of Cash Assistance (CILOCA) Discussion Guide (Rev. 1/3/17)
W-113K	Documentation Requirements and/or Assessment Follow-Up (Rev. 8/12/12)
W-113K (S)	Documentation Requirements and/or Assessment Follow-Up (Spanish) (Rev. 8/12/12)
W-273NN	Child Care Return Appointment (Rev. 1/18/17)
W-273NN (S)	Child Care Return Appointment (Spanish) (Rev. 1/18/17)
OCFS-LDSS-4699	ENROLLMENT FORM FOR PROVIDER OF LEGALLY-EXEMPT FAMILY CHILD CARE AND LEGALLY-EXEMPT IN-HOME CHILD CARE (Rev.9/2015)
OCFS-LDSS-4700	ENROLLMENT FORM FOR PROVIDER OF LEGALLY-EXEMPT GROUP CHILD CARE (Rev.9/2015)
OCFS-LDSS-4779	APPROVAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS (Rev. 9/2015)
OCFS-LDSS-4779 (S)	APPROVAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS (Spanish) (Rev. 9/2015)
OCFS-LDSS-4780	DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS (Rev. 9/2015)
OCFS-LDSS-4780 (S)	DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS (Spanish) (Rev. 9/2015)
OCFS-LDSS-4782	NOTICE OF INTENT TO DISCONTINUE CHILD CARE BENEFITS (Rev. 9/2015)
OCFS-LDSS-4782 (S)	NOTICE OF INTENT TO DISCONTINUE CHILD CARE BENEFITS (Spanish) (Rev. 9/2015)
OCFS-LDSS-4784 (E)	APPROVAL OF YOUR REDETERMINATION FOR CHILD CARE BENEFITS (Rev. 9/2015)
OCFS-LDSS-4784 (S)	APPROVAL OF YOUR REDETERMINATION FOR CHILD CARE BENEFITS (Spanish) (Rev. 9/2015)

Attachment A

Client Notice System (CNS) TEXT AND FILL OPTIONS FOR WMS CILOCA DENIAL CODE M55

This is to tell you that your application for Cash Assistance has been withdrawn at your request because you want to apply for Child Care in Lieu of Cash Assistance (CILOCA)

Your request for CILOCA has been denied because:

1. Your household does not meet the eligibility criteria for Cash Assistance and to be eligible for CILOCA you must first be eligible for Cash Assistance. You were not eligible for Cash Assistance because you failed to keep an appointment with the Bureau of Eligibility Verification on __/__/__.

2. Your household does not meet the eligibility criteria for Cash Assistance and to be eligible for CILOCA you must first be eligible for Cash Assistance. You were not eligible for Cash Assistance because you or another individual in your household 18 years of age or older failed to comply with the finger imaging requirement.

3. You are a single parent who is working or self-employed, you work in NYC, your employer has 11 or more employees and you are not earning at least $192.50/week or $834/month.

4. You are a two parent household and you and the other parent works in NYC your employer has 11 or more employees, and are not earning a combined income of at least $275/week or $1192/month.

5. You are a single parent household working at a job that is exempt from the state minimum wage requirement but you are not working at least 17.5 hours per week.

6. You are a two parent household where you and the other parent in the household are employed in a job that is exempt from the minimum wage requirement or are both self-employed but you are not working a minimum of at least 25 hours per week combined.

7. You or the other parent in the household failed to submit valid documentation to verify the employment income and the number of hours worked per week.

8. You are a two-parent household where both parents are employed but one parent is employed in NYC with an employer that has 11 or more employees earning minimum wage or more per hour and is not earning a minimum gross income of $192.50 per week or $834 per month.

9. You are a two-parent household where both parents are employed but one parent is in a job exempt from minimum wage that is paying less than minimum wage per hour but is not working at least 7.5 hours per week.

10. You are a two-parent household where one parent is employed in NYC with an employer that has 11 or more employees earning minimum wage or more per hour but is not earning a minimum gross income of $192.50 per week or $834 per month and the other parent is in a job exempt from minimum wage that is paying less than minimum wage per hour but is not working at least 7.5 hours per week.

11. You are a two-parent household where at least one parent is unemployed.

12. You are programmatically ineligible for child care in lieu of cash assistance because you are not employed/self-employed.

13. You are programmatically ineligible for child care benefits as your youngest child is over the age of 13.

14. The only parent/guardian does not meet the cash assistance immigrant eligibility and social security number requirement as defined in 18 NYCRR: 349.3 (b) and 351.2 (c).

15. Other - please allow 100 bytes - (requires free fill-in text for notice)

16. You are a single parent who is working in NYC, your employer has 10 or less employees and you are not earning at least $184/week or $797/month.

17. You are a single parent who is working in Long Island or Westchester and you are not earning at least $175/week or $758/month.

18. You are a single parent who is working in NY State and you are not earning at least $170/week or $737/month.

19. You are a two parent household and you and the other parent works in NYC your employer has 10 or less employees, and are not earning a combined income of at least $262.50/week or $1137.50/month.

20. You are a two parent household and you and the other parent works in Long Island or Westchester and are not earning a combined income of at least $250/week or $1083/month.

21. You are a two parent household and you and the other parent works in NY State and are not earning a combined income of at least $242.50/week or $1051/month.

22. You are a two-parent household where both parents are employed but one parent is employed in NYC with an employer that has 10 or less employees earning minimum wage or more per hour and is not earning a minimum gross income of $184 per week or $797 per month.

Attachment A

23. You are a two-parent household where both parents are employed but one parent is employed in Long Island or Westchester earning minimum wage or more per hour and is not earning a minimum gross income of $175 per week or $758 per month.

24. You are a two-parent household where both parents are employed but one parent is employed in NY State earning minimum wage or more per hour and is not earning a minimum gross income of $170 per week or $737 per month.

25. You are a two-parent household where one parent is employed in NYC with an employer that has 10 or less employees earning minimum wage or more but is not earning a minimum gross income of $184 per week or $797 per month and the other parent is in a job exempt from minimum wage that is paying less than minimum wage but is not working at least 7.5 hours per week.

26. You are a two-parent household where one parent is employed in Long Island or Westchester earning minimum wage or more but is not earning a minimum gross income of $175 per week or $758 per month and the other parent is in a job exempt from minimum wage that is paying less than minimum wage but is not working at least 7.5 hours per week.

27. You are a two-parent household where one parent is employed in NY State earning minimum wage or more per hour but is not earning a minimum gross income of $170 per week or $737 per month and the other parent is in a job exempt from minimum wage rules that is paying less than minimum wage per hour but is not working at least 7.5 hours per week.

The Regulation to support this action is 18 NYCRR 415.2(a)(1)(ii).

The statue which allows this and should be cited is: SSL 410w

Code M55 will allow multiple fills as follows:

1, 2, 15--- Use only by themselves and not with any other paragraph

3, 5, 14---Can be used together but not with #1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 13, 15,16, 17, 18, 19, 21, 21, 21, 23, 24, 25, 26, 27

#16, 5, 14—Can be used together but not with #1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

#17, 5, 14—Can be used together but not with #1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

#18, 5, 14—Can be used together but not with #1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27

Attachment A

4, 6, 7, 8, 9, 10, 11---Can be used together but not with #1, 2, 3, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

#19, 6, 7, 22, 9, 25, 11—Can be used together but not with #1, 2, 3, 4, 5, 8, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 24, 26, 27

#20, 6, 7, 23, 9, 26, 11—Can be used together but not with #1, 2, 3, 4, 5, 8, 10, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 24, 25, 27

#12, 13---Can be used together but not with #1,2,3,4,5,6,7,8,9,10,11,14, 15,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

ATTACHMENT B

Client Notice System (CNS) TEXT FOR WMS CILOCA DENIAL CODE G46

This is to tell you that your application for Cash Assistance has been withdrawn at your request because you want to apply for Child Care in Lieu of Cash Assistance (CILOCA). Your request for CILOCA has been denied because you and or the other parent in the household do not meet the eligibility criteria for Cash Assistance and to be eligible for CILOCA you must first be eligible for Cash Assistance. You were not eligible for Cash Assistance because you and/or the other parent in the household had excessive income (attach the budget information showing how the excess income was determined to the CNS notice like we currently do for E30 rejects).

The Regulation to support this action is 18 NYCRR 415.2(a)(1)(ii).

•A BUDGET SHOULD BE SAVED FOR EVERY CILOCA CASE BUT THE INFORMATION SHOULD ONLY BE PULLED INTO CNS FOR REJECTION CODE G46.

Attachment C

CILOCA Ineligible Language For Use With OCFS-LDSS-4780

Number	Heading	Snippet Language
1	Single Parent Hours	You applied for "Child Care in Lieu of Cash Assistance". You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a single parent making less than minimum wage from a job that is not required to pay the minimum wage but you are not working at least 17.5 hours per week.
2	Single Parent Wages – NYC – 11 or more employees	You applied for "Child Care in Lieu of Cash Assistance". You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a single parent, you work in New York City, your employer has 11 or more employees and must pay minimum wage, and you are not making at least $11.00 per hour, or at least $192.50 per week, or at least $834 per month.
3	Single Parent Wages - NYC - 10 or less employees	You applied for "Child Care in Lieu of Cash Assistance". You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a single parent, you work in New York City, your employer has 10 or less employees and must pay minimum wage, and you are not earning at least $10.50 per hour, or at least $184 per week, or at least $797 per month.
4	Single Parent Wages - Long Island & Westchester	You applied for "Child Care in Lieu of Cash Assistance". You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a single parent, you work in Long Island or Westchester, your employer must pay minimum wage, and you are not earning at least $10.00 per hour, or at least $175 per week, or at least $758 per month.
5	Single Parent - Greater New York State	You applied for "Child Care in Lieu of Cash Assistance". You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a single parent, you work in New York State, your employer must pay minimum wage, and you are not earning at least $9.70 per hour, or at least $170 per week, or at least $737 per month.

Attachment C

Number	Heading	Snippet Language
6	Two Parent Hours	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household and both parents are employed in jobs that are not required to pay minimum wage but are not working for a combined total of at least 25 hours per week.
7	Two Parent Wages - NYC -11 or more employees	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household, you both work in New York City, your employer has 11 or more employees and must pay minimum wage, and you are not making at least $11.00 per hour, or at least $275 per week, or at least $1192 per month.
8	Two Parent Wages - NYC - 10 or less employees	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household, you both work in New York City, your employer has 10 or less employees and must pay minimum wage, and you are not making at least $10.50 per hour, or at least $262.50 per week, or at least $1137.50 per month.
9	Two Parent Wages - Long Island & Westchester	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this Agency shows that you are a two-parent household, you both work in Long Island or Westchester, your employer must pay minimum wage, and you are not making at least $10.00 per hour, or at least $250 per week, or at least $1083 per month.
10	Two Parent Wages - Greater New York State	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this Agency shows that you are a two-parent household, you both work in New York State, your employer must pay minimum wage, and you are not making at least $9.70 per hour, or at least $242.50 per week, or at least $1051 per month.

Attachment C

Number	Heading	Snippet Language
11	Two Parent with two different employment criteria - NYC - 11 or more employees	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two parent household and that either the parent that is working in NYC, with an employer that has 11 or more employees and must pay minimum wage, does not make $192.50 per week or $834 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
12	Two Parent with two different employment criteria - NYC - 10 or less employees	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two parent household and that either the parent that is working in NYC, with an employer that has 10 or less employees and must pay minimum wage, does not make $184 per week or $797 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
13	Two Parent with two different employment criteria - Long Island & Westchester	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two parent household and that either the parent that is working in Long Island or Westchester with an employer that must pay minimum wage, does not make $175 per week or $758 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
14	Two Parent with two different employment criteria - Greater New York State	You applied for “Child Care in Lieu of Cash Assistance”. You do not meet the eligibility criteria for this program because the information you gave this agency shows that you are a two parent household and that either the parent that is working in New York State with an employer that must pay minimum wage, does not make $170 per week or $737 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
15	FTK Mandatory Appointment	You applied for “Child Care in Lieu of Cash Assistance” and you failed to keep a mandatory appointment to evaluate your continued eligibility for Child Care in Lieu of Cash Assistance (CILOCA) on _____.

Attachment C

Number	Heading	Snippet Language
16	Ineligible Income/Resources	You applied for “Child Care in Lieu of Cash Assistance” and your income/resources exceeds the Cash Assistance eligibility limits and, therefore, you are not eligible for Child Care in Lieu of Cash Assistance (CILOCA).
17	Failed to submit verification	You applied for “Child Care in Lieu of Cash Assistance” and you failed to submit the documentation listed below to verify your eligibility for Child Care in Lieu of Cash Assistance (CILOCA).
18	Ineligible Alien	You applied for “Child Care in Lieu of Cash Assistance” you do not meet the eligibility criteria for this program because based on the information you provided to this agency, at least one parent does not meet the alien eligibility criteria for Cash Assistance.
19	No Child Under 13	You applied for “Child Care in Lieu of Cash Assistance” and you do not meet the eligibility criteria for this program because your youngest child is over age 13.
20	Denial Failure to comply with BEV	You applied for “Child Care in Lieu of Cash Assistance” and you do not meet the eligibility criteria for Cash Assistance. To be eligible for CILOCA you must first be eligible for Cash Assistance. You were not eligible for Cash Assistance because you failed to keep an appointment with the Bureau of Eligibility Verification on __/__/__.
21	Denial Failure to cooperate with BEV	You applied for “Child Care in Lieu of Cash Assistance” and you do not meet the eligibility criteria for Cash Assistance. To be eligible for CILOCA you must first be eligible for Cash Assistance. You were not eligible for Cash Assistance because you failed to cooperate with the Bureau of Eligibility Verification.
22	Denial Failure to comply with Finger Imaging	You applied for “Child Care in Lieu of Cash Assistance” and you do not meet the eligibility criteria for Cash Assistance. To be eligible for CILOCA you must first be eligible for Cash Assistance. You were not eligible for Cash Assistance because you or another individual in your household 18 years of age or older failed to comply with the finger imaging requirement.
23	Ineligible Resources	You applied for “Child Care in Lieu of Cash Assistance” and your resources exceeds the Cash Assistance eligibility limits and, therefore, you are not eligible for Child Care in Lieu of Cash Assistance (CILOCA).

Attachment D

CILOCA Snippets For Use With OCFS-LDSS-4782

Number	Heading	Snippet Language
1	Single parent hours	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a single parent making less than minimum wage from a job that is not required to pay the minimum wage but you are not working at least 17.5 hours per week.
2	Single Parent Wages - NYC - 11 or more employees	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave to this agency show that you are a single parent, you work in New York City, your employer has 11 or more employees and must pay minimum wage, and you are not making at least $11.00 per hour, or at least $192.50 per week, or at least $834 per month.
3	Single Parent Wages - NYC - 10 or fewer employees	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave to this agency show that you are a single parent, you work in New York City, your employer has 10 or less employees and must pay minimum wage, and you are not earning at least $10.50 per hour, or at least $184 per week, or at least $797 per month.
4	Single Parent Wages - Long Island & Westchester	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave to this agency show that you are a single parent, you work in Long Island or Westchester, your employer must pay minimum wage, and you are not earning at least $10.00 per hour, or at least $175 per week, or at least $758 per month.
5	Single Parent Wages - Greater New York State	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave to this agency show that you are a single parent, you work in New York State, your employer must pay minimum wage, and you are not earning at least $9.70 per hour, or at least $170 per week, or at least $737 per month.

Attachment D

Number	Heading	Snippet Language
6	Two Parents Hours	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household and both parents are employed in jobs that are not required to pay minimum wage but are not working for a combined total of at least 25 hours per week.
7	Two Parents Wages - NYC - 11 or more employees	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency show that, you are a two-parent household, you both work in New York City, your employer has 11 or more employees and must pay minimum wage, and you are not making at least $11.00 per hour, or at least $275 per week, or at least $1192 per month.
8	Two Parents Wages - NYC - 10 or fewer employees	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household, you both work in New York City, your employer has 10 or less employees and must pay minimum wage, and you are not making at least $10.50 per hour, or at least $262.50 per week, or at least $1137.50 per month.
9	Two Parents Wages - Long Island & Westchester	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household, you both work in Long Island or Westchester, your employer must pay minimum wage, and you are not making at least $10.00 per hour, or at least $250 per week, or at least $1083 per month.
10	Two Parents Wages - Greater New York State	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a two-parent household, you both work in New York State, your employer must pay minimum wage, and you are not making at least $9.70 per hour, or at least $242.50 per week, or at least $1051 per month.
11	Two Parent with two different criteria - NYC - 11or more employees	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency show that you are a two parent household and that either the parent that is working in NYC, with an employer that has 11 or more employees and must pay minimum wage, does not make $192.50 per week or $834 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.

Attachment D

Number	Heading	Snippet Language
12	Two Parent with two different criteria - NYC - 10 or fewer employees	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency show that you are a two parent household and that either the parent that is working in NYC, with an employer that has 10 or less employees and must pay minimum wage, does not make $184 per week or $797 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
13	Two Parent with two different criteria - Long Island or Westchester	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a two parent household and that either the parent that is working in Long Island or Westchester with an employer that must pay minimum wage, does not make $175 per week or $758 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
14	Two Parent with two different criteria - Greater New York State	You were in receipt of “Child Care in Lieu of Cash Assistance”. You no longer meet the eligibility criteria for this program because the information you gave this agency shows that you are a two parent household and that either the parent that is working in the State of New York with an employer that must pay minimum wage, does not make $170 per week or $737 per month, or the parent that is in a job exempt from minimum wage is not working a minimum of 7.50 hours per week.
15	Failed to keep mandatory appointment	You were in receipt of “Child Care in Lieu of Cash Assistance” and you are no longer eligible because you failed to keep a mandatory appointment to evaluate your continued eligibility for Child Care in Lieu of Cash Assistance (CILOCA) on _____.
16	Ineligible income resources	You were in receipt of “Child Care in Lieu of Cash Assistance” and you no longer meet the eligibility criteria for this program because based on the information you provided to this agency, your income/resources exceed the Cash Assistance eligibility limits
17	Failed to submit verification	You were in receipt of “Child Care in Lieu of Cash Assistance” and you no longer meet the eligibility criteria for this program because you failed to submit documentation to verify your continued eligibility for Child Care in Lieu of Cash Assistance (CILOCA).
18	Ineligible Alien	You were in receipt of “Child Care in Lieu of Cash Assistance” and you are no longer eligible for this program because at least one parent does not meet the alien eligibility criteria for CILOCA.

Attachment D

Number	Heading	Snippet Language
19	No Child Under 13	You were in receipt of “Child Care in Lieu of Cash Assistance” and you are no longer eligible for this program because your youngest child is 13 or older.
20	Failure to comply with BEV	You were in receipt of “Child Care in Lieu of Cash Assistance” and you are no longer eligible for this program because your household no longer meets the eligibility criteria for Cash Assistance. To be eligible for CILOCA you must first be eligible for Cash Assistance. You are no longer eligible for Cash Assistance because you failed to comply with the Bureau of Eligibility Verification.
21	Failure to cooperate with BEV	You were in receipt of “Child Care in Lieu of Cash Assistance” and you are no longer eligible for this program because your household no longer meets the eligibility criteria for Cash Assistance. To be eligible for CILOCA you must first be eligible for Cash Assistance. You are no longer eligible for Cash Assistance because you failed to cooperate with the Bureau of Eligibility Verification.
22	Failure to comply with Finger Imaging	You were in receipt of “Child Care in Lieu of Cash Assistance” and you are no longer eligible for this program because your household no longer meets the eligibility criteria for Cash Assistance. To be eligible for CILOCA you must first be eligible for Cash Assistance. You are no longer eligible for Cash Assistance because you or another individual in your household 18 years of age or older failed to comply with the finger imaging requirement.
23	Ineligible resources	You were in receipt of “Child Care in Lieu of Cash Assistance” and you no longer meet the eligibility criteria for this program because based on the information you provided to this agency, your resources exceed the Cash Assistance eligibility limits.

Attachment E

CILOCA Minimum Wage Requirements as of 12/31/16

Single Parent

Place of Employment	Minimum Wage	Weekly Amount	Monthly Amount
NYC Employer with 11 or more employees	$11.00	$192.50	$834.00
NYC Employer with 10 or less employees	$10.50	$184.00	$797.00
Long Island & Westchester	$10.00	$175.00	$758.00
Greater New York State	$9.70	$170.00	$737.00

Two-Parent

Place of Employment	Minimum Wage	Weekly Amount	Monthly Amount
NYC Employer with 11 or more employees	$11.00	$275.00	$1192.00
NYC Employer with 10 or less employees	$10.50	$262.50	$1137.50
Long Island & Westchester	$10.00	$250.00	$1083.00
Greater New York State	$9.70	$242.50	$1051.00

Human Resources Administration
Department of Social Services

Investigation, Revenue and Enforcement Administration
Bureau of Eligibility Verification
109 East 16th Street, 2nd Floor
New York, NY 10003

Date: _____

Name: _____

MA/FS Case Number: _____

Folder/Ticket Number: _____

NOTICE TO REPORT TO BEV INTERVIEW

Dear Mr./Ms. _____

The Bureau of Eligibility Verification is conducting a review of the information you provided for Childcare Eligibility.

Please Report to:

Bureau of Eligibility Verification
109 East 16th Street, 2nd Floor
New York, NY 10003

Appointment Date: _____ **Time:** _____

Please bring this letter and a valid Photo ID when you report for your interview.

FIA Worker: _____ Telephone Number: _____

This is a mandatory eligibility appointment. Failure to keep this appointment may result in the loss of Childcare Benefits.

CS-274W (FACE)
REV. 4/08

Child Care Provider Enrollment Supplement*

To be used with LDSS-4699/LDSS-4700 for all unregulated providers

PARENT/CARETAKER'S NAME:		CASE NUMBER:
ADDRESS:		
TELEPHONE:	SOCIAL SECURITY NUMBER *(OPTIONAL, SEE BELOW)*:[1]	ACCIS CASE NUMBER:
PROVIDER'S NAME:		DATE OF BIRTH:[2]
ADDRESS WHERE CARE IS GIVEN:		
PROVIDER'S ADDRESS *(IF DIFFERENT)*:		
TELEPHONE:	PROVIDER'S SOCIAL SECURITY/LICENSE NUMBER/EIN	

[1] The parent/caretaker may, but does not have to, list his/her Social Security number. You cannot be required to disclose your Social Security number as a condition of eligibility for child care services. If provided, your Social Security number will be used to assist in identifying your child care file. It may also be used by Federal, State and local agencies to prevent duplication of services and fraud, and for Federal reporting.

[2] Legally-responsible relatives (parents, stepparents, and legal guardians) cannot be paid as child care providers for their own child(ren).

[3] If the provider is less than 18 years old, the Employment of Minors Form must be completed.

Provider/Agency Name: _____

ACCIS Provider Number (if available): _____

Provider's License Type: _____ License Number: _____

Expiration Date: _____ / _____ / _____
MM *DD* *YYYY*

Provider Rate (All providers, except ACS-contracted programs, must complete this section.)

My weekly child care rates are as follows:

Indicate the rate charged for each age level	**INFANT** Under 18 months	**TODDLER** 18 months – under 3 years	**PRESCHOOL** 3 years – under 6 years	**SCHOOL-AGE** 6 – 12 years
Full time (30 hours or more per week)				
Part time (15 – 29 hours per week)				
Hourly (1 – 14 hours per week but less than 3 hours per day)				

***ATTENTION:**

1. Regulated/licensed providers are not required to complete the **LDSS-4699** or the **LDSS-4700**. They should complete only pages 1 and 2 of this form and return to the parent/legal guardian. Regulated providers without an ACCIS number must also submit a copy of their license along with the competed **CS-274W**.
2. Informal providers must provide documentation of BOTH their identification and their address in order to be paid by ACS. Please ask your JOS/ACS Worker for the Proof of ID and Residency for Your Child Care Provider or "Babysitter" (**CS-574FF**), which is the list of approved types of ID.

NYC Children's Services

Indicate the weekly schedule(s) of child care services for the child(ren) listed below:

Child's Name	*CHILD'S NAME*		*CHILD'S NAME*		*CHILD'S NAME*	
Date of Birth	*MONTH DAY YEAR*		*MONTH DAY YEAR*		*MONTH DAY YEAR*	
Date Care Began	*MONTH DAY YEAR*		*MONTH DAY YEAR*		*MONTH DAY YEAR*	
Weekly Schedule	**From**	**To**	**From**	**To**	**From**	**To**
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
OFFICE USE ONLY	Total Hours per Week		Total Hours per Week		Total Hours per Week	
	ACS Child Care Rate		ACS Child Care Rate		ACS Child Care Rate	

☐ I acknowledge that receiving payment from the City of New York for child care services provided does not make me an employee of the City of New York. I am an employee of the parent/legal guardian of the child for whom I provide care.

Provider Certification

I am enrolling this child in a child care program. I understand that I will be paid only after the child's attendance data is received by ACS and for so long as the above parent/guardian is engaged in an FIA-approved activity or employed. If the parent/guardian fails to meet these criteria, I will be sent a letter from ACS informing me that ACS will no longer pay for child care. I agree that the amount I am charging this parent is not more than the amount I charge for other children of the same age. **I understand that I cannot be paid if I do not list all my rates.**

I will allow the parent/guardian of the children named on this form unlimited access to his/her children and the premises and will make myself available whenever the children are in my care.

I certify that the statements above are accurate and true to the best of my knowledge. I understand that providing false information may lead to the suspension or termination of payments and the recovery of any payments to which I was not entitled.

Provider's Name (print clearly): _____ Official Title (if applicable): _____

Signature: _____ Date: _____

Parent/Guardian Certification

I certify that I have reviewed the above information and that it is correct. I understand I must report any changes to ACS.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

For Agency Use Only:

Is child care authorized for this applicant/participant? ☐ Yes ☐ No

Agency-approved start date for child care: _____ / _____ / _____
MM *DD* *YYYY*

CS-274W-S (FACE)
REV. 4/08

NYC Children's Services

Suplemento de Inscripción del Proveedor de Cuidado Infantil*

(a ser usado con LDSS-4699-S/LDSS-4700s para todos los proveedores no regulados)

NOMBRE DE LA/DEL MADRE/PADRE/CUIDADOR:		NÚMERO DEL CASO:
DIRECCIÓN:		
TELÉFONO:	NÚMERO DE SEGURO SOCIAL (OPCIONAL, VEA MÁS ABAJO):[1]	NÚMERO DE CASO ACCIS
NOMBRE DEL PROVEEDOR:		FECHA DE NACIMIENTO:[2]
DIRECCIÓN EN DONDE SE CUIDA AL/A LOS NIÑO(S):		
DIRECCIÓN DEL PROVEEDOR (SI ES DISTINTA):		
TELÉFONO:	NÚMERO DE SEGURO SOCIAL/NÚMERO DE LICENCIA/EIN	

[1] La madre, el padre o el cuidador puede proporcionar su número de Seguro Social, pero no está obligado(a) a ello. No se le exige a usted que revele su número de Seguro Social como condición de elegibilidad de servicios de cuidado infantil. Si lo proporciona, su número de Seguro Social será utilizado para la identificación de su expediente de cuidado infantil. También puede ser usado por agencias Federales, Estatales o locales para evitar el fraude y la duplicación de servicios, y para elaborar informes Federales.

[2] Los parientes legalmente responsables (padres, padrastros, y guardianes legales) no pueden ser pagados como proveedores de cuidado infantil para su(s) propio(s) hijol(s).

[3] Si el proveedor es menor de 18 años, el Formulario de Empleo de Menores (Employment of Minors Form) tiene que llenarse.

Nombre del/de la Proveedor/Agencia: _____

Núm. de ACCIS del Proveedor *(si disponible)*: _____

Tipo de licencia del proveedor: _____ Núm. de licencia: _____

Fecha de Vencimiento: _____ / _____ / _____
DÍA *MES* *AÑO*

Tarifas del Proveedor (Todo proveedor, excepto programas contratados por ACS, tienen que llenar esta sección.)
Mis tarifas semanales de cuidado infantil son las siguientes:

Indique la tarifa cobrada para cada grupo de edad	**BEBÉ** Menor de 18 meses	**NIÑO PEQUEÑO** 18 meses – menor de 3 años de edad	**PRE-ESCOLAR** 3 años – menor de 6 años	**EDAD ESCOLAR** 6–12 años
Tiempo completo (30 horas o más a la semana)				
Tiempo parcial (15–29 horas a la semana)				
Por hora (1–14 horas a la semana pero menos de 3 horas al día)				

***ATENCIÓN:**
1. Los proveedores con licencia/regulados no tienen que llenar el **LDSS-4699-S** o el **LDSS-4700S**. Solamente deben llenar las páginas 1 y 2 de este formulario y devolvérselas al/a la padre/madre/tutor. Los proveedores regulados sin número de ACCIS también tienen que presentar una copia de la licencia junto con el **CS-274W-S** llenado.
2. Los proveedores informales deben proporcionar documentación de AMBOS su identificación y su dirección para poder recibir pagos por parte de HRA. Favor de pedirle a su Trabajador de JOS/ACS el formulario Prueba de Identidad y Domicilio de su Proveedor de Cuidado Infantil o "Niñera" (**CS-574FF-S**), que consiste en la lista de tipos de identificación admisibles.

NYC Children's Services

Indique el horario semanal de cuidado infantil para cada niño nombrado más abajo:

Nombre del Niño	*NOMBRE DEL NIÑO*		*NOMBRE DEL NIÑO*		*NOMBRE DEL NIÑO*	
Fecha de Nacimiento	*MES DÍA AÑO*		*MES DÍA AÑO*		*MES DÍA AÑO*	
Fecha de Inicio de Cuidado	*MES DÍA AÑO*		*MES DÍA AÑO*		*MES DÍA AÑO*	
Horario Semanal	**De**	**A**	**De**	**A**	**De**	**A**
Lunes						
Martes						
Miércoles						
Jueves						
Viernes						
Sábado						
Domingo						
OFFICE USE ONLY	Total Hours per Week		Total Hours per Week		Total Hours per Week	
	ACS Child Care Rate		ACS Child Care Rate		ACS Child Care Rate	

☐ Yo entiendo que el hecho de recibir pagos por parte de la Ciudad de Nueva York por servicios de cuidado infantil no significa que soy un empleado de la misma. Soy empleado del/de la padre/madre/tutor del niño a quien le presto cuidado.

Certificación del Proveedor

Estoy inscribiendo a este niño en un programa de cuidado infantil. Entiendo que seré pagado solo después de que la FIA reciba los datos de asistencia del niño siempre y cuando el/la antemencionado(a) padre/madre/tutor esté trabajando o participando en una actividad aprobada por la FIA. En caso de que el/la padre/madre/tutor no reúna estos criterios, la FIA me enviará una carta avisándome de que la FIA ya no pagará por el cuidado infantil. Yo doy fe de que la cantidad que le estoy cobrando a este/a padre/madre no es más de la que cobro por otros niños de la misma edad. **Entiendo que no se me pagará si no indico todas mis tarifas.**

Yo le permitiré al/a la padre/madre/tutor de los niños nombrados en este formulario acceso ilimitado a sus niños y al local de cuidado, y estaré disponible siempre que los niños estén bajo mi cuidado.

Doy fe de que las declaraciones más arriba son verídicas y exactas, según mi leal saber y entender. Entiendo que el proporcionar información falsa puede resultar en la suspensión o terminación de pagos y la recuperación de cualquier pago al cual yo no haya tenido derecho.

Nombre del Proveedor *(en letra de molde)*: _____ Cargo Oficial *(si corresponde)*: _____

Firma: _____ Fecha: _____

Certificación del/de la Padre/Madre/Tutor

Doy fe de que he leído y repasado la información más arriba y que la misma es correcta. Entiendo que tengo que reportar cualquier cambio a la FIA.

Nombre del/de la Padre/Madre/Tutor: _____

Firma del/de la Padre/Madre/Tutor: _____ Fecha: _____

For Agency Use Only:

Is child care authorized for this applicant/participant? ☐ Yes ☐ No

Agency-approved start date for child care: _____ / _____ / _____
MM DD YYYY

CS-560DD (FACE) (LDSS 4780)
REV. 5/07

nycACS
NYC Administration for Children's Services
Division of Child Care and Head Start

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Caseload: _____

FH&C Telephone Number: _____

Notice of Ineligibility for Transitional Child Care Benefits

We have determined that you are ineligible for Transitional Child Care benefits for the reason or reasons explained below.

☐ Your gross monthly income of $ _____ exceeds the allowable limit for your family size of _____ .

☐ You have not provided us with the following documents: _____

_____

_____

☐ Your public assistance case is active (open). You may be eligible for other child care benefits. Contact your Worker at the Job Center. Transitional Child Care benefits are available only to families who are working and whose public assistance cases are closed.

☐ You are a two-parent household. Both parents must submit pay information if both parents are working. Otherwise, the nonworking parent is deemed available to care for the child(ren) unless that parent is physically or emotionally incapacitated. A recent doctor's note must be submitted, describing the condition, treatment and prognosis for recovery in such cases.

☐ Your child care provider does not meet State/Agency guidelines.

☐ The child(ren) for whom you are requesting child care payments is/are over 13 years of age.

☐ You did not request child care assistance within the twelve-month period after your public assistance case closed.

☐ You did not receive public assistance in three of the six months prior to your case closing.

☐ Current income information is not on file for _____ . If you wish to have your case redetermined,
PARTICIPANT'S NAME

please have your employer complete the enclosed **Request for Information from Employer (CS-560U)** then submit it with your application for **Child Care Subsidy (CS-925)**.

☐ Current income information is not on file for _____ and child care was not in place at the time of
PARTICIPANT'S NAME

case closing. If you have your child care provider complete the enclosed Child Care Provider form and have your employer complete the enclosed **Request for Information from Employer (CS-560U)**, you may resubmit your request for Transitional Child Care Benefits.

☐ Other: _____

The law(s) and/or regulation(s) that allow(s) us to do this is/are: 18 NYCRR § 415.2.

_____ _____
Worker's Signature *Date*

_____ _____
Supervisor's Signature *Date*

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.

CS-560DD (REVERSE)
REV. 5/07

nycACS
NYC Administration for Children's Services
Division of Child Care and Head Start

Conference and Fair Hearing Information

CONFERENCE

If you think our decision is wrong, or if you do not understand our decision, please call us to set up a conference (informal meeting with us). To do this, call the Fair Hearing and Conference (FH&C) unit phone number on **page 1** of this notice or write to us at the address on **page 1** of this notice. Sometimes this is the fastest way to solve a problem you may have. We encourage you to do this even if you have asked for a Fair Hearing. If you ask for a conference, you are still entitled to a Fair Hearing.

STATE FAIR HEARING

How to Ask for a Fair Hearing: If you believe the decision(s) we are making is/are wrong, you may request a State Fair Hearing by telephone, writing, fax, in person or online.

(1) **TELEPHONE:** Call **(800) 342-3334**. (Please have this notice in hand when you call.)

(2) **WRITE:** Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:

Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201
(Please keep a copy for yourself.)

(3) **FAX:** Fax a copy of the entire notice, with the "Fair Hearing Request" section completed, to: **(518) 473-6735.**

(4) **IN PERSON:** Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at either:

14 Boerum Place, Brooklyn or 330 West 34th Street, 3rd floor, Manhattan

(5) **ONLINE:** Complete an online request form at: **http://www.otda.state.ny.us/oah/forms.asp**

What to Expect at a Fair Hearing: The State will send you a notice that tells you when and where the Fair Hearing will be held. At the hearing, you will have a chance to explain why you think our decision is wrong. To help explain your case, you can bring a lawyer and/or witnesses such as a relative or a friend to the hearing, and/or give the Hearing Officer any written documentation related to your case such as: pay stubs, leases, receipts, bills and/or doctor's statements, etc. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give that person a letter to show the Hearing Officer that you want that person to represent you. At the hearing, you, your lawyer or your representative can also ask questions of witnesses whom we bring, or you bring, to explain the case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the Yellow Pages under "Lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case files. If you call, write or fax us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax us, we will send you free copies of specific documents from your files which you think you may need to prepare for your Fair Hearing. To ask for documents or to find out how to look at your file, call **(718) 722-5012**, fax **(718) 722-5018** or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a Fair Hearing, how to see your file or how to get additional copies of documents, call or write to us at the phone number/address listed on **page 1** of this notice.

FAIR HEARING REQUEST

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of the notice for child care issues.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, in person or online, please write to ask for a Fair Hearing before the deadline.

☐ **I want a Fair Hearing. The Agency's decision is wrong because:**

_____

_____

_____

Print Name: _____ Case Number: _____
FIRST NAME M.I. LAST NAME

Address: _____ Telephone: _____

_____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

CS-560DD-S (CARA) LDSS-4780
REV. 8/07

nycACS
Administración de Servicios a la Niñez
División de Cuidado Infantil y Programa Head Start

Fecha: _____

Caso Número: _____

Nombre del Caso: _____

Centro: _____

Cantidad de Casos: _____

Teléfono de FH&C: _____

Aviso de No Elegibilidad para Beneficios de Atención Infantil Transitoria

Hemos determinado que usted no es elegible para los beneficios de Atención Infantil Transitoria por la razón o razones que se explican a continuación:

☐ Su ingreso bruto mensual de $ _____ excede el límite permisible para su tamaño de familia de _____.

☐ Usted no ha suministrado los siguientes documentos: _____

_____

_____

☐ Su caso de asistencia pública está activo (abierto). Puede ser elegible para otros beneficios de atención infantil. Contacte con su Asistente Social en el Centro de Trabajo. Los beneficios de Atención Infantil Transitoria están disponibles solamente para las familias que trabajan y cuyos casos de asistencia pública están cerrados.

☐ Usted pertenece a un hogar con 2 padres. Ambos padres deben enviar información de pago en caso que los dos estén trabajando. De lo contrario, el padre sin trabajo es considerado disponible para cuidar de los hijos a menos que ese padre esté física o emocionalmente incapacitado. Se debe enviar una nota reciente del profesional médico, describiendo la condición, tratamiento y pronóstico de recuperación, para dichos casos.

☐ Su proveedor de atención infantil no satisface las condiciones de la Agencia / Estado.

☐ El niño(s) para el cual está solicitando pagos de atención infantil tiene(n) más de 13 años de edad.

☐ Usted no solicitó asistencia de cuidado infantil dentro del período de 12 meses después que su caso de asistencia pública fue cerrado.

☐ Usted no recibió asistencia pública en tres de los seis meses anteriores al cierre de su caso.

☐ La información de ingresos actuales no está en el archivo de _____ y la atención infantil no estaba
NOMBRE DEL PARTICIPANTE
determinada en el momento del cierre del caso. Si hizo completar el formulario de Proveedor de Atención Infantil adjunto por el proveedor de atención infantil de su hijo; y que su empleador completara la **Solicitud de Información del Empleador (CS-560U),** puede re-enviar su solicitud de Beneficios de Atención Infantil Transitoria.

☐ Otra: _____

_____

La ley(es) y/o regulación(es) que nos permite(n) realizar esto es/son la 18NYCRR § 415.3, 414.4, 415.7.

_____ _____

Firma del Trabajador *Fecha*

_____ _____

Firma del Supervisor *Fecha*

USTED TIENE EL DERECHO DE APELAR ESTA DECISIÓN, ASEGÚRESE DE LEER LA SECCIÓN DE INFORMACIÓN DE CONFERENCIA Y AUDIENCIA JUSTA EN ESTA NOTIFICACIÓN PARA SABER CÓMO APELAR ESTA DECISIÓN.

nycACS
Administración de Servicios a la Niñez
División de Cuidado Infantil y Programa Head Start

Información de Conference and Fair Hearing
(Conferencia y Audiencia Justa)

CONFERENCIA

Si usted piensa que nuestra decisión es equivocada, o si no entiende dicha decisión, por favor llámenos para fijar una conferencia (una reunión informal con nosotros). Para esto, llame a la unidad de Conference and Fair Hearing (Conferencia y Audiencia Justa) (FH&C), al número de teléfono en la primera página de esta notificación o escríbanos a la dirección de la misma página. A veces esta es la forma más rápida de resolver un problema. Le recomendamos hacer esto incluso aunque haya pedido una Audiencia Justa. Si usted pide una conferencia, todavía tiene derecho a una Audiencia Justa.

AUDIENCIA JUSTA DEL ESTADO

Cómo pedir una Audiencia Justa: Si usted piensa que la decisión(es) que estamos tomando es/son incorrecta(s), puede solicitar una Audiencia Justa del Estado por teléfono, por escrito, fax, en persona o en línea.

(1) **TELÉFONO**: **(800) 342-3334** (Por favor tenga esta notificación a mano cuando llame)

(2) **POR ESCRITO**: Envíe una copia de toda la notificación, con la sección "Solicitud de Audiencia Justa" completa, para:

Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O.BOX 1930
Albany, NY 12201
(Por favor mantenga una copia para usted)

(3) **FAX**: Envíe un fax con la copia completa de la notificación, con la sección "Solicitud de Audiencia Justa" completa al número: **(518) 473-6735**.

(4) **EN PERSONA**: Traiga una copia completa de la notificación, con la sección "Solicitud de Audiencia Justa" completa a: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance en: **14 Boerum Place, Brooklyn o 330 West 34th Street, tercer piso, Manhattan**

(5) **EN LÍNEA**: Complete la solicitud en línea en: **http://www.otda.state.ny.us./oah/forms.asp**

Qué puede esperar en una Audiencia Justa: El Estado le enviará un aviso informándole cuándo y dónde será mantenida la Audiencia Justa. En la audiencia, usted tendrá la chance de explicar por qué usted considera que la decisión es incorrecta. Para ayudarlo a explicar su caso, usted puede traer a la audiencia un abogado y/o testigos tales como parientes o un amigo, y/o dar al Oficial de la Audiencia cualquier documentación escrita relacionada a su caso, tales como: talones de pago, rentas, recibos, cuentas o declaraciones médicas, etc. Si no puede asistir usted mismo, puede enviar a una persona en su lugar. En el caso de enviar a dicha persona a la Audiencia, sin ser su abogado, debe proveerla de una carta para exhibir frente al Oficial de Audiencia demostrando que usted desea ser representado por ella. En la audiencia, usted, su abogado o su representante también pueden realizar preguntas a los testigos que nosotros presentamos, o que usted presenta, para explicar el caso.

ASISTENCIA LEGAL: Si usted necesita asistencia legal gratuita, puede obtenerla contactando su Sociedad de Ayuda Legal local u otros grupos legales de abogados. Puede localizar su Sociedad de Ayuda Legal o grupo de abogados más cercanos, consultando las Páginas Amarillas en la sección "Abogados."

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarse a estar preparado para la audiencia, usted tiene derecho de revisar sus archivos de caso. Si llama, escribe o nos envía un fax, le enviaremos copias gratuitas de documentos específicos existentes en sus archivos que usted crea que puede necesitar para prepararse para su Audiencia Justa. Para pedir documentos o averiguar como revisar su archivo, llame al **(718) 722-5018** o escriba a **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**. Si usted desea copias de documentos existentes en su archivo de caso, debe pedirlas con anticipación. Ellas le serán suministradas dentro de un tiempo razonable con anterioridad a la fecha de la audiencia. Los documentos le serán enviados por correo postal, solamente en el caso en que lo solicite específicamente.

INFORMACIÓN: Si usted desea más información acerca de su caso, cómo pedir una Audiencia Justa, cómo revisar su archivo o cómo obtener copias de documentos adicionales, llame o escríbanos al número de teléfono/dirección detallados en la página 1 de esta notificación.

SOLICITUD DE AUDIENCIA JUSTA

Fecha Límite: Si usted desea que el Estado revea nuestra decisión, debe pedir una Audiencia Justa dentro de los sesenta (60) días desde la fecha de la notificación de las cuestiones de atención infantil.

Si usted no puede contactar a la New York State Office of Temporary and Disability Assistance (Oficina del Estado de Nueva York de Asistencia Temporaria y de Discapacidad) por teléfono, fax, en persona, o en línea, por favor escriba o pida una Audiencia Justa antes de la fecha límite.

☐ **Deseo una Audiencia Justa. La decisión de la Agencia es incorrecta porque:**

_____

_____

_____

Nombre en letra de Imprenta: _____ _____ _____ Caso Número: _____
NOMBRE *INICIAL 2º NOMBRE* *APELLIDO*

Dirección: _____ Teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

CS-574EE (FACE)
REV. 8/08

Child Care Fact Sheet and Planner

You Have Many Options in Choosing Child Care!

NYC Children's Services
Division of Child Care and Head Start

Regulated Child Care

A regulated child care provider is licensed or registered by the Department of Health and Mental Hygiene (DOHMH) and conforms to health, fire and building codes. Workers must pass medical, character and criminal background **checks.**

Family Child Care: Up to six children (8 in some cases) may be cared for in the provider's home. No more than two children under two years of age – including the provider's own – are allowed.

Group Family Child Care: Two providers caring for up to 12 children (14 in some cases) in the home of one of the providers.

Child Care Centers: Teachers and other trained staff provide child care in a classroom setting.

School Age Child Care: Many family day care providers and day care centers serve children up to age 13. There are also free programs; many are located in schools. Talk to an ACS worker in your job center or call 311 to find a school age program in your area.

ACS Child Care Centers: The Administration for Children's Services Division of Child Care and Head Start contracts with centers and family day care networks to provide regulated child care. Each program has an educational component to promote school readiness. Parents should call 311 for help locating a vacancy in an ACS Child Care Center.

Need help finding child care in your area?

Workers at your Job Center can assist you in locating child care. Other resources include: the Child Care Resource and Referral Consortium (CCRRC) at (888) 469-5999.

For children with special needs, call CCRRC or Resources for Children with Special Needs, Inc. at (212) 677-4650.

Child Development Programs

Head Start is a federally-funded, comprehensive child development program that serves children ages three to five and their families. Head Start offers activities and educational programs to prepare children for school and help them succeed later in life. Talk to an ACS worker in your Job Center or call 311 to locate a Head Start program in your neighborhood.

Universal Pre-Kindergarten (UPK) is a comprehensive Department of Education pre-kindergarten program that provides children with a nurturing environment and educational experiences to promote positive early childhood development. Parents may choose a UPK program in a public school or a community-based program. Talk to an ACS worker in your Job Center or call 311 for more information.

Out-of-School Time (OST) programs for youth offered by the Department of Youth and Community Development provide a mix of academic support, sports and recreational activities, arts and cultural experiences at no cost after school, on weekends and during school vacations. Talk to an ACS worker in your Job Center or call 311 for more information.

Informal/Legally-Exempt Providers

Informal care is often provided by relatives, neighbors and friends. Informal providers may care for no more than two unrelated children under age seven at the same time for three or more hours per day in the provider's home. Parents and informal providers must complete a checklist about the health and safety of the home.Background checks and inspections of the informal provider's home may be required. The City of New York will pay these providers if they are unrelated or related to the children – but not if they are the parents or guardians of the children or on the same public assistance case.

Family Day Care Networks

Networks provide referrals and support to groups of family day care providers. Networks are not regulated and affiliation with a network is not a requirement.

For more information call the Department of Health and Mental Hygiene's Family Day Care Registration Office at (212) 280-9251.

NYC Children's Services
Division of Child Care and Head Start

There Are Long-Lasting Benefits of Quality Early Childhood Education

Early Childhood Experiences and Brain Development

- Early experiences from birth to age five affect the development of the brain and lay the foundation for intelligence, social and emotional health.
- Research tells us that children, even in the earliest months, have an amazing ability to learn.
- Children who are nurtured and stimulated during the first years of life are more prepared for kindergarten.

Long-Lasting Benefits of Early Childhood Education

- Enhanced language development.
- Higher academic achievement in both reading and math.
- Completion of more years of education.
- More likely to attend college.

What To Consider When Looking for Child Care and Early Childhood Education Programs

- **A low child-to-teacher ratio** determines how much attention your child will get and is key to good care. The younger the child, the more individualized attention is needed.
- **Training in early childhood development** assures that staff understand how children grow and learn so they can be more effective teachers and caregivers.
- **Relationships** that are warm and sensitive help children develop a positive sense of self and encourage them to respect and cooperate with others.
- **Curriculum and materials** contribute to the quality of early childhood programs in helping children use their developing language, thinking and motor skills.
- **A safe and healthy environment.**
- **Backup and supplemental child care**
  Don't forget – make sure to plan backup child care for times when your main child care provider is sick or on vacation and for school breaks and summer vacations. You may need a supplemental provider if you choose a part-day Head Start or UPK program.

- Are all children under adult supervision at all times?
- How many other children will be with the child care provider? How many adult staff are with each group?
- What training does the provider have in child development and early childhood education?
- How many years of experience in child care does the provider have?
- Is the provider warm and caring toward children?
- Does the provider respect each child?
- What will my child learn from this child care provider?
- Are there plenty of toys, books and learning materials that offer challenging activities?
- Does the child care facility look clean?
- What are the health and safety procedures and policies for handling emergencies?
- Does the provider have a valid license or certificate?

Important Telephone Numbers

ACS Division of Child Care and Head Start	**311**
Child and Adult Care Food Program (CACFP)	**(212) 835-0163**
Child Care Automated Phone System (CAPS)	**(800) 692-0699**
Child Care Resource and Referral Consortium (CCRRC)	**(888) 469-5999**
Department of Health and Mental Hygiene	**311**
Early Childhood Professional Development Institute	**(646) 344-7355**
Children With Special Needs	**(212) 677-4650**
Transitional Child Care	**(212) 835-7681**

CS-574EE-S (CARA)
REV. 8/08

HOJA INFORMATIVA DE PLANIFICACION DE CUIDADO INFANTIL
¡Usted Dispone de Muchas Opciones respecto a Cuidado Infantil!

Servicios para Niños
División de Cuidado Infantil y Programa Head Start

ATENCIÓN INFANTIL REGULADA

Un proveedor de atención infantil regulado está licenciado o registrado por el Departamento de Salud e Higiene (DOHMH) y cumple con los códigos de salud, incendio y edificación. Los Trabajadores deben pasar **verificaciones** médicas, de carácter y antecedentes criminales.

Atención Infantil Familiar:
Hasta seis niños (8 en algunos casos) pueden ser atendidos en el hogar del proveedor. No más de dos niños por debajo de los dos años de edad – incluyendo los propios del proveedor – están permitidos.

Atención Infantil Familiar en Grupo:
Dos proveedores atendiendo hasta 12 niños (14 en algunos casos) en el hogar de uno de los proveedores.

Centros de Atención Infantil:
Profesores y otros personas capacitadas suministran atención infantil en un ambiente de clases.

Atención Infantil en Edad Escolar:
Muchos proveedores de atención diaria familiar y centros de atención diaria atienden a niños de hasta 13 años de edad. Existen también programas gratuitos, muchos están localizados en escuelas. Entre en contacto con un asistente de ACS en su centro de trabajo o llame al 311 para encontrar un programa de edad escolar en su área.

Centros de Atención Infantil ACS:
La División de Atención Infantil y Programa Head Start de la Admin-istración de Servicios a la Niñez (Administration for Children's Services) contrata con centros y redes de atención infantil diurna de familia para suministrar atención infantil regulada. Cada programa tiene un componente educacional para promover la disponibilidad escolar. Los padres deben llamar al 311 para conseguir ayuda en localizar una vacante en un Centro de Atención Infantil de ACS.

¿Necesita ayuda para encontrar atención infantil en su área?

Los asistentes en su Centro Laboral pueden asistirlo a localizar atención infantil. Otros recursos incluyen: El Child Care Resource and Referral Consortium (CCRRC) en el (888) 469-5999.

Para Niños con Necesidades Especiales, llame al CCRRC o Resources for Children with Special Needs, Inc, al (212) 677-4650.

PROGRAMAS DE DESARROLLO INFANTIL

Head Start es un extenso programa de desarrollo infantil finaciado federalmente que atiende a niños de tres a cinco años y sus familias. Head Start ofrece actividades y programas educacionales para preparar niños para la escuela y ayudarlos a tener éxito mas tarde en sus vidas. Entre en contacto con un asistente de ACS en su Centro Laboral o llame al 311 para localizar un programa Head Start en su barrio.

Universal Pre-Kindergarten (Pre-Jardín de Infantes Universal) (UPK) es un extenso programa pre- jardín de infantes que brinda a los niños un ambiente de cuidado y protección y experiencias educacionales para promover el desarrollo positivo temprano de la niñez. Los padres pueden elegir un programa UPK en una escuela pública o un programa basado en la comunidad. Entre en contacto con un asistente de ACS en su Centro Laboral o llame al 311 para más información.

Tiempo Fuera de la Escuela (OST), son los programas ofrecidos por el Departamento de la Juventud y Desarrollo Comunitario brindando una mezcla de soporte académico, deportes y actividades recreativas, artes y experiencias culturales sin costo después de la escuela, los fines de semana y durante las vacaciones escolares. Entre en contacto con un asistente de ACS en su Centro Laboral o llame al 311 para más información.

PROVEEDORES INFORMALES / LEGALMENTE EXENTOS

La atención informal es a menudo suministrada por parientes, vecinos y amigos. Los proveedores informales pueden atender a no más de dos niños sin parentezco por debajo de los siete años de edad al mismo tiempo durante tres o más horas por día en el hogar del proveedor. Los padres y proveedores informales deben completar una lista de verificación acerca de la salud y seguridad del hogar. Verificaciones de fondo e inspecciones del hogar del proveedor informal son requeridas. La Ciudad de Nueva York pagará a estos proveedores sea que ellos tienen o no parentezco con los niños - aunque no puede pagar si ellos son los padres o tutores de niños en el mismo caso de asistencia pública.

REDES DE ATENCIÓN DIARIA DE FAMILIA

Las Redes brindan recomendaciones y soporte a grupos de proveedores de atención diurna de familia. Las redes no están reguladas y la afiliación a una red no es obligatoria.

Para más información llame la Oficina de Registro de Atención Diurna de Familia del Departamento de Salud e Higiene Mental al (212) 280-9251.

Servicios para Niños
División de Cuidado Infantil y Programa Head Start

EXISTEN BENEFICIOS DE LARGA DURACIÓN DE LA EDUCACIÓN DE CALIDAD DE LA NIÑEZ TEMPRANA

Experiencias de Niñez Temprana y Desarrollo Cerebral

- Las experiencias tempranas desde el nacimiento hasta los cinco años de edad afectan el desarrollo del cerebre y fijan las bases para la salud emocional, social, y la inteligencia.
- La investigación nos dice que los niños, incluso en los meses más tempranos, tienen una sorprendente capacidad de aprendisaje.
- Los niños que son protegidos y atendidos y estimulados durante los primeros años de vida están más preparados para el jardín de infantes.

Beneficios de Larga Duración de Educación de Niñez Temprana

- Desarrollo aumentado del lenguage.
- Logros académicos más altos en lectura y matemáticas.
- Más años de educación completados.
- Mayor probabilidad de asistir a la universidad.

QUÉ CONSIDERAR AL BUSCAR ATENCIÓN INFANTIL Y PROGRAMAS DE EDUCACIÓN DE LA NIÑEZ TEMPRANA

- **Un índice bajo de niño a profesor** determina cuánta atención su niño obtendrá y es clave para la buena atención. Cuando más joven es el niño, mayor atención individualizada es necesaria.
- **Capacitación en el desarrollo temprano de la niñez** asegura que el personal entiende cómo los niños crecen y aprenden de forma que ellos pueden ser profesores y cuidadores más eficaces.
- **Las relaciones** que son cálidas y sensibles ayudan a los niños a desarrollar un sentido positivo de sí mismos y los estimula a respetar y cooperar con otros.
- **Currículum y materiales** contribuyen a la calidad de programas de la niñez temprana ayudando a los niños en el desarrollo del lenguaje, el pensamiento y la capacidad motora.
- **Un ambiente saludable y seguro**
- **Respaldo y atención infantil suplementaria**
- No olvide – asegúrese de planificar atención infantil de respaldo para el momento en que su proveedor de atención infantil principal esté enfermo o de vacaciones y para recesos escolares y vacaciones de verano. Usted puede necesitar un proveedor extra si elige un programa UPK o Head Start de medio día.
- ¿Están los niños bajo supervisión adulta en todo momento?
- ¿Cuántos otros niños estarán con el proveedor de atención infantil? ¿Cuántos adultos del personal están con cada grupo?
- ¿Qué entrenamiento tiene el proveedor en desarrollo infantil y educación de la niñez temprana?
- ¿Cuántos años de experiencia en atención infantil tiene el proveedor?
- ¿Es el proveedor cálido y protector con los niños?
- ¿El proveedor es respetuoso con los niños?
- ¿Qué es lo que mi hijo(a) aprenderá con este proveedor de atención infantil?
- ¿Existen cantidades de juguetes, libros y materiales de aprendizaje ofreciendo actividades estimulantes?
- ¿El establecimiento de atención infantil se ve limpio?
- ¿Cuáles son los procedimientos de seguridad y salud, y las normas de manejo de emergencias?
- ¿Tiene el proveedor un certificado o licencia válidos?

NÚMEROS IMPORTANTES DE TELÉFONO

ACS Division of Child Care and Head Start (División de Atención Infantil y Programa Head Start de ACS)	**311**
Child and Adult Care Food Program (CACFP) (Programa Alimentario de Atención Infantil y Adultos)	**(212) 835-0163**
Child Care Automated Phone System (CAPS) (Sistema Telefónico Automatizado de Atención Infantil)	**(800) 692-0699**
Child Care Resource and Referral Consortium (CCRRC) (Recurso de Atención Infantil y Consorcio de Recomendación)	**(888) 469-5999**
Department of Health and Mental Hygiene (Departamento de Salud e Higiene Mental)	**311**
Early Childhood Professional Development Institute (Instituto de Desarrollo Profesional de la Niñez Temprana)	**(646) 344-7355**
Children With Special Needs (Niños con Necesidades Especiales)	**(212) 677-4650**
Transitional Child Care (Atención Infantil Transitoria)	**(212) 835-7681**

Children's Services

Proof of ID and Residency for Child Care Providers

All legally exempt family and in-home child care providers must:

(1) provide proof of identity and residency in order to receive payment

(2) complete the top portion of page 2 of this notice.

Verification of Provider Identity

Providers must submit one of the following forms of documentation for WHEDCo to verify the provider's identity (copies of the original document are acceptable):

- At least **one** of the following forms of a current valid photo ID issued by government, employer, school or other official/institution/agency including but not limited to:
    - Driver's license/non-drivers identification card
    - Passport or visa
    - Naturalization or citizenship certificate
    - School or Military ID card
    - Employment Authorization Card
    - Permanent Resident Card
    - Government Benefit Card (e.g., Cash Assistance/Medicaid/Supplemental Nutrition Assistance Program)

OR

- At least two of the following non-photo-IDs including but not limited to:
    - Social Security card
    - Birth certificate
    - Baptismal certificate
    - Government benefit card (e.g., Welfare/Medicaid/Food Stamps)
    - Life Insurance Policy

Verification of Provider Residence

Providers must submit **one** of the following forms of documentation, either a copy or an original to be copied by WHEDCo, to verify the provider's residence. The provider may, for privacy reasons, cross out any specific financial information on the document.

- Statement from landlord on his/her official stationery*
- Lease or deed with the provider's name
- Rent statement/receipt with preprinted address*
- Mortgage records
- Tax records for residence (property tax bill)
- A utility bill (electricity, gas, heating, oil, water or landline phone) with the provider's address*
- A bank statement with the provider's address*
- Provider's school records indicating address*

* Documents cannot be more than 60 days old.

If a provider **cannot** verify their residence and/or care is taking place at a location other than the home of the child or provider, the provider must complete and submit the bottom portion of page 2 of this notice or provide to WHEDCo a notarized letter from the owner or primary tenant of the residence approving the use of their residence for such care along with the documentation listed above to verify the residence of the property owner or primary tenant.

Division of Early Care and Education
66 John Street
New York, NY 10038

Children's Services

CS-574FF

LOCATION OF LEGALLY EXEMPT FAMILY AND IN-HOME CHILD CARE

Name of child _____

Name of provider _____

Location of child care _____

The above location is the address of (please check one):

[ ] Child in care

[ ] Provider (please check one)

[ ] I am able to provide verification of my residence

If you have checked this box, stop here. No additional information is required to be completed below.

* [ ] I am not able to provide verification of my residence and the name of the owner or primary tenant is: _____

* [ ] Third party location (not where you or the child in care lives)

Name of third party owner or tenant: _____

---

* ***Attention Providers:*** *If you checked the box indicating that you are unable to verify your residence or you are providing care at a third party location, you must have the owner or primary tenant with whom you live, sign the statement below and have it notarized before providing the document to WHEDCo. A notarized letter from the owner or primary tenant of your residence approving the use of their residence for such care is also acceptable.*

Notarized statement by owner or tenant:

I, _____, the owner/primary tenant at

Name of owner/primary tenant

_____

Address

approve the use of my residence for child care provided by _____

Name of provider

to _____.

Name of child

Signature of owner/primary tenant: _____

Date: _____

Sworn to and subscribed in my presence by _____this _____ day of _____yr.

My commission expires: _____

Notary Name: _____

Notary Public

Date: _____

Children's Services
CS-574FF

Prueba de identificación y residencia para proveedores de cuidado infantil

Todos los proveedores de cuidado infantil familiar y dentro del hogar, legalmente exentos deben:

(1) **proporcionar evidencia de identificación y residencia para recibir el pago**

(2) **completar la parte superior de la página 2 de este aviso.**

Verificación de identidad del proveedor

Los proveedores deben presentar uno de los siguientes documentos para que WHEDCo verifique la identidad del proveedor (se aceptan copias del documento original):

- Al menos **uno** de los siguientes tipos de identificación con fotografía válidos y vigentes que haya emitido el gobierno, empleador, escuela u otra agencia/institución oficial, lo que incluye, pero que no se limita a:
    - Licencia de conducir/tarjeta de identificación para personas que no conducen
    - Pasaporte o visa
    - Certificado de naturalización o ciudadanía
    - Tarjeta de identificación de la escuela o militar
    - Tarjeta de autorización de empleo
    - Tarjeta de residente permanente
    - Tarjeta de beneficios del gobierno (por ejemplo, Asistencia monetaria/Medicaid/Programa de Asistencia nutricional complementaria)

O

- Por lo menos dos de las siguientes identificaciones sin fotografía, lo que incluye pero no se limita a:
    - Tarjeta del Seguro Social
    - Certificado de nacimiento
    - Certificado de bautismo
    - Tarjeta de beneficio gubernamental (por ejemplo, Bienestar/Medicaid/Cupones para alimentos)
    - Póliza de seguro de vida

Verificación de residencia del proveedor

Los proveedores deben presentar **una** de las siguientes formas de documentación, ya sea una copia o un original para que WHEDCo la copie para verificar la residencia del proveedor. El proveedor puede, por motivos de privacidad, tachar cualquier información financiera específica en el documento.

- Declaración del arrendador en su papel membretado oficial*
- Contrato de arrendamiento o escritura con el nombre del proveedor
- Declaración/recibo de alquiler con la dirección ya impresa*
- Registros de hipotecas
- Registros de pago de impuestos de la residencia (factura de impuesto de la propiedad)
- Una factura de servicios públicos (electricidad, gas, calefacción, petróleo, agua o teléfono de línea fija) con la dirección del proveedor*
- Un estado de cuenta bancario con la dirección del proveedor*
- Registros escolares del proveedor que indiquen la dirección*

* Estos documentos no pueden tener más de 60 días desde su emisión.

Si un proveedor **no puede** verificar su residencia y/o el cuidado se está realizando en un lugar que no sea la casa del niño o del proveedor, el proveedor debe completar y presentar la parte inferior de la página 2 de este aviso o proporcionar a WHEDCo una carta legalizada por un notario de parte del propietario o arrendatario principal de la residencia, en la que autoriza el uso de su residencia para dicho cuidado, junto con la documentación que se enumeró anteriormente para verificar la residencia del propietario o arrendatario principal.

Division of Early Care and Education
66 John Street
New York, NY 10038

Children's Services

CS-574FF

UBICACIÓN DEL CUIDADO INFANTIL FAMILIAR Y DENTRO DEL HOGAR LEGALMENTE EXENTO

Nombre del niño _____

Nombre del proveedor _____

Ubicación del cuidado del niño _____

La ubicación anterior es la dirección de (marque uno):

[ ] Niño bajo cuidado

[ ] Proveedor (marque uno)

[ ] Estoy en la capacidad de proporcionar la verificación de mi residencia

Si marcó esta casilla, deténgase aquí. No es necesario que complete la siguiente información adicional.

* [ ] No estoy en la capacidad de proporcionar la verificación de mi residencia, y el nombre del propietario, o el arrendatario principal es: _____

* [ ] Ubicación de un tercero (no es el lugar en donde viven usted o el niño)

Nombre del tercero propietario o arrendatario: _____

---

* ***Atención:*** *si marcó la casilla que indica que usted no puede verificar su residencia o que proporciona cuidado en otro lugar, debe pedirle al propietario o arrendatario principal con quien vive, que firme la siguiente declaración y la legalice ante un notario antes de proporcionar el documento a WHEDCo. También aceptamos una carta legalizada por un notario de parte del propietario o arrendatario principal de su residencia, en la cual autoriza el uso de su residencia para dicho cuidado.*

Declaración del propietario o arrendatario principal legalizada por un notario:

Yo, _____, el propietario/arrendatario principal de

Nombre del propietario/arrendatario principal

_____

Dirección

autorizo el uso de mi residencia para el cuidado infantil proporcionado por _____

Nombre del proveedor

para _____.

Nombre del niño

Firma del propietario/arrendatario principal: _____

Fecha: _____

Juramentado y suscrito en mi presencia por _____ este ____ día de _____ del año _____

Mi nombramiento vence: _____

Nombre del Notario: _____

Notario Público

Fecha: _____

Date: _____

ACCIS Case Number: _____

Case Name: _____

Last Known CA Case Number: _____

Child Care In Lieu of Cash Assistance (CILOCA)
Recertification Appointment Notice

You must recertify by _____ to continue getting Child Care In Lieu of Cash Assistance (CILOCA). We made an appointment for you to bring documents to show that you are still eligible for Cash Assistance and for CILOCA. See the CILOCA eligibility requirements listed on the back of this form.

If you are a two-parent household, both parents must come in for the interview:

Appointment Date: _____ Time: _____ Telephone: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

This is a required appointment. If you do not keep this appointment, it will affect your eligibility for child care payments. If you have any questions or cannot keep this appointment, please call **(929) 252-5544** before your appointment date. You can also call this number if you have a physical, mental health or learning problem that makes it hard for you to keep this appointment.

Bring in proof of the items below that apply to you:

- Proof that you pay for shelter such as rent or mortgage;
- Proof that you received earned or unearned income in the last 30 days. Proof can be:
  - Paystubs;
  - Letter from employer that has your pay and hours worked or;
  - If self-employed, tax records;
  - If your income changes a lot, you must bring 3 to 6 months of paystubs.

  If you are a two-parent household, proof of income for both parents must be submitted.

  If you have any questions about proof of income, please call **(929) 252-5544**.
- Proof of assets/resources such as motor vehicle registration or title, savings/checking accounts;
- Proof of changes in your living situation such as if anyone moved in or out of your household. If you have a newborn, bring the birth certificate and social security number.

(See page 2)

You must also bring the child care provider form(s) we sent with this letter. You and your child care provider must complete the form(s).

See the list below to find out what forms you must bring.

Type of Child Care:	You must bring:
Informal child care provider (babysitter)	Completed forms **OCFS-LDSS-4699**, **OCFS-LDSS-4699-2**, and **CS-274W**, and a copy of your provider's current photo identification document (ID).
Informal group care includes unlicensed family day care providers or unlicensed group day care providers (includes school aged children).	Completed forms **OCFS-LDSS-4700** and **CS-274W**.
Licensed child care facility	Completed form **CS-274W**.

If you do not bring the documents and child care forms, your CILOCA case may stop.

To be eligible for CILOCA, you must be eligible for Cash Assistance. You must also meet the eligibility standards listed below.

Single-parent households:

- The parent/guardian makes at least the State minimum wage per hour; **OR**
- The parent/guardian works at least 17.5 hours per week in a job that doesn't have to pay the minimum wage.

Two-parent households:

- A two-parent household with both parents making at least the State minimum wage per hour; **OR**
- A two-parent household with both parents working for a combined total of at least 25 hours per week in jobs that don't have to pay the minimum wage; **OR**
- A two-parent household that has one parent working and making at least the State minimum wage and the other parent is working in a job that doesn't have to pay minimum wage. The parent working a job making less than minimum wage must be working a minimum of 7.5 hours per week.

Fecha: _____

Número del Caso de ACCIS: _____

Nombre del Caso: _____

Último Número Conocido del Caso de CA: _____

Aviso de Cita de Recertificación de Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA)

Usted tiene que recertificarse para el_____ para seguir recibiendo Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA). Nosotros le hemos programado a usted una cita para que traiga documentos que demuestren que usted aún es elegible para Asistencia en Efectivo y para CILOCA. Vea los requisitos de elegibilidad de CILOCA listados al dorso de este formulario.

En caso de tratarse de un hogar de dos padres/madres, ambos padres deben asistir a la entrevista.

Fecha de la Cita: _____ Hora: _____ Teléfono: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Esta cita es obligatoria. El no cumplir esta cita afectará su elegibilidad para pagos de cuidado infantil. Si usted tiene cualquier pregunta o si no puede cumplir esta cita, favor de llamar al **(929) 252-5544** antes de la fecha de su cita. Usted también puede llamar a este número si tiene un problema físico, psiquiátrico, o de aprendizaje que le dificulte cumplir esta cita.

Favor de traer consigo comprobantes correspondientes de lo siguiente:

- Prueba de que usted paga albergue, como alquiler o hipoteca;
- Prueba de haber recibido ingreso salarial o no salarial en los últimos 30 días. Dicha prueba puede incluir:
  - talones de paga;
  - carta de parte del empleador que indique salario y horas trabajadas; o
  - si trabaja por cuenta propia, expedientes de impuestos;
  - si su ingreso cambia a menudo, usted debe traer talones de paga de 3 a 6 meses.

  Si usted es parte de un hogar de dos padres/madres, debe presentar prueba de ingreso para ambos padres/madres.

  Si tiene alguna pregunta sobre tal prueba de ingreso, favor de llamar al **(929) 252-5544**.
- Prueba de activos/recursos, como matrícula o título de vehículo, cuenta de ahorros/corriente;
- Prueba de cambios en su situación de vivienda, por ejemplo, si alguien se ha mudado a su hogar o se ha mudado del mismo. Si hay recién nacidos, traiga el/los certificado(s) de nacimiento y el/los número(s) de seguridad social.

(Vea la página 2)

Además, usted debe traer el/los formulario(s) del proveedor de cuidado infantil, que enviamos con esta carta. Usted y su proveedor de cuidado infantil deben llenar el/los formulario(s).

Vea más abajo los formularios que debe traer consigo.

Tipo de Cuidado Infantil:	Usted debe traer:
Proveedor informal de cuidado infantil (niñera)	Formularios **OCFS-LDSS-4699-S**, **OCFS-LDSS-4699-2S**, y **CS-274W-S** llenados, y una copia del documento actual de identificación con foto de su proveedor (ID).
Cuidado informal en grupo incluye a los proveedores de guarderías familiares sin licencia, o a los proveedores de guardería en grupo sin licencia (incluye a los niños de edad escolar)	Formularios **OCFS-LDSS-4700** y **CS-274W-S** llenados.
Local de cuidado infantil con licencia	Formulario **CS-274W-S** llenado.

El no presentar los documentos y formularios de cuidado infantil, su caso de CILOCA se puede discontinuar.

Para ser elegible para CILOCA, usted debe ser elegible para Asistencia en Efectivo. Además, usted debe cumplir las normas de elegibilidad listadas más abajo.

Hogares con Padre/Madre Soltero(a):

- El padre/madre/tutor gana a la hora por lo menos el salario mínimo estatal; **O**
- El padre/madre/tutor trabaja por lo menos 17.5 horas a la semana en un trabajo que no tenga que pagar el salario mínimo.

Hogares con Dos Padres:

- Un hogar con dos padres en que ambos ganen a la hora por lo menos el salario mínimo estatal; **O**
- Un hogar de dos padres quienes trabajen un total combinado de por lo menos 25 horas a la semana en trabajos que no tienen que pagar el salario mínimo; **O**
- Un hogar de dos padres en que un(a) padre/madre trabaje y gane por lo menos el salario mínimo estatal y en que el otro padre esté empleado en un trabajo que no tenga que pagar el salario mínimo. El/la padre/madre quien tengan un trabajo que pague menos del salario mínimo debe trabajar un mínimo de 7.5 horas a la semana.

Date: _____
ACCIS Case Number: _____
Case Name: _____

Notice of Rescheduled Appointment for
Child Care In Lieu of Cash Assistance (CILOCA)

You asked to change your appointment for Child Care in Lieu of Cash Assistance (CILOCA). You must come to the address listed below at the date and time shown.

Appointment Date: _____ Time: _____ Telephone: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

If you are a two-parent household, both parents must be at the interview.

This is a required appointment. If you have any questions or cannot keep this appointment, please call **(929) 252-5544** before your appointment date. You can also call this number if you have a physical, mental health, or learning problem that makes it hard for you to keep this appointment.

Bring in proof of the items below that apply to you:

- Proof that you pay for shelter such as rent or mortgage;
- Proof that you received earned or unearned income in the last 30 days. Proof can be:
  - Paystubs;
  - Letter from employer that has your pay and hours worked or;
  - If self-employed, tax records;
  - If your income changes a lot, you must bring 3 to 6 months of paystubs.

  If you are a two-parent household, proof of income for both parents must be submitted.

  If you have any questions about proof of income, please call **(929) 252-5544**.
- Proof of assets/resources such as motor vehicle registration or title, savings/checking accounts;
- Proof of changes in your living situation such as if anyone moved in or out of your household. If you have a newborn, bring the birth certificate and social security number.

(See page 2)

You must also bring the child care provider form(s) we sent with this letter. You and your child care provider must complete the form(s).

See the list below to find out what forms you must bring.

Type of Child Care:	You must bring:
Informal child care provider (babysitter)	Completed forms **OCFS-LDSS-4699**, **OCFS-LDSS-4699-2**, and **CS-274W**, and a copy of your provider's current photo identification document (ID).
Informal group care includes unlicensed family day care providers or unlicensed group day care providers (includes school aged children).	Completed forms **OCFS-LDSS-4700** and **CS-274W**.
Licensed child care facility	Completed form **CS-274W**.

If you do not bring the documents and child care forms, your CILOCA case may stop.

To be eligible for CILOCA, you must be eligible for Cash Assistance. You must also meet the eligibility standards listed below.

Single-parent households:

- The parent/guardian makes at least the State minimum wage per hour; **OR**
- The parent/guardian works at least 17.5 hours per week in a job that doesn't have to pay the minimum wage.

Two-parent households:

- A two-parent household with both parents making at least the State minimum wage per hour; **OR**
- A two-parent household with both parents working for a combined total of at least 25 hours per week in jobs that don't have to pay the minimum wage; **OR**
- A two-parent household that has one parent working and making at least the State minimum wage and the other parent is working in a job that doesn't have to pay minimum wage. The parent working a job making less than minimum wage must be working a minimum of 7.5 hours per week.

Fecha: _____

Número del Caso de ACCIS: _____

Nombre del Caso: _____

Aviso de Cita Reprogramada
para Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA)

Usted solicitó que se cambiara su cita de Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA). Usted debe presentarse al local listado más abajo en la fecha y hora indicadas.

Fecha de la Cita: _____ Hora: _____ Teléfono: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

En caso de tratarse de un hogar de dos padres/madres, ambos padres deben asistir a la entrevista.

Esta cita es obligatoria. Si usted tiene alguna pregunta o si no puede cumplir la cita, favor de llamar al **(929) 252-5544** antes de la fecha de su cita. Además, puede llamar a este número si tiene cualquier problema físico, psiquiátrico o de aprendizaje que le dificulte cumplir esta cita.

Favor de traer consigo comprobantes de lo que le corresponda de lo siguiente:

- Prueba de que usted paga albergue, como alquiler o hipoteca;
- Prueba de haber recibido ingreso salarial o no salarial en los últimos 30 días. Dicha prueba puede incluir:
  - talones de paga;
  - carta de parte del empleador que indique salario y horas trabajadas; o
  - si trabaja por cuenta propia, expedientes de impuestos;
  - si su ingreso cambia a menudo, usted debe traer talones de paga de 3 a 6 meses.

  Si usted es parte de un hogar de dos padres/madres, debe presentar prueba de ingreso para ambos padres/madres.

  Si tiene alguna pregunta sobre tal prueba de ingreso, favor de llamar al **(929) 252-5544**.
- Prueba de activos/recursos, como matrícula o título de vehículo, cuenta de ahorros/corriente;
- Prueba de cambios en su situación de vivienda, por ejemplo, si alguien se ha mudado a su hogar o se ha mudado del mismo. Si hay recién nacidos, traiga el/los certificado(s) de nacimiento y el/los número(s) de seguridad social.

(Vea la página 2)

Además, usted debe traer el/los formulario(s) del proveedor de cuidado infantil, que enviamos con esta carta. Usted y su proveedor de cuidado infantil deben llenar el/los formulario(s).

Vea más abajo los formularios que debe traer consigo.

Tipo de Cuidado Infantil:	Usted debe traer:
Proveedor informal de cuidado infantil (niñera)	Formularios **OCFS-LDSS-4699-S**, **OCFS-LDSS-4699-2S**, y **CS-274W-S** llenados, y una copia del documento actual de identificación con foto de su proveedor (ID).
Cuidado informal en grupo incluye a los proveedores de guarderías familiares sin licencia, o a los proveedores de guardería en grupo sin licencia (incluye a los niños de edad escolar)	Formularios **OCFS-LDSS-4700** y **CS-274W-S** llenados.
Local de cuidado infantil con licencia	Formulario **CS-274W-S** llenado.

El no presentar los documentos y formularios de cuidado infantil, su caso de CILOCA se puede discontinuar.

Para ser elegible para CILOCA, usted debe ser elegible para Asistencia en Efectivo. Además, usted debe reunir las pautas de elegibilidad listadas más abajo.

Hogares con Padre/Madre Soltero(a):

- El padre/madre/tutor gana a la hora por lo menos el salario mínimo estatal; **O**
- El padre/madre/tutor trabaja por lo menos 17.5 horas a la semana en un trabajo que no tenga que pagar el salario mínimo.

Hogares con Dos Padres:

- Un hogar con dos padres en que ambos ganen a la hora por lo menos el salario mínimo estatal; **O**
- Un hogar de dos padres quienes trabajen un total combinado de por lo menos 25 horas a la semana en trabajos que no tienen que pagar el salario mínimo; **O**
- Un hogar de dos padres en que un(a) padre/madre trabaje y gane por lo menos el salario mínimo estatal y en que el otro padre esté empleado en un trabajo que no tenga que pagar el salario mínimo. El/la padre/madre quien tengan un trabajo que pague menos del salario mínimo debe trabajar un mínimo de 7.5 horas a la semana.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Name: _____

ACCIS Case Number: _____

Applicant/
Registration Number: _____

Child Care in Lieu of Cash Assistance (CILOCA)
Recertification Return Appointment

You must give us the document(s) in the checked boxes below by the appointment date. We need these to complete your Child Care in Lieu of Cash Assistance (CILOCA) recertification.

Appointment Date: _____ Time: _____ Telephone: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

☐ **LDSS-4699** ☐ **LDSS-4700** ☐ **CS-274W**

Name	Eligibility Factor

REMINDER: We must get all of the documents by the above date.

(See Page 2)

You can give us the documents in one of the following ways:

In person on the appointment date.

By fax to: (929) 252-5544

By mail using the return envelope we gave you with this letter to the above address.

By the appointment/due date, you must:

- give us the documents; or
- keep the appointment; or
- call your worker.

If you do not do this, you will not be eligible for CILOCA.

Parent/Guardian Signature _____ Date _____

Worker's Name (Please print) _____ Worker's Telephone Number _____

Do you have a disability or health condition that makes it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? Call us at **212-331-4640** and we can help you. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Nombre del Caso: _____

Número del Caso de ACCIS: _____

Número de Registro/Solicitante: _____

Cita de Vuelta para Recertificación de Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA)

Usted debe presentar la documentación en las casillas marcadas a continuación para la fecha de la cita. Nosotros la necesitamos para llevar a cabo su recertificación de Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA).

Fecha de la Cita: _____ Hora: _____ Teléfono: _____

Dirección: _____

_____

Ciudad: _____ Estado: _____ Código Postal: _____

☐ **LDSS-4699-S** ☐ **LDSS-4700** ☐ **CS-274W-S**

Nombre	Factor de Elegibilidad

RECORDATORIO: Nosotros necesitamos recibir todos los documentos para la fecha antemencionada.

(Vea la página 2.)

Usted puede proporcionarnos los documentos por uno de los siguientes modos:

En persona en la fecha de la cita.

Por fax al: (929) 252-5544

A la dirección más arriba por correo postal en el sobre con franqueo pagado adjunto a esta carta.

Usted debe hacer lo siguiente para la fecha de la cita/fecha de vigencia:

- proporcionarnos los documentos; o
- cumplir la cita; o
- llamar a su trabajador.

De no hacerlo, usted no será elegible para CILOCA.

Firma del/la Padre/Madre/Tutor

Fecha

Nombre del Trabajador (en letra de molde)

Número telefónico del trabajador

¿Padece usted una discapacidad o afección médica que le dificulte entender este avsio o cumplir el mismo? ¿Le dificulta esta afección obtener otros servicios de la HRA? Llámenos al **212-331-4640** y nosotros podremos ayudarle. Usted también puede pedir asistencia al visitar las oficinas de la HRA. Conforme a la ley, usted tiene el derecho de solicitar este tipo de ayuda.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Work Schedule For Child Care

You must complete this form to get child care. This form asks about your employer and the days and hours you work. If the days and hours you work change often, give the days and hours you work the most.

Applicant/Participant's Name:	**Cash Assistance Case Number:**
Employer's Name:	
Employer's Address:	
Work Location if Different from Employer's Address:	

If the work location is in New York City, answer the following question to the best of your knowledge.

The employer has a total of ☐ 11 or more employees ☐ 10 or fewer employees

Weekly Schedule								
Days	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**	
Start Time:								
End Time:								**Total Weekly hours worked:**
Number of hours worked:								

Total Weekly Travel Time: If your travel time changes each day, use your longest travel time and multiply by five (5). For example: Two (2) days a week your travel time is two (2) hours, and three (3) days a week your travel time is one (1) hour, your total travel time should be 5x2 = 10 Hours.

Total Weekly Travel Time: ☐

Work Schedule For Other Adults in Household

Relationship to Child: ☐ Parent ☐ Guardian

Applicant/Participant's Name:	**Cash Assistance Case Number:**
Employer's Name:	
Employer's Address:	
Work Location if Different from Employer's Address:	

If the work location is in New York City, answer the following question to the best of your knowledge.

The employer has a total of ☐ 11 or more employees ☐ 10 or fewer employees

Weekly Schedule								
Days	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**	
Start Time:								
End Time:								**Total Weekly hours worked:**
Number of hours worked:								

Total Weekly Travel Time: If your travel time changes each day, use your longest travel time and multiply by five (5). For example: Two (2) days a week your travel time is two (2) hours, and three (3) days a week your travel time is one (1) hour, your total travel time should be 5x2 = 10 Hours.

Total Weekly Travel Time: ☐

I swear or affirm that the Information on this form is true and correct.

Applicant/
Participant's Signature: _____ **Date:** _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Horario de Trabajo para Cuidado Infantil

Usted debe llenar este formulario para obtener cuidado infantil. El presente le solicita información sobre su empleador, y sobre sus horas de trabajo. En caso de que cambien a menudo los días y horas trabajados, proporcione su horario de trabajo más frecuente.

Nombre del Solicitante/Participante:	**Número del Caso de Asistencia en Efectivo:**
Nombre del Empleador:	
Dirección del Empleador:	
Local de Trabajo si Distinto de la Dirección del Empleador:	

Si el local de trabajo está ubicado en la Ciudad de Nueva York, conteste la siguiente pregunta según su leal saber y entender:

El empleador cuenta con un total de ☐ 11 o más empleados ☐ 10 o menos empleados

Horario Semanal								
Días	**Lun**	**Mar**	**Miér**	**Jue**	**Vier**	**Sáb**	**Dom**	
Hora de Comienzo:								
Hora Final:								**Total de Horas Trabajadas a la Semana:**
Número de Horas Trabajadas:								

Total del tiempo de viaje semanal: Si su tiempo de viaje varía cada día, use su tiempo de viaje más largo y multiplique por cinco (5). Por ejemplo: Dos (2) días a la semana usted viaja dos (2) horas, y tres (3) días a la semana viaja una (1) hora, el total de su tiempo de viaje debe ser 5x2 = 10 horas.

Total del Tiempo de Viaje Semanal ☐

Horario de Trabajo de Otros Adultos del Hogar

Relación con el/la niño(a): ☐ Padre/madre ☐ Tutor

Nombre del Solicitante/Participante:	**Número del Caso de Asistencia en Efectivo:**
Nombre del Empleador:	
Dirección del Empleador:	
Local de Trabajo si Distinto de la Dirección del Empleador:	

Si el local de trabajo está ubicado en la Ciudad de Nueva York, conteste la siguiente pregunta según su leal saber y entender:

El empleador cuenta con un total de ☐ 11 o más empleados ☐ 10 o menos empleados

Horario Semanal								
Días	**Lun**	**Mar**	**Miér**	**Jue**	**Vier**	**Sáb**	**Dom**	
Hora de Comienzo:								
Hora Final:								**Total de Horas Trabajadas a la Semana:**
Número de Horas Trabajadas:								

Total del tiempo de viaje semanal: Si su tiempo de viaje varía cada día, use su tiempo de viaje más largo y multiplique por cinco (5). Por ejemplo: Dos (2) días a la semana usted viaja dos (2) horas, y tres (3) días a la semana viaja una (1) hora, el total de su tiempo de viaje debe ser 5x2 = 10 horas.

Total del Tiempo de Viaje Semanal: ☐

Juro o afirmo que la información en el presente es verídica y exacta.

Firma del Solicitante/Participante:_____ **Fecha:** _____

Employer's Verification

Employee's Name: _____

In order to receive New York City Child Care, your employee listed above must provide this agency with a work schedule verified by his/her employer. Please complete your employee's work schedule in the spaces below. If your employee works a variable schedule, please fill in his/her most commonly worked schedule.

Work Schedule For Child Care

Employer's Name: _____

Employer's Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

Work Location if Different from Employer's Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

If this employee's work location is in New York City, check one of the following:

☐ The employer has a total of 11 or more employees.

☐ The employer has a total of 10 or fewer employees.

Weekly Schedule								
Days	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	
Start Time:								
End Time:								**Total Weekly Hours Worked**
Number of hours worked:								

The above schedule is (please check one):

☐ **Standard** ☐ **Variable**

Employer or Employer Designee's Signature: _____ **Date**: _____

Title: _____ **Phone number**: _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

ACCIS Number: _____

Caseload: _____

Notice of Temporary Child Care Assistance

On _____, you applied for Cash Assistance or Child Care in Lieu of Cash Assistance (CILOCA). We are giving you temporary child care assistance so that you can participate in an Agency-approved work-related activity or keep your employment.

Child care assistance will begin _____ and will continue until a decision is made on your Cash Assistance or CILOCA application.

The child care assistance will continue if your application for Cash Assistance or CILOCA is accepted and as long as you are participating in an Agency-approved work activity or you meet the CILOCA criteria.

If you are not eligible for Cash Assistance or CILOCA, your child care assistance will end on the same date your Cash Assistance or CILOCA application is denied.

Child care is provided as a supportive service to Cash Assistance applicants, in accordance with: 18 NYCRR § 385.4(a).

Child care is provided to CILOCA applicants, in accordance with: 18 NYCRR § 415.2(a)(1)(ii).

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Número de ACCIS: _____
Unidad de Casos: _____

Aviso de Asistencia Temporaria de Cuidado Infantil

El _____, usted ha solicitado Asistencia en Efectivo o Cuidado Infantil en Lugar de Asistencia en Efectivo (CILOCA). A usted le estamos brindando asistencia de cuidado infantil provisional de modo que pueda participar en una actividad de trabajo aprobada por la agencia o conservar su empleo.

La asistencia de cuidado infantil comenzará a partir del _____ y seguirá vigente hasta que se tome una decisión sobre su solicitud de Asistencia en Efectivo o CILOCA.

La asistencia de cuidado infantil continuará si se acepta su solicitud de Asistencia en Efectivo o CILOCA, con tal que usted participe en una actividad de trabajo aprobada por la agencia o que reúna los criterios de CILOCA.

Si usted no es elegible para Asistencia en Efectivo o CILOCA, su asistencia de cuidado infantil se terminará en la misma fecha que se deniegue su solicitud de Asistencia en Efectivo o CILOCA.

El cuidado infantil se brinda a los solicitantes de Asistencia en Efectivo conforme a:
18 NYCRR § 385.4(a).

El cuidado infantil se brinda a los solicitantes de CILOCA conforme a:
18 NYCRR § 415.2(a)(1)(ii).

CA/CILOCA
Eligibility Checklist

NYC Human Resources Administration | Family Independence Administration
Department of Social Services

Center: _____ **Liaison:** _____

Case Profile

Case head Name: _____

2nd Adult Name: _____ Case Number: _____

Address: _____ Application Registration Number: _____

_____ Eligibility Determination Due Date: _____

1) FH Decision Number:	Decision Due Date:
2) FH Decision Number:	Decision Due Date:
3) FH Decision Number:	Decision Due Date:

Application File Date: _____

1st Application/Date: _____

Re-Application/Date: _____

CA Case Status: _____

Has the applicant Re-applied for CA in less than 4 months? ☐ **No** ☐ **Yes**

If Yes, the Applicant is eligible for Earned Income Disregard (EID)

CA/CILOCA Eligibility Requirements ***(Use W-119D Eligibility Factors Guide for Appropriate Documentation)***

For this section: The scan/index date should be entered for each H/H member

Eligibility Factors	H/H Members	Identity	Relationship	Residency	Age	Immigration/ Citizenship Status	SSN	H/H COMP	Marital Status
Casehead									
2nd Adult									
H/H Member									
H/H Member									
H/H Member									
H/H Member									
H/H Member									
H/H Member									

Absent/Death of Parent

H/H Member	Type of Verification Submitted	Type of Potential Benefits from Deceased Parent	Amount	Frequency	Scan/ Index Date

Matches (TALX/RFI)

H/H Member	Match Type	RFI		TALX VERIFICATION						Scan/ Index Date
		Amount of Resource/ Income	Is RFI Resolved?	TALX Hit?	Still Employed?	Amount of Earned Income	Frequency of Earned Income	Frequency of Employment	Is the Income being budgeted?	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Part-Time ☐ Full-Time	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Part-Time ☐ Full-Time	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Part-Time ☐ Full-Time	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Part-Time ☐ Full-Time	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Part-Time ☐ Full-Time	☐ Yes ☐ No	

Earned Income - (CA Eligibility Criteria)

Note: Earned income reported by an applicant must be budgeted in his/her initial CA budget at the time of an eligibility determination. Once the applicant has been deemed financially eligible for Cash Assistance, the applicant will be eligible for the Earned Income Disregard.

Income Exclusions: Certain incomes are excluded and must not be counted as income when calculating the 185% gross income to allow the EID to be applied. The incomes that are excluded are:	**Eligible for EID?**
1) The 1st $100 received for 1 child and the 1st $200 received for 2 or more children in a month which represents support payments timely paid in and for such month and the first $100 received for 1 child and the 1st $200 received for 2 or more children in such month which represents supports payments timely paid in and for which of any prior months, including support payment collected and paid to the Cash Assistance household by the Agency;	
2) All of the **earned income** of a dependent child receiving assistance who is a full-time or part-time student:	
3) All income of a dependent child living with a parent or other caretaker relative, who is receiving assistance or for whom an application for assistance has been made, which income is derived from participation in a program carried out under the Job Training Partnership Act. In the case of earned income, such disregard must be applied for at least, but no longer than 6 months per calendar year for each such child.	

Once these exclusions have been applied and the applicant/participant has passed the Gross Income (185%) Test, the EID must be applied.

H/H Member	Is Verification Current?	Date Employment Began	Type of Current Verification Submitted	Amount of Gross Earned Income.	FREQUENCY			Work Schedule FIA-1100/ 1100A	Scan/ Index Date
					Gross Earned Income (weekly/ monthly, etc)	Number of Hours Worked	Frequency of Hours (weekly/ monthly, etc)		
	☐ Yes ☐ No								
	☐ Yes ☐ No								
	☐ Yes ☐ No								
	☐ Yes ☐ No								
	☐ Yes ☐ No								

Self-Employment

H/H Member	Is Verification Current?	Type of Current Verification Submitted	Amount of Gross Earned Income	Frequency of Earned Income	Deduction of Monthly Business Expenses	Work Schedule FIA-1100/1100A	Scan/ Index Date
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						

Current Income - Potential Benefits (Unearned Income)

H/H Member	Type of Unearned income	Type of Current Verification Submitted	Amount of Unearned Income	Frequency of Unearned Income	Date Income Began	Date Income Ended	Scan/ Index Date

Resources

H/H Member	Type of Unearned income	Type of Current Verification Submitted	Amount of Resources	Are Resources Available?	Scan/ Index Date
NOTE: Staff should assess bank accounts in the names of children and the amounts above the agency resource level. Determine the type of account and if parents have access to the funds.					
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Medical

H/H Member	Type of Illness - Temporary Disability	Type of Current Verification Submitted	Approximate Date of Illness/ Disability Began	Other Information	Scan/ Index Date

Household Shelter Expenses

Expense Type	Type of Verification Submitted	Type of Dwelling: Apt/PH/ ETC.	Primary or Secondary Tenant?	Monthly Expense	$ Amount Excess	Excess Paid to:	Scan/ Index Date
Shelter Expenses							
Shelter Type							

Air Conditioning	Type of Current Verification Submitted		
	Monthly Expense		

Utilities	Type of Current Verification Submitted	Monthly Expense	Scan/ Index Date

Fuel for Heating	Type of Current Verification Submitted		Scan/ Index Date
	Type of Fuel		
	Monthly Expense		

Other Expenses

H/H Member	Type of Current Verification Submitted	Frequency	Amount Paid	Scan/ Index Date

Education/Training (H/H members age 16 - 24)

H/H Member	Type of Current Verification Submitted	Was EP Plan Initiated?	Scan/ Index date	H/H Member	Type of Current Verification Submitted	Was EP Plan Initiated?	Scan/ Index Date
		☐ Yes ☐ No				☐ Yes ☐ No	
		☐ Yes ☐ No				☐ Yes ☐ No	
		☐ Yes ☐ No				☐ Yes ☐ No	
		☐ Yes ☐ No				☐ Yes ☐ No	

Referrals

BEV- Outcome Code:	Recommendation:	Outcome Date:

AFIS

H/H Member	Required?	Result/Code
	☐ Yes ☐ No	

FORMS	H/H Member	Date to Return Docs? (FAD Date)	Were all Requested Docs Submitted Timely?	Is a 2nd Return Appointment Needed?	Action Taken - Did Applicant/Participant Comply?	Scan/ Index Date
W113K			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
W273NN			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

NOTICES	H/H Member	Required?	Appointment Date (FAD) Due	Result/Action Taken	Scan/ Index Date
M3g		☐ Yes ☐ No			

FORMS	Appellant Name(s)	Required?	Appointment Date (FAD) Due	Result/Action Taken	Scan/ Index Date
W-186D		☐ Yes ☐ No			
W-186C		☐ Yes ☐ No			
W-186D FH#		☐ Yes ☐ No			
W-186C FH#		☐ Yes ☐ No			

Other CA Actions	H/H Member	Required?	Result/Code	H/H Member	Required?	Result/ Code	Scan/ Index Date
		☐ Yes ☐ No			☐ Yes ☐ No		
		☐ Yes ☐ No			☐ Yes ☐ No		

Childcare Activity

Parent/Caregiver ACCIS Case Number	Submitting Agency		If ACD, Was Agency Transfer Processed?	Agency Transfer Processed		Type of Childcare Being Requested		
	HRA	ADC		Date Requested	Date Processed	Regulated	Informal	Legally Exempt
			☐ Yes ☐ No					

COMPLETE THIS SECTION FOR INFORMAL AND/OR LEGALLY EXEMPT PROVIDERS REFERRED TO WHEDCO

*** If the Program/Provider slot capacity exceeds 16 and they have a Certificate of Filing or Permit, Programs/Providers must be referred to Whedco. This is primarily for Pre-school and school-aged children.**

Childcare enrolled by - Job Center?	☐ Yes ☐ No	Reason for Enrollment	
Childcare enrolled by - FHTRMU?	☐ Yes ☐ No	Reason for Enrollment	

	1	2	3	4	5	6
H/H Member Name of Child						
Number of Available Slots						
(ACCIS) Program/ Provider License Expiration Date						
CS 274 W - Include Date Care Began?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
CS 274 W - Include Provider & Parent Signatures/Dates?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
CS 274 W - Lists the Applicable Provider Rates?						
LDSS 4699 Completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
LDSS 4699.2 Completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
CS 574FF & Documentation Submitted?						
LDSS 4700 Completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Results (Enter WhedCo Code)						
Scan/Index Date						

Tax Identification Number (TIN) Confirmation - FOR INFORMAL PROVIDERS ONLY

H/H Member Name of Child	Program/Provider Number	TIN Validation Code	Scan/Index Date

LDSS-2921

PAPER APPLICATION - LDSS 2921					POS APPLICATION - LDSS 2921	
Number of Persons in H/H and on the Paper Application	Are All H/H Members Listed in POS as Listed on Paper LDSS 2921?	Does the Paper Application Exceed 8 H/H Members?	Signature(s) Captured for All H/H Members on Pages 1, 4, and 16?	Scan/Index Date	POS APPLICATION SIGNATURE Capture for all adult H/H Members on Pages 1, 3 & 11?	Index Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

Other Actions/Forms Activity	Yes	No	N/A	Completed Correctly?	Comments	Scan/Index Date
POS - All questions in the case activity answered?	☐ Yes	☐ No		☐ Yes ☐ No		
EXP-76R Documentation Receipt	☐ Yes	☐ No		☐ Yes ☐ No		
M 528N - Request for Child Care Assistance or Request to Close My Cash Assistance (CA) Case	☐ Yes	☐ No		☐ Yes ☐ No		
W-680FF - Language Questionnaire	☐ Yes	☐ No		☐ Yes ☐ No		
W-532 - Letter to Past/Present Employer	☐ Yes	☐ No		☐ Yes ☐ No		
LDSS 4013A NYC - Action Taken On Your Application PA/SNAP/MA	☐ Yes	☐ No		☐ Yes ☐ No		
Other:	☐ Yes	☐ No		☐ Yes ☐ No		
Other:	☐ Yes	☐ No		☐ Yes ☐ No		

Entering Hours of Paid Employment into ABEL: Earned income is entered into ABEL based on the frequency of pay. The Income Frequency Codes are "B" for Biweekly, "M" for Monthly, "S" for Semi-monthly and "W" for Weekly.

When budgeting earned income, the number of hours worked must be entered in the "HW" field. The average hours of paid employment entered into ABEL must always be monthly. To calculate the monthly hours worked when the hours are reported in a weekly frequency the worker must take the weekly hours and multiply by 4 and 1/3 weeks (4.333).

NOTE: Staff should *not* use WMS case status code Y99 when a case has been determined ineligible for CILOCA for CA reasons. Use a WMS case status code related to eligibility reason of denial.

Corrective Action:	**Due Date:**

Review completed with No Errors, Date E-mailed to FIA Child Care Review Team:

To be completed by CCRT Only:

CILOCA Income Criteria:

Which Income Criteria Applies			
Single Parent H/H?	Employed or Self-Employed	☐ Yes ☐ No	Parent/guardian is employed or self-employed earning at least the State Minimum wage; **or**
	Employed in Job Exempt from Minimum Wage rules	☐ Yes ☐ No	The parent is employed at least 17.5 hours per week in a job exempt from minimum wage rules that is paying less than minimum wage.
2 Parent H/H?	Employed or Self-Employed	☐ Yes ☐ No	2-Parent household in which both parents are employed or self-employed earning at least the State Minimum wage; **or**
	Employed in Job Exempt from Min. Wage rules	☐ Yes ☐ No	2-Parent household in which both parents are employed for a combined total of at least 25 hours per week in jobs exempt from minimum wage rules that pay less than minimum wage; **or**
	1 Parent- Employed or Self Employed 1 Parent - Employed in Job Exempt from Minimum Wage rules	☐ Yes ☐ No	2-Parent household in which one parent is employed or self-employed who is earning at least the State Minimum wage and the other parent is employed in a job exempt from minimum wage rules that is paying less than minimum wage. The parent earning at least minimum wage or who is self-employed must earn at least minimum wage and the parent working in a job earning less than minimum wage must be working a minimum of 7.5 hours per week.

Other Employment Information

H/H Member	Place of Employment	If Place of Employment is NYC, Number of Employees

To determine the minimum wage requirement for CILOCA: If the employers verification has monthly Gross earnings and weekly hours the example to calculate the minimum wage is as follows: Employee gross earnings = 800/month and works 30 hours weekly. Calculate 30 x 4.333 = 130 hours. Then divide 800/130 = 6.15, which is the hourly wage; which is below the State minimum wage requirement. In this instance the household is eligible for CA, and ineligible for CILOCA.

Budget	Preliminary Saved Budget Number	Is H/H Eligible for EID?	Number of Monthly Hours budgeted	Number of Hours Calculated Correctly?	Was Minimum Wage Requirement Met?	Hourly Wage?	Budget Calculations/ Results (Deficit or Surplus)	WMS Denial code applied to this determination	Scan/Index Date
Parent 1		☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No				
Parent 2		☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No				
Other Adult		☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No				

Corrective Action:	Due Date:

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Child Care Guarantee Informational

This is to notify you that there has been a change in law that allows more **working** families to receive a guarantee of child care. You may decide that, instead of receiving Cash Assistance (CA), what you really need is help paying for child care. **Families who are applying for and are found eligible for, or are receiving, CA and need child care in order to work,** may be eligible for a child care guarantee for working families. A child care guarantee means that if you meet the eligibility requirements, the social services district must pay an eligible child care provider for your child care. **This guarantee applies only to the hours you are working and a reasonable amount of time for you to get to and from work to your child care provider.**

Who is eligible?

You are eligible for this guarantee if you are applying for and found eligible for CA and choose child care instead of CA, or if you are receiving CA and ask that your CA case be closed, and:

- You are earning at least minimum wage or are employed in a job where minimum wage is made by the combination of gross earnings and tips, or you are self-employed; **AND**
- Your gross earnings are equal to or greater than the amounts listed below; **OR**
- If you are employed in a job exempt from minimum wage rules and you are earning less than minimum wage, you work the minimum number of hours listed below.

What if I am earning at least minimum wage, am I eligible?

Because minimum wage in New York State is different depending on your work location and the number of employees that your employer has, below are two tables with income standards that must be met to be eligible for CILOCA. One is for a single parent household and the other for a two-parent household.

Single Parent

Place of Employment	Minimum Wage	Weekly Amount	Monthly Amount
NYC Employer with 11or more employees	$11.00	$192.50	$834.00
NYC Employer with 10 or less employees	$10.50	$184.00	$797.00
Long Island & Westchester	$10.00	$175.00	$758.00
Greater New York State	$9.70	$170.00	$737.00

Two-Parent

Place of Employment	Minimum Wage	Weekly Amount	Monthly Amount
NYC Employer with 11or more employees	$11.00	$275.00	$1192.00
NYC Employer with 10 or less employees	$10.50	$262.50	$1137.50
Long Island & Westchester	$10.00	$250.00	$1083.00
Greater New York State	$9.70	$242.50	$1051.00

What if I am self-employed?

The same income standards as regular employment apply. See tables above.

What if my earned income falls below any of the above amounts?

If your gross earnings fall below the above amounts, you will no longer be eligible for this guarantee. If this happens, you may want to ask your Worker if you are eligible for child care under another program.

What if my job doesn't pay minimum wage?

If you are a single parent whose employer is not required to pay minimum wage and you are earning less than $9.00 per hour, you must be working at least 17.5 hours per week. If you are a two-parent household with both parents working, you must have a combined total of at least 25 hours per week.

What if we are a two-parent household where one of us earns below minimum wage and the other earns at least minimum wage or is self employed?

A two-parent household where one parent earns at least minimum wage or is self-employed and the other parent is employed in a job exempt from minimum wage rules that pays less than minimum wage is eligible for the child care guarantee if:

- the parent earning at least minimum wage or who is self-employed earns an amount equal to the amounts on the single parent table; and
- the parent earning less than minimum wage is working a minimum of 7.5 hours per week.

What if my work hours drop below these amounts?

If you are earning less than minimum wage and your hours drop below the above number, you will not be eligible for the guarantee.

What if my income or hours of work change all of the time?

If your hours of work or earnings are constantly changing, we will look at an average number of hours and amount of income that occurs over a period of three to six months. As long as the average number of hours or amount of income meets the minimum described above, you will still be eligible.

What happens if my income rises above the CA income limit and I become ineligible for CA?

Once your family income is at or above the amount that would allow you to remain eligible for CA but is at or below 200% of the State Income Standards, you may be eligible for transitional child care.

What if I am working and going to school?

The guarantee applies only to the hours that you are working and a reasonable amount of time for you to get to and from work from your child care provider. You also may be eligible for child care for the hours that you are in school. If you need child care in order to go to school, you should discuss this with your Worker.

Are all of my children eligible for the child care guarantee?

Any child under the age of 13 is covered by the guarantee. If you have older children with special needs who need child care, they may be eligible under a different child care program. You should let your Worker know about any of your children who have special needs.

How will receipt of the child care guarantee affect my child support money?

If you are eligible for the child care guarantee and receive court ordered child support, you will be able to keep all of your child support money.

Does my eligibility for this child care guarantee have a time limit like the 60-month time limit for CA?

No, your child care benefits under this guarantee are not limited to 60 months. You can continue to receive child care benefits for as long as you are eligible.

Why don't I have a child care guarantee while I am on CA?

Actually, you do. CA participants who are participating as required in work activities also have a child care guarantee as long as they meet certain requirements. However, the child care in lieu of CA guarantee discussed in this letter allows you to receive the same guarantee of child care without having to remain on CA.

If I decide all I really need is child care, how do I apply for the child care guarantee?

If you are eligible for CA and decide that all you really need is child care, your Worker can tell you how to apply for the child care guarantee. If you are already receiving CA and are otherwise eligible for the program, you will need to close your CA case in order to get this guarantee.

Will all of my child care be paid?

If you choose to receive child care assistance instead of receiving CA and child care, you will have to pay part of your child care costs, in the amount of $15 per week for full time care or $12 per week for part time care. This is called your family share. Additionally, if your provider charges above the market rate, you will need to pay the amount that your provider charges above the market rate.

Who can care for my child?

You can choose any eligible child care provider. This may be a licensed or registered day care center, family or group family day care home, or school-age child care program. You can also choose a relative, neighbor, or friend. If you want a relative, neighbor, or friend to care for your child, he or she will need to meet certain eligibility requirements and enroll with a legally-exempt caregiver enrollment agency. Ask your Worker for the enrollment forms.

What if I change my mind and decide that I need CA as well as child care?

You can still apply for CA at any time. If you are found eligible for CA, you may still be eligible for child care.

What about other benefits like Supplemental Nutrition Assistance Program (SNAP) Benefits and Medical Assistance?

Your SNAP eligibility will not be affected if you request child care instead of CA.

If you are applying for Medical Assistance and you choose to receive child care instead of CA, your application will be referred to the Medicaid program for a separate determination. If you are currently receiving Medicaid and request that your CA case be closed, your Medicaid will continue unchanged until Medicaid can complete a separate determination.

What if I have any questions about this letter?

You can contact your Worker.

Información Sobre Garantía de Cuidado Infantil

Por el presente le informamos que ha habido un cambio en la ley que permite a más familias **que trabajan** recibir una garantía de cuidado infantil. Usted puede decidir que en lugar de Asistencia en Efectivo (CA), lo que realmente necesita es ayuda para pagar el cuidado infantil. **Las familias que estén solicitando y a las que se les determine elegibles para CA, o que reciban la misma, y que necesiten cuidado infantil para poder trabajar**, pueden ser elegibles para una garantía de cuidado infantil para las familias que trabajan. La garantía de cuidado infantil significa que si usted reúne los requisitos de elegibilidad, el distrito de servicios sociales tendrá que pagar los servicios de un proveedor elegible de cuidado infantil para su cuidado infantil. **Esta garantía sólo cubre las horas en que usted esté trabajando y un tiempo razonable para ir al trabajo y volver al local del proveedor de cuidado infantil.**

¿Quién es elegible?

Usted es elegible para esta garantía si está solicitando y se le determina elegible para CA y elige cuidado infantil en lugar de CA, o si recibe CA y solicita el cierre de su caso de CA, y si:

- usted gana por lo menos el salario mínimo o está empleado(a) en un trabajo en el cual gane el salario mínimo compuesto de la combinación del ingreso bruto más las propinas, o usted trabaja por cuenta propia; **Y**
- su ingreso bruto equivale a o es superior a las cantidades indicadas más abajo; **O**
- si usted está empleado(a) en un trabajo exento de las reglas del salario mínimo y gana menos del salario mínimo, usted trabaja la cantidad mínima de horas indicadas más abajo.

¿Qué tal si gano por lo menos el salario mínimo, aún soy elegible?

Puesto que el salario mínimo en el Estado de Nueva York depende de la ubicación de su trabajo y el número de empleados con que tiene su empleador, vea en la próxima página dos tablas con las normas de ingreso que se deben cumplir para ser elegible para CILOCA. La primera tabla es para los hogares de un solo(a) padre/madre, y la segunda para los hogares de dos padres/madres.

Un Solo(a) Padre/Madre

Ubicación del Empleo	Salario Mínimo	Cantidad Semanal	Cantidad Mensual
Empleador de NYC con 11 o más empleados	$11.00	$192.50	$834.00
Empleador de NYC con 10 o menos empleados	$10.50	$184.00	$797.00
Long Island y Westchester	$10.00	$175.00	$758.00
Estado de Nueva York	$9.70	$170.00	$737.00

Dos Padres/Madres

Ubicación del Empleo	Salario Mínimo	Cantidad Semanal	Cantidad Mensual
Empleador de NYC con 11 o más empleados	$11.00	$275.50	$1192.00
Empleador de NYC con 10 o menos empleados	$10.50	$262.50	$1137.50
Long Island & Westchester	$10.00	$250.00	$1083.00
Estado de Nueva York	$9.70	$242.50	$1051.00

¿Qué tal si trabajo por cuenta propia?

Rigen las mismas normas que en el caso de empleo normal. Vea las tablas más arriba.

¿Qué tal si mi ingreso salarial se reduce y resulta inferior a las cantidades indicadas arriba?

Si su ingreso bruto es inferior a las cantidades indicadas arriba, usted ya no será elegible para esta garantía. En tal caso, puede consultar con su trabajador para averiguar si usted es elegible para cuidado infantil de otro programa.

¿Qué tal si mi empleo no paga el salario mínimo?

Si usted es un(a) padre/madre soltero(a) cuyo empleador no está obligado a pagar el salario mínimo, y usted gana menos de $9.00 a la hora, debe estar trabajando por lo menos 17.5 horas semanales. Si usted forma parte de un hogar de dos padres que trabajan, debe tener un total combinado de por lo menos 25 horas semanales.

¿Qué tal si somos un hogar con los dos padres, donde uno de los padres gane menos del salario mínimo y el otro gane por lo menos el salario mínimo o trabaje por cuenta propia?

Un hogar con los dos padres, donde uno de ellos gane por lo menos el salario mínimo o trabaje por cuenta propia y el otro esté empleado en un trabajo exento de las reglas del salario mínimo y gane menos del salario mínimo, es elegible para la garantía de cuidado infantil si:

- el padre/madre que gana por lo menos el salario mínimo o trabaja por cuenta propia gane una cantidad igual a las cantidades en la tabla para los padres/madres solteros(as); y
- el padre/madre que gana menos del salario mínimo esté trabajando por lo menos 7.5 horas a la semana.

¿Qué tal si mis horas laborables se reduce a menos de las horas indicadas?

Si usted gana menos del salario mínimo y sus horas laborables se reducen a menos de las horas indicadas, usted no será elegible para esta garantía.

¿Qué tal si mis ingresos u horas de trabajo cambian a menudo?

Si su horario de trabajo o sus ingresos cambian a menudo, tendremos en cuenta el promedio de horas y cantidad de ingreso de un período de tres a seis meses. Mientras el promedio de horas o cantidad de ingreso cumpla las cantidades mínimas señaladas más arriba, usted aún será elegible.

¿Qué tal si mis ingresos aumentan en exceso del límite de ingresos de CA y llego a ser inelegible para CA?

Una vez que los ingresos familiares igualen o superen la cantidad que le permitiría permanecer elegible para Asistencia en Efectivo, pero equivalgan o sean inferiores al 200% de las Normas Estatales de Ingresos, usted puede ser elegible para beneficios de cuidado infantil transitorio.

¿Qué tal si trabajo y estudio?

Esta garantía sólo cubre las horas en las que usted está trabajando y un tiempo razonable que le permita ir al trabajo desde el local del proveedor de cuidado infantil y del trabajo de vuelta al local del proveedor. Además usted puede ser elegible para cuidado infantil durante las horas que usted asista a la escuela. Si necesita cuidado infantil para asistir a la escuela, debe tratar del tema con su trabajador.

¿Son elegibles todos mis hijos para la garantía de cuidado infantil?

La garantía cubre a todos los niños menores de 13 años de edad. Si usted tiene hijos mayores de 13 años de edad con necesidades especiales que necesiten cuidado infantil, pueden ser elegibles para un programa distinto de cuidado infantil. Usted debe informarle a su trabajador sobre cualquiera de sus niños que tengan necesidades especiales.

¿Cómo se verá afectado mi dinero de manutención de niños debido al recibo de la garantía de cuidado infantil?

Si usted es elegible para la garantía de cuidado infantil y recibe manutención de niños por orden judicial, puede retener todo su dinero de la manutención de niños.

¿Tiene límite de tiempo mi elegibilidad para esta garantía de cuidado infantil como el límite de 60 meses de CA?

No, sus beneficios de cuidado infantil bajo esta garantía no se limitan a 60 meses. Usted puede seguir recibiendo los beneficios de cuidado infantil siempre y cuando sea elegible.

¿Por qué no tengo una garantía de cuidado infantil mientras reciba CA?

En realidad, sí la tiene. Los participantes de CA que participen como debido en actividades laborales también tienen una garantía de cuidado infantil siempre que cumplan ciertos requisitos. Sin embargo, la garantía de cuidado infantil en lugar de CA tratada en esta carta le permite recibir la misma garantía de cuidado infantil sin tener que seguir recibiendo CA.

Si decido que lo único que realmente necesito es cuidado infantil, ¿cómo solicito la garantía de cuidado infantil?

Si usted es elegible para recibir Asistencia en Efectivo y decide que lo único que necesite es cuidado infantil, su trabajador le puede informar cómo solicitar la garantía de cuidado infantil. Si usted ya está recibiendo Asistencia en Efectivo y es por lo demás elegible para el programa, usted tendrá que cerrar su caso de CA para obtener esta garantía.

¿Se pagará todo mi cuidado infantil?

Si usted opta por recibir asistencia de cuidado infantil en lugar de CA y cuidado infantil, tendrá que pagar parte de los costos de cuidado infantil, en la cantidad de $15 semanales para cuidado a tiempo completo o $12 semanales para cuidado a tiempo parcial. Esto se denomina su porción familiar. Además, si su proveedor cobra en exceso de la tarifa del mercado, usted tendrá que pagar la cantidad que su proveedor cobre en exceso de la tarifa del mercado.

¿Quién puede cuidar a mi hijo(a)?

Usted puede a elegir cualquier proveedor elegible de cuidado infantil. Puede ser un centro de guardería registrado o con licencia, hogar individual o de grupo para cuidado infantil o programa de guardería escolar con licencia. También puede elegir a un familiar, vecino o amigo. Si usted opta por un familiar, vecino o amigo para que cuide a su hijo(a), dicha persona tendrá que reunir ciertos requisitos de elegibilidad e inscribirse en una agencia de proveedores legalmente exentos. Pídale a su Trabajador los formularios de inscripción.

¿Qué tal si cambio de parecer y decido que además de cuidado infantil necesito CA?

En tal caso, aún puede solicitar CA en cualquier momento. Si se determina que usted es elegible para CA, aún puede ser elegible para cuidado infantil.

¿Qué tal de los otros beneficios, como del Programa de Asistencia de Nutrición Suplementaria (SNAP) y Asistencia Médica?

Su elegibilidad para SNAP no se verá afectada si usted solicita cuidado infantil en lugar de CA.

Si usted solicita Asistencia Médica y opta por recibir cuidado infantil en lugar de CA, su solicitud se trasladará al programa de Medicaid para una determinación por separado. Si usted actualmente está recibiendo Medicaid y solicita que se cierre su caso de Asistencia en Efectivo, sus beneficios de Medicaid continuarán sin cambios hasta que Medicaid pueda llevar a cabo una determinación por separado.

¿Qué tal si tengo alguna pregunta sobre esta carta?

Puede comunicarse con su trabajador.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Request for Child Care Assistance or Request to Close My Cash Assistance (CA) Case

I am requesting that the Human Resources Administration (HRA) determine if I am eligible for a child care subsidy guarantee "in lieu of CA." I understand that I may be eligible for the "in lieu of CA" child care guarantee for the following reasons:

- I work the number of hours or earn the minimum income required of me;
- My family's income and resources are within CA limits;
- I need child care for a child or children under age 13; and
- I am using an eligible child care provider.

If I am found eligible for and choose the "in lieu of CA" child care guarantee, I also understand that:

- I may use a licensed or registered child care provider. If I want to use a friend, relative, or neighbor to provide child care instead of a licensed or registered child care provider, that provider must meet certain eligibility requirements and be enrolled by the Informal child care provider Enrollment Agency.
- My child care provider determines how much he/she will charge.
- I will be required to pay some of my child care costs. This amount will be $15 per week for full time care or $12 per week for part time care. If my provider charges more than the market rate, I understand that I will have to pay the amount above the market rate plus my family's share. If I hire a child care provider to come to my home, I understand that, as that person's employer, I must pay him/her minimum wage and provide benefits.
- I must immediately report any changes that might affect my eligibility for child care to my Worker. This includes any changes regarding where I am living, who is living in my household, my work schedule, my employer, my child care needs, my child care provider, and my income and resources.

- By withdrawing my request for CA, or asking that my CA case be closed, I will not receive CA at this time. However, if I change my mind, I may apply for CA in the future.
- The 60-month time limit for CA does not apply to this child care guarantee.
- I may be eligible for 12 months of transitional child care services when my income or resources are no longer within CA limits.
- Withdrawing my request for CA, or asking that my CA case be closed, will not affect my application for or eligibility for Supplemental Nutrition Assistance Program (SNAP) benefits or Medicaid.
- If I have any questions about my eligibility for this child care guarantee, I can call:

Worker's Name _____ Telephone Number _____

If I am found eligible for the "in lieu of CA" child care guarantee, I am requesting the following:

Applicant

☐ I want to apply for child care assistance only, instead of applying for CA, under which child care assistance may also be paid. I understand that if I change my mind in the future, I can still apply for CA at that time. If I also applied for Medicaid and SNAP benefits, a separate determination will be made.

Participant

☐ I request that my CA case be closed **because I want child care instead of CA**. A separate Medicaid determination and a separate SNAP determination will be made.

Applicant's/Participant's Signature _____ Date _____

Withdrawal from the child care subsidy guarantee "in lieu of CA"

☐ I have changed my mind and do **not** want child care instead of CA.

Applicant's/Participant's Signature _____ Date _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Petición de Asistencia de Cuidado Infantil o Petición del Cierre de Mi Caso de Asistencia en Efectivo

Por la presente solicito que la Administración de Recursos Humanos (Human Resources Administration – HRA) determine si soy elegible para la garantía de subsidio de cuidado infantil "en vez de Asistencia en Efectivo". Entiendo que podría ser elegible para la garantía de subsidio "en vez de Asistencia en Efectivo" para el cuidado infantil por las siguientes razones:

- Trabajo el número de horas o gano el ingreso mínimo que se me exige;
- Los ingresos y bienes de mi familia caen dentro de los límites de Asistencia en Efectivo;
- Necesito cuidado infantil para un niño o niños menores de 13 años; y
- Estoy utilizando un proveedor de cuidado infantil elegible

Además si se determina que soy elegible y elijo la garantía de cuidado infantil "en vez de Asistencia en Efectivo", entiendo que:

- Puedo hacer uso de un proveedor de cuidado infantil autorizado o registrado. Si deseo asignar a un amigo, pariente o vecino como proveedor de cuidado infantil en lugar de un proveedor de cuidado infantil autorizado o registrado, dicho proveedor debe reunir ciertos requisitos de elegibilidad y estar inscrito por la Agencia de Inscripción del proveedor informal de cuidado infantil.
- Mi proveedor de cuidado infantil determinará su tarifa de cobro.
- Yo tendré que pagar una parte del pago del cuidado de mis niños. Esta cantidad será de $15 semanales por cuidado de tiempo completo o $12 semanales por cuidado de tiempo parcial. Si mi proveedor cobra por encima de la tarifa del mercado, entiendo que tendré que proveer toda cantidad que exceda a la tarifa del mercado además de mi cuota familiar. Si contrato a un proveedor de cuidado infantil en mi hogar, entiendo que como empleador de dicha persona, debo pagarle el sueldo mínimo y suministrar beneficios.
- Debo informar de inmediato a mi Trabajador sobre cualquier cambio que pueda afectar mi derecho al cuidado infantil. Esto incluye cualquier cambio en mi situación de vivienda, las personas que vivan conmigo, mi horario de trabajo, mi empleador, mi proveedor de cuidado infantil y cambios en mis ingresos y bienes.

- No recibiré Asistencia en Efectivo en este momento si retiro mi solicitud de dicha asistencia, o si solicito que se cierre mi caso. Sin embargo, si cambio de parecer, posteriormente tendré el derecho de solicita Asistencia en Efectivo.
- El plazo de 60 meses de Asistencia en Efectivo no corresponde a esta garantía de cuidado infantil.
- Si mi ingreso o recursos exceden el límite establecido para la Asistencia en Efectivo, puede que tenga derecho a 12 meses de servicios de transición de cuidado infantil.
- En caso de cualquier pregunta sobre mi elegibilidad respecto a esta garantía de cuidado infantil, puedo llamar a:

Nombre del Trabajador

Número de Teléfono

Si se determina que tengo derecho a la garantía de cuidado infantil "en vez de Asistencia en Efectivo", solicito lo siguiente:

Solicitante

☐ Deseo solicitar sólo asistencia de cuidado infantil en lugar de solicitar Asistencia en Efectivo, conforme a la cual se puede pagar además la asistencia de cuidado infantil. Entiendo que si posteriormente cambio de parecer, aún podré solicitar Asistencia en Efectivo en ese momento. Si también solicito para Medicaid y beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP), se llegará a una determinación por separado.

Participante

☐ Solicito que mi caso de Asistencia en Efectivo se cierre **ya que prefiero cuidado infantil en vez de Asistencia en Efectivo**. La decisión respecto al Medicaid se tomará independientemente de la decisión respecto a los beneficios de SNAP.

Firma del Solicitante/Participante

Fecha

Retiro de garantía de asignación de cuidado infantil "en lugar de Asistencia en Efectivo"

☐ He cambiado de parecer, **no** deseo cuidado infantil en vez de Asistencia en Efectivo.

Firma del Solicitante/Participante

Fecha

NYC Human Resources Administration | Family Independence Administration
Department of Social Services

Childcare in Lieu of Cash Assistance (CILOCA) Discussion Guide

The goal of CILOCA is to assist families in becoming financially independent. It is very important for the Worker to present the option of CILOCA completely and clearly, and to ask the appropriate questions in order to help each applicant/participant determine if CILCOA is the best option for their family at that time. The following is a discussion guide, not a script. Tailor each discussion to the individual's circumstances.

Once you have established that an applicant/participant is employed: "I see that you are employed, and that you have children in your household under the age of 13. Did you know that you may be eligible for childcare assistance instead of Cash Assistance (CA)? You may decide that instead of receiving CA, what you really need is help paying for childcare. If you meet the eligibility requirements of the CILOCA program (CILOCA is Childcare in Lieu of Cash Assistance), HRA must pay an eligible childcare provider for your childcare."

"Of course, if you are working and need childcare while on CA, HRA will also pay for your childcare. However, while in receipt of CA, you are using up your 60-month lifetime limit of CA. What is great about CILOCA is that it **does not count** against your time limit. Therefore, you can save your months of eligibility for CA for a time when you are in greater need of financial help. If, at any time while in receipt of CILOCA, you decide that you need or want CA, you can always apply for it. Also, choosing CILOCA has no effect on your Supplemental Nutrition Assistance Program (SNAP) or Medicaid eligibility. If you ever become financially ineligible for CILOCA, you will be evaluated for an additional year of Transitional Childcare benefits."

"Another benefit of choosing CILOCA instead of CA is that you do not have to make up the difference between the hours you already work and the hours of work activity required to receive CA. For example, to qualify for CA, you must work and/or be engaged in a work activity for 35 hours per week. If you are working 30 hours per week, to qualify for CA, you would have to participate in a work-related activity for an additional five hours per week. But, if you choose CILOCA, you would not be required to be engaged those additional hours to qualify.

"Lastly, if you receive child support payments while in receipt of CA, HRA keeps most of your child support money as reimbursement for assistance paid to you. You will only receive up to $100 per month or up to a maximum of $200 of the support money paid to you if you have 2 or more children. With CILOCA, you will receive all of your child support money."

(See page 2)

"So, if all you really need is childcare assistance and you choose not to receive CA, let me know at any time."

"Would you be interested in learning more about CILOCA and seeing if you qualify for it?"
If the applicant/participant answers, "Yes," then continue as follows. Otherwise, finish with client contact as appropriate.

"How many hours per week are you working?"

Only continue the discussion if the individual qualifies for CILOCA by working in a job that is exempt from minimum wage rules and that pays less than minimum wage, and he/she works a minimum of:

- 17.5 hours per week for single-parent households;
- 25 combined hours per week for two-parent households with both parents working; **OR**

Because minimum wage in New York State is different depending on the work location and the number of employees that the employer has, there are two different scripts below with corresponding table. One is for a single parent household and the other for a two-parent household. Use the script that corresponds to the household.

Single Parent Household

"Is your place of employment in NYC, Long Island, Westchester or another area of NY State?"

If the individual states that the work place is in NYC (Brooklyn, Queens, Bronx, Staten Island or Manhattan), ask the following question:

"Does your employer have 11 or more employees?"

Based on the place of employment and number of employees, if working in NYC, that the individual told you, use the table below and tell the individual what the minimum income requirement is to be eligible for CILOCA.

Place of Employment	Minimum Wage	Weekly Amount	Monthly Amount
NYC Employer with 11 or more employees	$11.00	$192.50	$834.00
NYC Employer with 10 or less employees	$10.50	$184.00	$797.00
Long Island & Westchester	$10.00	$175.00	$758.00
Greater New York State	$9.70	$170.00	$737.00

(See page 3)

Two-Parent Household

"Is your place of employment in NYC, Long Island, Westchester or another area of NY State?"

If the individual states that the work place is in NYC (Brooklyn, Queens, Bronx, Staten Island or Manhattan), ask the following question:

"Does your employer have 11 or more employees?"

Based on the place of employment and number of employees, if working in NYC, that the individual told you, use the table below and tell the individual what the minimum income requirement is to be eligible for CILOCA.

Place of Employment	Minimum Wage	Weekly Amount	Monthly Amount
NYC Employer with 11 or more employees	$11.00	$275.00	$1,192.00
NYC Employer with 10 or less employees	$10.50	$262.50	$1,137.50
Long Island & Westchester	$10.00	$250.00	$1,083.00
Greater New York State	$9.70	$242.50	$1,051.00

If one parent makes at least minimum wage or is self-employed and the other parent is employed in a job that is exempt from minimum wage rules and pays less than minimum wage, the eligibility criteria for CILOCA would be as follows:

- The parent earning at least minimum wage or who is self-employed must meet the income requirements on the Single Parent table; and
- The parent earning less than minimum wage must be working a minimum of 7.5 hours per week.

If the individual is already receiving CA (in the case of a participant), inform him/her that their CA case must be closed in order to receive CILCOA but their SNAP and Medicaid will not be affected.

*From here, continue with the rest of the eligibility verification, budgeting, and childcare processes as outlined in the CILOCA procedure (***PD-#16-04-ELI***). Once eligibility has been verified, reinforce that he/she may change his/her mind and reapply for CA at any time. Refer to* **PD-#16-04-ELI** *to answer any questions the individual may have.*

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____
Center Number: _____
SNAP Filing Date: _____
Subject: _____

Documentation Requirements and/or Assessment Follow-Up

NOTE: As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

In order to determine your current or continued eligibility for Cash Assistance (CA), Supplemental Nutrition Assistance Program (SNAP), Medical Assistance (MA), or to process your request for an allowance or special status you must provide the documents indicated below, together with this form, by the due date. If you cannot get the required documents/information by the due date, contact your Worker and ask for an extension. If you cannot get the required documents/information at all, contact your Worker immediately, as he/she may assist you in obtaining the required documents/information. The **W-119D**, which lists the common documents that may be used to verify any eligibility factors listed on **page 2**, is attached.

Due Date: _____ ☐ Must see Worker upon return.

Forms Reminder *(Please return the following Agency form(s), completed and signed where necessary.)*

☐ **LDSS-2474** SSI Referral and Certification of Contact	☐ **W-274U** Attestation of Employment as an Informal Child Care Provider
☐ **M-15** Inquiry Regarding Veteran's Benefits/Allotment	☐ **W-299** Notice to Applicants and Participants Regarding Third Party Health Insurance
☐ **W-146E** Request to Pay Rent Arrears in Excess of PA Maximum Shelter Allowance	☐ **W-451** NYPD – New York Police Department Report/Referral
☐ **W-146W** Verification of Tenant's Rent in Section 8 Housing	☐ **W-582A** Family Care Assessment
☐ **W-147CC** Certification of Move Statement	☐ **W-700E** School Attendance Verification Letter
☐ **W-147M** Landlord's Statement (Regarding Broker's Fee)	
☐ **W-147Q** Primary Tenant's Statement Regarding Occupancy of Secondary Tenant	

CA Appointment Reminder

☐ BEV – Bureau of Eligibility Verification Appointment	☐ CASAC – Credentialed Alcoholism/and Substance Abuse Counselor Appointment
☐ OCSE – Office of Child Support Enforcement Appointment	☐ WeCARE – Wellness, Comprehensive Assessment, Rehabilitation and Employment Medical Provider Appointment
☐ BTW (Back to Work) Vendor Appointment	☐ ACS – Agency for Children's Services Appointment

Notes: For FS, copies of documents are acceptable whenever proof of eligibility is presented. For CA and MA, original documents are needed to verify identity and citizenship/alien status. Copies of documents for all Eligibility Factors other than identity and citizenship/alien status are acceptable.

The following household member(s) must return in person for the reason indicated below:

Name of Household Member	☐ To be finger-imaged	☐ For an employability assessment	☐ To sign the cash assistance application
Name of Household Member	☐ To be finger-imaged	☐ For an employability assessment	☐ To sign the cash assistance application
Name of Household Member	☐ To be finger-imaged	☐ For an employability assessment	☐ To sign the cash assistance application
Name of Household Member	☐ To be finger-imaged	☐ For an employability assessment	☐ To sign the cash assistance application

Outstanding documentation – see the **W-119D** for a list of documents that can be used to verify the outstanding Eligibility Factors.

Name	Eligibility Factor

If this notice does not indicate that you (case head) must see the Worker, you may submit any required documents/information by mail. However, it remains your responsibility to ensure that the required information reaches the Agency by the prescribed deadline.

FAILURE TO SUBMIT VERIFICATION/DOCUMENTATION OR FAILURE TO CONTACT YOUR WORKER ON OR BEFORE THE DUE DATE MAY MAKE YOU INELIGIBLE FOR CASH ASSISTANCE AND/OR SNAP, OR MAY CAUSE A REDUCTION IN YOUR CASH ASSISTANCE AND/OR SNAP BENEFITS FOR A SPECIFIC PERIOD OF TIME.

Notes: For FS, copies of documents are acceptable whenever proof of eligibility is presented. For CA and MA, original documents are needed to verify identity and citizenship/alien status. Copies of documents for all Eligibility Factors other than identity and citizenship/alien status are acceptable.

***By signing this notice, you (applicant/participant) are acknowledging that you have received notification of all reminders, required referrals, and dates of appointments as indicated in this notice.**

Applicant/Participant's Signature _____ Date _____

Worker's Signature _____ Date _____

Worker's Telephone Number _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Número del Centro: _____

Fecha de Registro de SNAP: _____

Tema: _____

Requisitos de la Documentación y/o Seguimiento de Evaluación

NOTA: A partir del 29 de agosto, toda referencia al Programa de Cupones para Alimentos en este aviso se denominará el Programa de Asistencia de Nutrición Suplementaria (SNAP), y toda referencia a Cupones para Alimentos se denominará beneficios de SNAP.

Para llegar a una determinación de su actual estado de elegibilidad de Asistencia en efectivo, Programa de Asistencia de Nutrición Suplementaria, Asistencia Médica y/o procesar su pedido para una asignación o condición especial usted debe proporcionar los documentos y/o datos indicados abajo, junto con el presente formulario, a más tardar para la fecha de presentación. Si no puede conseguir los documentos/datos necesarios para dicha fecha, comuníquese con su Trabajador y pida una extensión. Si le es imposible conseguir los documentos/datos necesarios comuníquese con su Trabajador puesto que éste puede ayudarle a obtener los documentos/datos necesarios. El **W-119D (S),** que lista los documentos comunes que pueden servir para comprobar los factores de elegibilidad indicados en la **página 2**, se encuentra adjunto.

Fecha de Presentación: _____ ☐ Tiene que reunirse con el Trabajador al regresar.

Recordatorio de Formularios *(Favor de devolver el/los siguiente(s) formulario(s) de la Agencia, llenado(s) y firmado(s) si necesario.)*

☐ **LDSS-2474 (S)** SSI Referencia y Certificación de Contacto	☐ **W-274U (S)** Atestación de Empleo como Proveedor de Cuidado Infantil Informal
☐ **M-15 (S)** Investigación Respecto a Beneficios de Veteranos/Asignación	☐ **W-299 (S)** Aviso a Solicitantes y Participantes con Respecto a Seguros de Salud de Tercera Persona
☐ **W-146E (S)** Solicitud para Pagar Alquiler Atrasado que Exceda la Asignación Máxima de Asistencia en Efectivo para Refugio	☐ **W-451 (S)** NYPD – Reporte del Departamento de la Policía de Nueva York/ Referencia
☐ **W-146W (S)** Verificación del Alquiler del Inquilino, Sección 8	☐ **W-582A (S)** Evaluación de Cuidado Familiar
☐ **W-147CC (S)** Certificación Respecto a Declaración de Mudanza	☐ **W-700E (S)** Carta de Verificación de Asistencia a la Escuela
☐ **W-147M (S)** Declaración del Casero (Respecto a Honorarios del Agente)	
☐ **W-147Q (S)** Declaración del Inquilino Principal con Respecto a la Ocupación del Inquilino Secundario	

Recordatorio de Cita de Asistencia En Efectivo

☐ BEV – (Bureau of Eligibility Verification) Cita en la Oficina de Verificación de Elegibilidad	☐ CASAC – (Credentialed Alcoholism/and Substance Abuse Counselor Appoinment) Cita con el Consejero de Control de Abuso de Alcoholismo/Sustancias
☐ OCSE – (Office of Child Support Enforcement Appoinment) Cita en la Oficina de Aplicación de Manutención de Niños	☐ WeCARE – (Wellness, Comprehensive Assessment, Rehabilitation and Employment Medical Provider Appoinment) Cita con el Proveedor Médico de Bienestar, Evaluación Total, Rehabilitación y Empleo
☐ De Regreso al Trabajo (Back to Work) Cita del Contratista	☐ ACS – (Agency for Children's Services Appointment) Cita en la Agencia de Servicios al Niño

Aviso: Se pueden aceptar fotocopias de documentos para SNAP, siempre y cuando se presente prueba de elegibilidad. Para Asistencia en Efectivo y Asistencia Médica, los documentos usados para comprobar la identidad y el estado de ciudadanía/extranjero tienen que ser originales. Las fotocopias de documentos son aceptadas para todos los otros Factores de Elegibilidad, con la excepción de identidad y del estado de ciudadanía/extranjero.

El/los siguiente(s) miembro(s) del hogar tiene(n) que regresar en persona por la razón indicada más abajo:

Nombre del Miembro del Hogar	☐ Para que se le tomen imágenes digitales	☐ Para una evaluación de empleabilidad	☐ Para firmar la solicitud de asistencia en efectivo
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Documentación pendiente – vea el **W-119D (S)** para una lista de documentos que pueden usarse para verificar los Factores de Elegibilidad pendiente.

Nombre	**Factor de Elegibilidad**

Si este aviso no indica que usted (jefe del caso) tiene que reunirse con su Trabajador al regresar, puede enviar los documentos/información por correo. Sin embargo, sigue siendo su responsabilidad que la información requerida llegue a la Agencia a más tardar para la fecha de entrega.

EL NO PRESENTAR VERIFICACIÓN/DOCUMENTACIÓN O NO COMUNICARSE CON NOSOTROS A MÁS TARDAR EN LA FECHA DE PRESENTACIÓN PUEDE RESULTAR EN LA PÉRDIDA DE SU ELEGIBILIDAD RESPECTO A ASISTENCIA EN EFECTIVO Y/O SNAP, O PUEDE CAUSARLE UNA REDUCCIÓN EN SUS BENEFICIOS DE ASISTENCIA EN EFECTIVO Y/O BENEFICIOS DE SNAP DURANTE UN PERÍODO DE TIEMPO ESPECÍFICO.

Aviso: Se pueden aceptar fotocopias de documentos para SNAP, siempre y cuando se presente prueba de elegibilidad. Para Asistencia en Efectivo y Asistencia Médica, los documentos usados para comprobar la identidad y el estado de ciudadanía/extranjero tienen que ser originales. Las fotocopias de documentos son aceptadas para todos los otros Factores de Elegibilidad, con la excepción de identidad y del estado de ciudadanía/extranjero.

***Al firmar el presente aviso usted (solicitante/participante) acusa recibo de notificación de todo recordatorio, envío necesario, y fecha de cita, según indicados en este aviso.**

Click here to insert a picture

Firma del Solicitante/Participante ____________________ Fecha ____________________

Firma del Trabajador ____________________ Fecha ____________________

Número de Teléfono del Trabajador ____________________

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Job Center: _____

Action Code: _____

Child Care Return Appointment

You must give us documents to get help with child care. We made an appointment for you.

Appointment Date: _____ Time: _____ Telephone: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Travel Directions: _____

You must keep this appointment. If you do not keep this appointment, your Cash Assistance and/or SNAP benefits may be reduced. Please call the telephone number above if you need to change this appointment.

(See page 2)

You must return for the following reason(s):

I. CHILD CARE IS NEEDED

Documents to bring:

II. MORE INFORMATION IS NEEDED

Check the boxes that apply ☑

☐ Complete and return the child care provider form(s) given.

☐ Get and return all documents listed.

Check the boxes that apply ☑

☐ **OCFS-LDSS-4699**

☐ **OCFS-LDSS-4700**

☐ **CS-274W**

☐ **FIA-1100**

☐ **FIA-1100a**

Documents to bring:

If you choose an informal provider, the Enrollment Agency must review and stamp your Child Care Provider Enrollment Supplementary form **(CS-274W)** before your appointment date.

Applicant's/Participant's Signature

Date

Do you have a disability or health condition that makes it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? Call us at **212-331-4640** and we can help you. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro de Trabajo: _____

Código de Acción: _____

Cita de Vuelta de Cuidado Infantil

Usted debe proporcionarnos documentos para obtener asistencia de cuidado infantil. Nosotros hemos programado una cita para usted.

Fecha de la Cita: _____ Hora: _____ Teléfono: _____

Dirección: _____

_____

Ciudad: _____ Estado: _____ Código Postal: _____

Indicaciones de viaje: _____

Usted debe cumplir esta cita. Si no la cumple, sus beneficios de Asistencia en Efectivo y/o de SNAP pueden reducirse. Favor de llamar al número de teléfono más arriba si necesita reprogramar esta cita.

(Vea la página 2)

Usted debe regresar por la(s) siguiente(s) razón(es):

I. SE NECESITA CUIDADO INFANTIL

Documentos a traer consigo:

_____

_____

_____

II. SE NECESITA MÁS INFORMACIÓN

Marque las casillas que correspondan ☑

☐ Llene y devuelva el/los formulario(s) de inscripción del proveedor de cuidado infantil proporcionado(s).

☐ Obtenga y devuelva toda documentación listada.

Documentos a traer consigo:

_____

_____

_____

Marque las casillas que correspondan ☑

☐ **OCFS-LDSS-4699-S**
☐ **OCFS-LDSS-4700**
☐ **CS-274W-S**
☐ **FIA-1100 (S)**
☐ **FIA-1100a**

Si usted elige a un proveedor informal, la Agencia de Inscripción debe revisar y sellar su formulario de Suplemento de Inscripción del Proveedor de Cuidado Infantil (**CS-274W-S**) antes de la fecha de su cita.

_____ _____

Firma del Solicitante/Participante Fecha

¿Padece usted una discapacidad o afección médica que le dificulte entender este avsio o cumplir el mismo? ¿Le dificulta esta afección obtener otros servicios de la HRA? Llámenos al **212-331-4640** y nosotros podremos ayudarle. Usted también puede pedir asistencia al visitar las oficinas de la HRA. Conforme a la ley, usted tiene el derecho de solicitar este tipo de ayuda.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ENROLLMENT FORM FOR PROVIDER OF LEGALLY-EXEMPT FAMILY CHILD CARE AND LEGALLY-EXEMPT IN-HOME CHILD CARE

Child Care providers who are not required by NYS law to be licensed or registered to operate a day care program use this form to enroll with a legally-exempt caregiver enrollment agency to provide subsidized child care.

Instructions: *Please use black/blue pen.*

- *Provider: Complete the "Child Care Provider Section" of this form.*
- *Parent/caretaker: Complete the "Parent Information Section" of this form.*
- *The provider and parent/caretaker walk though and inspect the site, review sections of the form, then sign and date where indicated.*
- *Submit the completed form to the enrollment agency serving the location where the child care is being provided.*

I. CHILD CARE PROVIDER SECTION

A. CHILD CARE PROVIDER AND PROGRAM

1. **Child Care Provider Name:**

☐ Mr. ☐ Mrs. ☐ Ms.

Last First MI Suffix

Other names known by:
Maiden, married, aliases, etc.

2. **Identifying and Contact Information:**

Enrollment Number: (If Applicable)

Site Phone: ( ) ☐ Listed ☐ Unlisted

Date of Birth: / / (mm/dd/yyyy)

Home Phone: ( ) ☐ Listed ☐ Unlisted

Gender (M or F):

Cell Phone: ( )

Social Security # [1]:

E-Mail Address[2]: ☐ No E-Mail Address

3. **Child Care Location:** *Give address where child care is provided.*

House Number Street Apt.

Address Line 2 Floor

City State Zip County

4. **Home Address:** Is your home address the same as the child care location given above?
☐ Yes. ☐ No. *If No, give address below.*

House Number Street Apt.

Address Line 2 Floor

City State Zip County

(For Enrollment Agency Use)	**(For Local District Use)** ☐WMS
Received Date: _____	Parent's Case No.:_____ Type: ☐Local
Complete Date:	LSSD Office/Unit/Wkr. No.: / /

[1] The social security number is **required** when the local social services district issues child care subsidy payments directly to a child care provider. Failure to provide the social security number may delay payment. The social security number of provider is **optional** when a local social services district issues child care subsidy checks to the subsidy recipient (parent/ caretaker). If the social security number is provided, it may be used by federal, State and local agencies for federal reporting, to prevent the duplication of services and to prevent fraud.

[2] The E-mail address if given may be used by the enrollment agency to contact you.

5. **Mailing Address:** Is your mailing address the same as the child care location or home address given above?
☐ **Yes,** same as child care location. ☐ **Yes,** same as home address.
☐ **No.** *If No, give address below.*

House Number Street Apt.

Address Line 2 Floor

City State Zip County

6. Were you previously enrolled as a legally-exempt child care provider?
☐ **Yes.** If **Yes,** give year enrolled, _____, and county where you resided, _____.
☐ **No.**

7. List below the Counties/Districts issuing subsidy payments for child care that you currently provide.

District: Local ID/Vendor Number[3] if any:

District: Local ID/Vendor Number, if any:

District: Local ID/Vendor Number, if any:

8. Do you read English? ☐ **Yes.** ☐ **No.** If No**,** what language do you read best? _____.

9. Do you speak English? ☐ **Yes.** ☐ **No.** If No, what language do you speak best? _____.

10. Does any other person provide child care at the SAME location you intend to provide child care?
☐ **Yes. Describe:** _____
☐ **No.**

B. TYPE OF LEGALLY-EXEMPT CHILD CARE THAT YOU PROVIDE:

1. Choose the statement which describes the child care services you provide. *Check ☑ A, B, or C. Provide additional information as indicated.*

☐ A) **I am an "In-Home Child Care" Provider.** I provide care **in the child's home** and I care only for children **who live in the home**. *(Provider and parent/caretaker: Please read the OCFS-LDSS-4699.2A, then complete and ATTACH the OCFS-LDSS-4699.2, Agreement For Legally-Exempt In-Home Child Care form.)*

☐ B) **I am a "Family Child Care" Provider.** I provide care in my own home, or another person's home. I care for at least one child who **does not live in the home where care is given.** *(Choose ☑ 1, 2, or 3 below, whichever describes your situation best.)*

☐ 1) **Relative Care-** I am either the grandparent, great-grandparent, great-great-grandparent, aunt/uncle, great aunt/great uncle, brother/sister or first cousin of **ALL** the children in care; OR

☐ 2) I care for no more than 2 children (not counting my own children or any children older than 13 years); OR

☐ 3) I care for 3 or more children. However, I never have more than 2 children in care at the same time for more than three hours a day.

☐ C) **Other--**I provide care other than choices A or B above. **Explain:** _____
_____
_____

(You cannot be enrolled until you prove that you are legally-exempt from the licensing and registering requirements).

2. Are you less than 18 years of age?

☐ **Yes.** You must comply with the NYS Department of Labor's requirements. *Provide the documents listed below to show you meet the requirements. Check ☑ to show item is attached.*
☐ I have **ATTACHED** the OCFS-LDSS-4699.1, Employment of Minors Form (**Rev. 2010**).
☐ I have **ATTACHED** a copy of my *working papers* which are required if I am a minor providing **Family Child Care**. (*Not required for "In-Home" child care providers.)*

☐ **No.**

[3] Provider/Vendor Number is an identifying number assigned and used by the local social services district to track the provider.

C. PEOPLE WHO MAY BE PRESENT AT CHILD CARE LOCATION

People who are present at the child care location when child care is provided and may have contact with child(ren) you care for must have background checks as required by NYS health and safety regulations. These checks apply to the following people:

- An employee-a person you hire to work at the child care location.
- A volunteer-a person who is sometimes at the child care location and who may have contact with the children you provide care for.
- For family child care, a household member-a person who lives in the home where care is provided.

NOTE: The *enrolled child care provider* is the person *authorized* to care for the subsidized child(ren). The enrolled child care provider must be present and supervising at all times. Employees, volunteers and household members **CANNOT** substitute for the provider in caring for the child(ren) and cannot be left alone with the child(ren).

1. Do you have any employees or volunteers, as described above*?*
☐ **No.** ☐ **Yes.** *If yes, list all in Table 1, below and attach more sheets as necessary.*

TABLE 1-CHILD CARE PROVIDER'S VOLUNTEERS AND EMPLOYEES

NAME (INCLUDE AND SPECIFY MAIDEN NAME AND ANY OTHER ALIAS NAMES BY WHICH VOLUNTEERS AND EMPLOYEES MAY BE KNOWN)	ROLE: EMPLOYEE, OR VOLUNTEER	GENDER (M OR F)	DATE OF BIRTH
A) Last First MI Suffix			/ /
B) Last First MI Suffix			/ /
C) Last First MI Suffix			/ /
D) Last First MI Suffix			/ /
E) Last First MI Suffix			/ /

2. *Only "Family Child Care" providers must answer this following question:*
Are there any adults, age 18 and older, (not including the child care provider) living in the residence where child care is given? This includes: family members, non-family members, renters sharing the home, apartment mates, adults placed in your care, and any other adult person who lives in the residence where child care is provided.
☐ **No.**
☐ **Yes.** Identify in Table 2 below everyone who lives in the residence where care is provided. *Attach more sheets as necessary.*

TABLE 2-HOUSEHOLD MEMBERS AGE 18 AND OVER, LIVING AT CHILD CARE SITE

NAME (INCLUDE AND SPECIFY MAIDEN NAME AND ANY OTHER ALIAS NAMES BY WHICH HOUSEHOLD MEMBERS MAY BE KNOWN)	GENDER (M OR F)	DATE OF BIRTH
A) Last First MI Suffix		/ /
B) Last First MI Suffix		/ /
C) Last First MI Suffix		/ /
D) Last First MI Suffix		/ /
E) Last First MI Suffix		/ /
F) Last First MI Suffix		/ /

D. OTHER QUALIFICATIONS & PROGRAM CHARACTERISTICS

1. PROVIDER'S ELIGIBILITY FOR ENHANCED RATE BASED ON TRAINING

Have you completed in the **past 12 months**, 10 hours of training aimed at improving the quality of the care you provide?

☐ **Yes.** If **Yes**, you may be eligible to receive an enhanced rate. ***ATTACH*** *the OCFS-LDSS-4699.3- Legally-Exempt Child Care Provider Training Record and your training certificates.*

☐ **No**.

2. FEDERAL FOOD PROGRAM ASSISTANCE

The Child and Adult Care Food Program (CACFP) helps Family Child Care programs to pay for meals and snacks served to child(ren) in care. Are you currently participating in CACFP?

☐A) **No**. *If you want information about CACFP call: 1(800) 942-3858.*

☐B) **Yes**. *If "yes", provide information about your participation in CACFP and ATTACH proof of your participation dated within the past 12 months below:*

1) Sponsor Agency Name: _____

2) Sponsoring Agency ID Number (if known): _____

3) Your CACFP Provider Number:_____

4) Agreement Number: _____

5) Proof of Participation:

Date on Proof:_____

Type of Proof: (Check ☑ *below to show proof attached)*

☐ CACFP Claim Reimbursement Stub

☐ CACFP Monitoring Checklist (DOH-4118)

☐ CACFP Continuous Application and Agreement (DOH-3705)

3. AMOUNT YOU CHARGE

Do you charge parents receiving subsidy the same amount that you charge parents for non-subsidy child(ren) of the same age and similar care?

☐A) **Yes.**

☐B) **No.** If, **No** choose the statement below which describes the amount you charge.

☐1) I charge parents receiving subsidy **less** than I charge other parents.

☐2) I charge parents receiving subsidy **more** than I charge other parents.

4. ADMINISTRATION OF MEDICATION

NYS Law restricts the right to administer medication other than over-the-counter topical ointments, sunscreen and topically applied insect repellent to specific medical professionals who are authorized by NYS to administer medication. Some individuals are exempt from this requirement based on their relationship to the child, family, or household and are permitted to administer medications, including:

- The child's parent/caretaker, step-parent, legal custodian, legal guardian, or member of the child's household,
- A child care provider employed by the parent/caretaker to provide child care in the child's home,
- Family members who are related within the 3rd degree of consanguinity to the child's parent or step parent. This includes the child's grandparent, great-grandparent, great-great grandparent, aunt/uncle (and spouse), great aunt/uncle (and spouse), first cousin (and spouse), and brother /sister.
- Child care providers who are trained and authorized by the Office of Children and Family Services (OCFS) under the Health Care Plan for Administration of Medication, approved by a qualified health care consultant, and who are:
  - Operating in compliance with the NYS regulation which includes receiving training on medication administration,
  - Authorized by the child's parent/caretaker, step parent, legal guardian, or legal custodian to administer medication, and
  - Administering medication to subsidized children in care.

To receive OCFS authorization to administer medication, a child care provider must be at least 18 years of age and literate in the language in which the parental permissions and health care provider's instructions will be given. Any person who is NOT AUTHORIZED by NYS Law or NOT EXEMPT from this legal requirement, may ONLY administer over-the-counter topical ointments, sunscreen and topical insect repellent. Examples of medication they MAY NOT ADMINISTER include, but are not limited to: Tylenol, Ritalin, insulin, antibiotics, and ear, eye, or nose drops.

A) Are you, your employees or volunteers LEGALLY PERMITTED to administer medication to child(ren) in subsidized care?
Check ☑ all statements that apply to you. Provide all other information as it applies.

☐ 1) **Yes**. I am RELATED within the 3rd degree by blood or marriage to the child(ren)'s parent or step-parent. Therefore, I am allowed to administer medication to the child(ren) following the health care provider's instructions and when I have appropriate permission from the parent.

☐ I am grandparent of: _____

☐ I am great-grandparent of: _____

☐ I am great-great-grandparent of: _____

☐ I am aunt/uncle of (includes spouse) of: _____

☐ I am great aunt/great uncle (includes spouse) of: _____

☐ I am first cousin (includes spouse) of: _____

☐ I am brother/sister of: _____

☐ 2) **Yes.** I am PROVIDING CARE IN THE HOME of the following child(ren): _____ _____. Therefore, I am PERMITTED to administer medication to these children when I have appropriate permission from the parent and I am following the health care provider's instructions.

☐ 3) **Yes.** I am a NYS medical professional AUTHORIZED BY NYS DEPARTMENT OF EDUCATION (NYSED) to administer medication. Therefore, I am allowed to administer medication to child(ren) in my care when there are appropriate permissions from the parent and when following the health care provider's instructions.

a) My profession is *(check ☑ one)*:
- ☐ Registered Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Physician Assistant

b) License number: _____
- ☐ I have attached a copy of my current NYS professional medical license. (*Required*).

☐ 4) **Yes**. I HAVE a Health Care Plan for the Administration of Medication (OCFS-LDSS-7000) approved within the past 2 years. Therefore, the qualified medications administrant named below is AUTHORIZED BY OCFS to administer medication to subsidized children in my care according to the health care provider's instructions and when there are appropriate permissions from the parent.

a) Plan approval date: _____
- ☐ I have attached a copy of the **first page AND the approval page** of my Health Care Plan for the Administration of Medication (OCFS-LDSS-7000).

b) Name of the qualified Medications Administrant: _____.

c) Health Care Consultant (HCC) name: _____.

d) Health Care Consultant Profession *(check ☑ one)*:
- ☐ Registered Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Physician Assistant

e) License Number: _____.

☐ 5) **No.** None of the above permissions apply to me. I am not authorized by OCFS or NYSED. I understand I **cannot administer** medication to the child(ren) in care, except: *Over-the-counter topical ointments, sunscreen, and topically applied insect repellent.*

B) Are you interested in seeking authorization to administer medication to child(ren) in subsidized care?

☐ **Yes**. I want to learn how to start the process. Please send me the OCFS-LDSS-7007, Obtaining Authorization to Administer Medication to Children in Legally-Exempt Care.

☐ **No**. I will not be seeking authorization to administer medication at this time.

C) I agree I will administer medication in compliance with NYS Law and only to the extent that I am permitted by NYS Law which I have indicated by my choice on this page above.
☐ **Yes.** ☐ **No.**

D) If I have employees or volunteers, I will make sure that each of my employees and volunteers administers medication in compliance with NYS Law and only to the extent permitted by NYS Law.
☐ **Yes.** ☐ **No.**

5. HOURS OF OPERATION

What hours do you generally provide care? *Check ☑ all that apply.*

☐ Mornings ☐ Afternoons ☐ Evenings ☐ Overnight ☐ *Back-Up Only*
☐ Before School ☐ After School
☐ Weekends ☐ Saturday ☐ Sunday
☐ Weekdays ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

E. VERIFICATION OF LEGALLY EXEMPT STATUS

1. CHILD CARE SCHEDULES

A) For each **subsidized child** you provide child care for or plan to provide care for, provide ALL the requested information.
B) For each **non-subsidized child** provide the same information, *except DO NOT provide the Child's LAST name.*

CHILD INFORMATION AND CHILD CARE SCHEDULES									
	CHILD NAME:			CHILD NAME:			CHILD NAME:		
	CHILD AGE:			CHILD AGE:			CHILD AGE:		
	PARENT NAME:			PARENT NAME:			PARENT NAME:		
	PROVIDER'S RELATIONSHIP TO THE CHILD:			PROVIDER'S RELATIONSHIP TO THE CHILD:			PROVIDER'S RELATIONSHIP TO THE CHILD:		
	SUBSIDY CASE? ☐YES ☐NO			SUBSIDY CASE? ☐YES ☐NO			SUBSIDY CASE? ☐YES ☐NO		
	SCHEDULE OF CHILD CARE			SCHEDULE OF CHILD CARE			SCHEDULE OF CHILD CARE		
	DROP OFF	PICK UP	HRS / DAY	DROP OFF	PICK UP	HRS / DAY	DROP OFF	PICK UP	HRS / DAY
MONDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
TUESDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
WEDNESDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
THURSDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
FRIDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
SATURDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
SUNDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
	TOTAL HOURS PER WEEK			TOTAL HOURS PER WEEK			TOTAL HOURS/ PER WEEK		

CHILD INFORMATION AND CHILD CARE SCHEDULES									
	CHILD NAME:			CHILD NAME:			CHILD NAME:		
	CHILD AGE:			CHILD AGE:			CHILD AGE:		
	PARENT NAME:			PARENT NAME:			PARENT NAME:		
	PROVIDER'S RELATIONSHIP TO THE CHILD:			PROVIDER'S RELATIONSHIP TO THE CHILD:			PROVIDER'S RELATIONSHIP TO THE CHILD:		
	SUBSIDY CASE? ☐YES ☐NO			SUBSIDY CASE? ☐YES ☐NO			SUBSIDY CASE? ☐YES ☐NO		
	SCHEDULE OF CHILD CARE			SCHEDULE OF CHILD CARE			SCHEDULE OF CHILD CARE		
	DROP OFF	PICK UP	HRS / DAY	DROP OFF	PICK UP	HRS / DAY	DROP OFF	PICK UP	HRS / DAY
MONDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
TUESDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
WEDNESDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
THURSDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
FRIDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
SATURDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
SUNDAY	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
	TOTAL HOURS PER WEEK			TOTAL HOURS PER WEEK			TOTAL HOURS/ PER WEEK		

2. CHILD(REN) IN THE PROVIDER'S CARE

A) How many of **your own** child(ren) do you care for at this child care location during child care hours? *Give numbers below. Do not leave spaces blank. Write "zero," if applicable.*

1) Age newborn through 4 years: _____.

2) Age 5 through 12 years old: _____.

B) Are you caring for any children, *other than your own*, who are **NOT** receiving child care subsidy funds?

1) ☐ **Yes.** *If yes, indicate the number of non-subsidized children, other than your own, below.*

a) Number of relative non-subsidized children:_____.

b) Number of non-relative non-subsidized children: _____.

Note: All non-subsidized children in care MUST be listed on the preceding schedule page.

2) ☐ **No.**

C) Have you started providing child care for all of the children whose schedules you listed above?

1) ☐ **Yes.**

2) ☐ **No**. If No, when care will begin? _____

NOTE: Any changes in the number of children you care for, the hours you provide care and the location where you provide care may affect your eligibility as a legally-exempt child care provider and/or require that you become licensed or registered to operate a day care program. Such changes must be reported to the enrollment agency immediately.

F. HEALTH AND SAFETY CHECKLIST

The provider and parent/caretaker inspect the child care location and complete this section together.

I meet and agree to continue to meet the basic health and safety requirements listed below.
Check ☑ an answer for each item below.

YES	NO	The provider meets the following basic health and safety requirements before caring for children:
☐	☐	1. The provider and all children have two separate & remote ways to leave the building in an emergency.
☐	☐	2. The rooms for children at my child care location are well-heated, well-lighted and well-ventilated.
☐	☐	3. My child care location is free of unsafe areas (such as swimming pools, open drainage ditches, wells, holes, wood or coal burning stoves, fireplaces, and gas space heaters). If there are unsafe areas, sturdy barriers are in place around the areas that keep the child(ren) from getting to them.
☐	☐	4. If child care is provided above the first floor, there are barriers or locks on the windows so the child(ren) cannot fall out.
☐	☐	5. The water supply at my child care location is safe. I have working toilets. There is hot and cold running water all the time.
☐	☐	6. I, all employees, and volunteers who are likely to have regular contact with the child(ren) are physically, emotionally and mentally able to provide child care.
☐	☐	7. I, all employees, and volunteers who are likely to have regular contact with the child(ren) are free from any communicable diseases that pose a risk to the health and safety of the child(ren) in care. If I, any employee, or volunteer who is likely to have regular contact with the child(ren) has a communicable disease, I must have a statement from such person's health care provider that indicates that the presence of a communicable disease does not pose a risk to the health and safety of the child(ren) in care. ☐ I have ATTACHED a doctor's statement, if I, any employee or volunteer who is likely to have regular contact with the child(ren) has a communicable disease and that such disease does not pose a risk to the health and safety of the child(ren) in care.

☐	☐	8. My child care location is free of any dangerous or unsafe conditions that could hurt a child(ren). This includes but is not limited to: • Knives and other sharp objects are out of the reach of child(ren). • Small rugs, runners, and electrical cords are held in place so a child won't trip. • Electrical cords do not run under furniture or rugs and are out of the reach of small children. • Extension cords are not overloaded. • Any guns and other firearms are unloaded and stored in a locked drawer or cabinet and the key is kept in a safe place. Ammunition is locked separately. • Cords to window blinds and shades are out of the reach of child(ren). • Hot liquids are out of the reach of children. • Small items that the child(ren) could choke on are out of the child(ren)'s reach. • Carbon monoxide detectors are installed where the child(ren) that I provide care for sleep or nap and on each story of the home where care is provided where a carbon monoxide source is located.
☐	☐	9. All matches, lighters, medicines, drugs, cleaning materials, detergents, aerosol cans, and other poisonous or toxic materials are stored in their original containers. Care is taken so that they do not come in contact with child(ren), where food is prepared, or otherwise may be a danger to the child(ren). I store all of these materials safely away from the child(ren).
☐	☐	10. I will give each child(ren) meals and snacks according to what the parent/caretaker and I have agreed.
☐	☐	11. I will refrigerate milk, formula and any other food that goes bad if not refrigerated.
☐	☐	12. I agree not to heat formula, breast milk and other food items for infants in a microwave oven.
☐	☐	13. I will always allow the custodial parent/caretaker or caretaker to have unlimited access to his/her child(ren) in care, to the program site while the child(ren) is in care, and to any written records concerning the child(ren).
☐	☐	14. I will hold fire/evacuation drills monthly with child(ren) during hours that the child(ren) are in care so that the child(ren) and I will know what to do in the case of an emergency.
☐	☐	15. I have a working telephone OR can get to one very quickly in an emergency. Emergency telephone numbers for the fire department, local or State police or sheriff's department, poison control center and ambulance service are posted near the phone and are easy to see.
☐	☐	16. I will use protective caps, covers or permanently installed safety devices on all electrical outlets that a child(ren) could reach when I am caring for a child(ren) under 5 years old.
☐	☐	17. Paint and plaster are in good repair so that there is no danger of a child(ren) putting paint or plaster chips in their mouths or of it getting into food.
☐	☐	18. I have at least one operating smoke detector on each floor of my child care location. I will check regularly to make sure all detectors work.
☐	☐	19. I have a portable first aid kit at my child care location that is easy to get to in an emergency and my first aid supplies are kept in a clean container or cabinet away from child(ren). It is stocked to treat common childhood injuries and problems. I will always replace things in the first aid kit as soon as possible after something has been used or is too old to be used.
☐	☐	20. I have RECEIVED from the child(ren)'s parent/caretaker: • Signed proof from a doctor or other health care provider that: the child(ren) has received all of the immunizations appropriate for the child(ren)'s age; **OR** • Proof that one or more of the immunizations would harm the child(ren)'s health; **OR** • A statement saying that the child(ren) has not been immunized due to the parent/caretaker's religious beliefs.
☐	☐	21. The stairs, railings, porches and balconies are in good repair.

Only **Family Child Care** providers must answer question *number 22* below.

YES	NO	**The provider meets the following basic health and safety requirements before caring for the child(ren):**
☐	☐	22. All persons living in the home where care is given are free of any communicable diseases. If any person living in the home does have a communicable disease, I must have a statement from the person's health care provider that indicates that the presence of a communicable disease does not pose a risk to the health and safety of the child(ren) in care. ☐ I have attached a doctor's statement, if any person living in home has a communicable disease and that such disease does not pose a risk to the health and safety of the child(ren) in care.

G. PROVIDER BEHAVIORAL CONDITIONS

All child care providers must answer the questions below.

YES	NO	The provider meets and agrees to continue to meet the following basic health and safety requirements before caring for the child(ren):
☐	☐	1. I understand and agree that I will never use physical punishment or let others use physical punishment while child(ren) are in my care. Physical punishment means doing things directly to a child(ren)'s body to punish child, such as: • Spanking, biting, slapping, shaking, twisting, or squeezing; • Making the child(ren) do physical exercises beyond what is normal; • Forcing the child(ren) to stay still for long periods of time; • Making the child(ren) stay in positions that hurt the child or are bizarre; • Bathing the child(ren) in unusually hot or cold water; and • Forcing child(ren) to eat or have in child(ren)'s mouth soap, foods, hot spices or foreign substances.
☐	☐	2. I understand and agree that I will never use or be under the influence of alcohol or drugs while children are in care and will make sure that child(ren) being cared for do not have contact with people using drugs or alcohol.
☐	☐	3. I understand and agree that I will not smoke or allow smoking in indoor areas or other enclosed areas, such as cars or other vehicles, when child(ren) are present.
☐	☐	4. I understand and agree that I will never leave child(ren) alone or unsupervised.
☐	☐	5. I understand and agree that I will ALWAYS be present when the child(ren) are in the care of employees, volunteers and if care is provided in a home other than the child's home, household members.

H. RELEVANT HISTORY-PEOPLE AT THE CHILD CARE LOCATION

1. PROVIDER ONLY

A) PROVIDER TERMINATION OF PARENTAL RIGHTS

I certify and attest that *(check ☑* one):

1) ☐ I have **never had** my parental rights terminated under Social Services Law 384-b or equivalent legal authority.

2) ☐ I **have had** my parental rights terminated under Social Services Law 384-b or equivalent legal authority.
   ☐ I have **ATTACHED** the OCFS-LDSS-4917, History of Termination of Parental Rights and/or Court Ordered Article 10-Removal of a Child and Parental Acknowledgement form[4] .

B) PROVIDER COURT ORDERED ARTICLE 10 REMOVAL

I certify and attest that *(check ☑*: one):

1) ☐ I have **never had** a child(ren) removed from my care by court order in a proceeding under Article 10 (child protective) of the Family Court Act.
2) ☐ I **have had** a child(ren) removed from my care by court order in a proceeding under Article 10 (child protective) of the Family Court Act.
   ☐ I have **ATTACHED** the OCFS-LDSS-4917, History of Termination of Parental Rights and/or Court Ordered Article 10-Removal of a Child and Parental Acknowledgement form [4].

C) PROVIDER DAY CARE ENFORCEMENT

Note: A child "day care" program includes licensed or registered day care centers, family day care homes, group family day care homes, small day care centers and/or school age child care programs.

1) I certify and attest that *(check ☑*: one):
   ☐ I **have had** an application for a license or registration to operate a child day care program denied.
   ☐ I **have not had** an application for a license or registration to operate a child day care program denied.
2) I certify and attest that (c*heck ☑*: *one*):
   ☐ I **have** had a license or registration to operate a child day care program revoked or suspended.
   ☐ I **have not** had a license or registration to operate a child day care program revoked or suspended.
3) If you have **been denied** a license or registration to operate a child day care program, **or** if you have had a license or registration to operate a child day care program **revoked or suspended,** complete the following:
   a) **Program Name and Location:**_____

[4] If you need a copy of this form, please contact your local social services district or your legally-exempt caregiver enrollment agency.

b) ☐ I have **ATTACHED** the OCFS-LDSS-4916, History of Day Care Enforcement and Parental Acknowledgement[4] .

2. PROVIDER, EMPLOYEES, VOLUNTEERS, AND HOUSEHOLD MEMBERS

A) CRIMINAL HISTORY

1) I have listed on subsection I. C of this form: ALL employees, volunteers, and if I provide care in a home other than the child's home, all of the household members, 18 years of age or older who are likely to have regular contact with the child(ren) in care.
   - ☐ **Yes.**
   - ☐ **No.**
2) If I provide care in a home other than the child(ren)'s home, I also have listed all household members on subsection I. C of this form.
3) I certify that I have asked the following people if they **have been convicted of a crime:**
   - Each person living in the home (other than the child(ren)'s own home) who is age 18 or over,
   - Each volunteer who is likely to have regular contact with child(ren) in care, and
   - Each employee.

   ☐ **Yes.**
   ☐ **No.**
4) Have you, your employee, or your volunteer ever **been convicted of a crime** in New York State or any other place?
   - ☐ **Yes**. Give name(s) of person(s) convicted _____.
     - ☐ I have **ATTACHED** a completed OCFS-LDSS-4915, History of Criminal Convictions and Parental Acknowledgement for each person with a criminal history.
   - ☐ **No.**
5) For provider type of Family Child Care only: has any person living in the home where care is given and who is 18 years of age or older been convicted of a crime in New York State or any other place?
   - ☐ **Yes**. Give name(s) of person(s) convicted: _____.
     - ☐ I have **ATTACHED** a completed OCFS-LDSS-4915, History of Criminal Convictions and Parental Acknowledgement for each household member with a criminal history.
   - ☐ **No**.

B) INDICATED REPORTS OF CHILD ABUSE AND MALTREATMENT

I have asked ALL employees, volunteers, and individuals who may be helping to care for or who have regular contact with the child(ren), and, if I provide care in a home other than the child(ren)'s home, all household members 18 years of age or older, if they have been the subject of an indicated report of child abuse or maltreatment. I have informed the parent/caretaker whether I or any of these individuals have been the subject of any indicated reports of child abuse or maltreatment. When an indication of child abuse or maltreatment exists, I have given the parent/caretaker, in writing, true and accurate information, including:

- a description of the incident(s), and
- the date of the indication(s), and
- any other relevant information regarding the indication(s).

☐ **Yes.**

☐ **No.**

I. PROVIDER AGREEMENTS AND CERTIFICATIONS

1. SUBMITTING UPDATES AND CHANGES OF ENROLLMENT INFORMATION

- I will immediately submit a new enrollment form to the enrollment agency if I start providing child care at a child care location different from the one given on this form.
- I will inform the enrollment agency immediately if there are changes in:
  - my contact information,
  - the child(ren) I care for, or, the hours that I provide care,
  - the people who have contact with the child(ren) in my care,
  - any information provided on the enrollment form or changes to the attachments.
- I will inform the enrollment agency immediately when:
  - Any person 18 years or older moves into the household where "Family Child Care" is provided or stays there for more than a few days (**Family** Child Care only).

- Any child(ren) living in the household where "Family Child Care" is provided, turns 18. (**Family** Child Care only)
- I hire or receive help caring for the child(ren).

2. HEALTH AND SAFETY REQUIREMENTS

- I understand that I cannot be enrolled and payment cannot be made until all items marked "No" on the Health and Safety Checklist and Provider Behavioral Conditions Checklist have been corrected.
- I will continue to meet all the basic health and safety requirements listed on the checklists and
  - The parent/caretaker and I have inspected the home and completed the Health and Safety Checklist and Provider Behavioral Conditions Checklists together.
  - I will notify and provide documentation to the enrollment agency when any item on the checklists has been corrected or changed.

3. INFORMATION SHARING AND DATABASE CHECKS

- I authorize the enrollment agency and the Child and Adult Care Food Program (CACFP) to exchange information regarding my child care enrollment status and my participation in the CACFP.
- I understand the enrollment agency and the local social services district will exchange information regarding my child care enrollment status.
- I understand that the local social services district will check its child welfare database for my history of any court ordered removal of a child under Family Court Act (FCA) Article 10 and any termination of parental rights.
- I understand that the enrollment agency will check the New York State Sex Offender Registry to determine if I, any volunteer who is likely to have regular contact with child(ren) in care, any employee, and for the legally-exempt **family** child care provider, any person living in the home where child care is provided, age 18 years or older is listed on the Sex Offender Registry.
- I understand that the enrollment agency will check the New York State Child Care Facility System to determine whether I have ever been denied a child day care license or registration or had a child day care license or registration suspended or revoked.

4. ELIGIBILITY AND PAYMENT

- I understand I cannot be paid as a legally-exempt child care provider if I am the child(ren)'s parent, stepparent, adoptive parent, legal guardian or other person legally responsible for that child(ren), or, if I live in the same household and have a child(ren) in common with the parent.
- I agree to collect the family share (fee) if instructed to do so by the local social services district. I will immediately notify the local social services district if the parent/caretaker fails to pay the required family share.
- I agree to provide accurate attendance records in a timely manner, as required by the local social services district.
- I understand that I will not be paid by the local social services district for any child care that I provide to a child(ren) receiving a child care subsidy while I am deemed an ineligible provider by the enrollment agency.
- I understand that I must be enrolled with the enrollment agency before any payment may be made.
- I understand that I may not be eligible to provide child care AND that the local social services district may not be able to pay me when:
  - I have a history of Article 10 (child protective) removal of a child by family court order, or
  - I have a history of termination of parental rights, or
  - I have a history of denial, revocation and/or suspension of a license or registration to operate a child day care program or
  - I, any volunteer who is likely to have regular contact with the child(ren), any employee, or, for family child care, any person age 18 years or older living in the home has been convicted of a crime.
- I understand I am not eligible to provide child care if I, any volunteer who is likely to have regular contact with the child(ren), any employee, or person living in the home (other than the child(ren)'s home) age 18 years or older has been convicted of a crime against a child or is listed on the Sex Offender Registry.
- I understand that if the enrollment agency determines I cannot be enrolled, then the local social services district cannot issue payment for care that I have provided. The parent/caretaker has the right and responsibility to decide whether he/she wants to use my child care services. If the parent/caretaker chooses to use my child care services when I cannot be enrolled, the parent/caretaker is responsible to pay me for the child care.

5. OTHER AGREEMENTS

- I understand and agree to allow representatives of the enrollment agency, the local social services district and the State of New York access to the premises where subsidized child care is provided to confirm that information on my enrollment form and/or on attendance forms is true and accurate and that child care services are being provided as listed on these forms. I understand that if I do not allow such access, then I will be considered an ineligible provider, my enrollment will be terminated and I will not be paid by the local social services district.
- I understand that if I am denied enrollment I may request that the enrollment agency review any extenuating circumstances to determine if an exception could be made to allow me to provide child care. If I request an exception, I must provide all documents or references required by the enrollment agency.
- I understand and agree to meet all of the conditions stated on this form for as long as I am providing child care. I understand that I am required to inform the enrollment agency and the parent/caretaker if there is a change in the information stated on the enrollment form.

6. PROVIDER CERTIFICATION

By signing this form I certify to the best of my knowledge that:

- I understand and agree to continue to meet all of the conditions stated above.
- I have reviewed the "Parent Information Section" of this form.
- I understand the decision to enroll me is based on the facts provided and attested to on the enrollment form. Providing false information or deliberately concealing information may result in an inaccurate determination of my eligibility to provide subsidized child care, and/or a denial or termination of enrollment. If I provide child care services while enrolled under false pretenses, or while I am an ineligible child care provider, the Local Social Services District may refuse to issue child care subsidy payments, terminate child care subsidy payments, take legal action against me or the parent/caretaker and I may be required to repay any money I receive for such services.
- Under the penalty of perjury, I agree that to the best of my knowledge all statements made on this enrollment form and any attachments to it are true and accurate.

PROVIDER SIGNATURE:	DATE:
X	

ENROLLMENT FORM FOR PROVIDER OF LEGALLY-EXEMPT FAMILY CHILD CARE AND LEGALLY-EXEMPT IN-HOME CHILD CARE

II. PARENT INFORMATION SECTION

The parent/caretaker receiving or applying for child care subsidy must complete this section AND review the "Child Care Provider" Section.

A. PARENT/CARETAKER[5] INFORMATION

1. **Parent/Caretaker's Name**:

☐ Mr. ☐ Mrs. ☐ Ms.

Last First MI Suffix

Other names known by:
Maiden, married, aliases, etc.

2. **Identifying and Contact Information**:

Date of Birth: / / (mm/dd/yyyy) Home Phone: ( ) ☐ Listed ☐ Unlisted

Work Phone: ( ) Cell Phone:( )

E-Mail Address[6]: ☐ No E-Mail Address

3. Do you read English? ☐ **Yes.** ☐ **No.** If No, what languages do you read best? _____.

4. Do you speak English? ☐ **Yes.** ☐ **No.** If No, what languages do you speak best? _____.

5. Is the child care provided in your home? ☐ **Yes.** ☐ **No.**

6. Give your home address below

Home Address:

House Number Street Apt.

Address Line 2 Floor

City State Zip County/Borough

7. **Mailing Address**: Is your mailing address the same as your home address? ☐ **Yes.** ☐ **No.** *If your mailing address is <u>different</u> from your home address please give your mailing address below.*

House Number Street Apt.

Address Line 2 Floor

City State Zip

8. Provide information about your Child Care Subsidy case:

Subsidy Paying County: Temporary Assistance No.[7]:

Subsidy Case Number[7]: Parent's CIN Number[7]:

[5] Caretaker means the child's parent, legal guardian, caretaker relative or any other person with whom a child lives who has assumed responsibility for the day-to–day care and custody of the child.
[6] The e-mail address if given may be used by the enrollment agency to contact you.
[7] The temporary assistance number, subsidy case number and parent's CIN (client identification number) are optional. If provided, they will be used to facilitate information sharing with the local social services district regarding your eligibility and payment for child care.

B. YOUR CHILD(REN) IN THE PROVIDER'S CARE

1. LIST YOUR CHILD(REN) THAT THE PROVIDER CARES FOR

Add additional sheets if necessary.

A) Child's Name: _____ Date of Birth: / /
Last First (mm/dd/yyyy)

Provider's Relationship to Child: _____ Child's CIN[8]: _____

B) Child's Name: _____ Date of Birth: / /
Last First (mm/dd/yyyy)

Provider's Relationship to Child: _____ Child's CIN: _____

C) Child's Name: _____ Date of Birth: / /
Last First (mm/dd/yyyy)

Provider's Relationship to Child: _____ Child's CIN: _____

D) Child's Name: _____ Date of Birth: / /
Last First (mm/dd/yyyy)

Provider's Relationship to Child: _____ Child's CIN: _____

2. MY CHILD(REN)'S MEDICATION NEEDS

I understand that child care providers **cannot** administer medication to the child(ren) except as follows:

- Any child care provider may administer only over-the-counter topical ointments, insect repellent, and sunscreen with the parent's permission.
- When the child care provider provides care in the child(ren)'s home, the provider may administer over-the-counter medicine and prescription medication with the permission of the parent and following physician's instructions.
- When the child care provider is related to the child(ren)'s parent or stepparent within the 3rd degree of consanguinity (blood or marriage), the provider may administer over-the-counter medicine and prescription medication with the permission of the parent and following physician's instructions. The child care provider must have one of the following relationships to be considered a relative within the 3rd degree.
  - the child's grandparent,
  - the child's great-great-grandparent,
  - the child's great aunt/great uncle (and spouse),
  - the child's first cousin (and spouse),
  - the child's great-grandparent,
  - the child's aunt/uncle (and spouse),
  - the child's brother/sister
- When the child care provider is a licensed physician, physician's assistant, registered nurse, or nurse practitioner, the provider can administer prescription and over-the-counter medication to subsidized child(ren) with the parent's permission parent and following physician's instructions.
- When the child care program is authorized by OCFS and following a Health Care Plan for the Administration of Medication, the medications administrant designated in the Health Care Plan for the Administration of Medication may administer over-the-counter medication and some prescription medication to subsidized child(ren) with the permission of the parent and following physician's instructions.

[8] Client Identification Number (CIN) is optional, if given, it will be used to facilitate information sharing with the local social services district regarding your eligibility and payment for child care.

I have read the "Provider's Qualifications to Administer Medication" in Provider Section I, and "My Child(ren)'s Medication Needs", above, and I understand the extent to which my child care provider is legally permitted to administer medication to my child(ren). My child care provider and I have agreed that:

☐ The parent will be responsible for the medication needs of the following child(ren):

_____.

☐ The provider will be responsible for the medication needs of the following child(ren):

_____.

3. My Child(ren)'s Meals and Snacks

For each child(ren) listed on the preceding page, either the parent or the provider must provide meals and snacks. Who will provide meals and snacks for your child(ren) while in care?

☐ The parent will be responsible for the meals and snacks for the following child(ren):

_____.

☐ The provider will be responsible for the meals and snacks for the following child(ren):

_____.

C. Relevant History of Provider and People At the Child Care Location

1. I understand the child care provider must tell me whether the following people, who may be in contact with my child(ren), have been the subject of an indicated report of child abuse or maltreatment:
   - the provider,
   - volunteers who are likely to have regular contact with child(ren) in care,
   - employees, and
   - if care is not provided in my home, persons living in the home age 18 years or older.

   ☐ **Yes.**
   ☐ **No.**

- I have specifically asked the provider if the provider, volunteers who are likely to have regular contact with child(ren) in care, employees, and if care is provided in the provider's home, persons living in the home age 18 years or over, have been the subject of an indicated report of child abuse or maltreatment.
- The provider has informed me whether any indicated reports of child abuse or maltreatment exist, who was the subject of the report: the provider, employees, volunteers who are likely to have regular contact with child(ren) in care, and, if care is provided in the provider's home, persons living in the home age 18 years or over.
- When an indication of child abuse or maltreatment exists, the provider has given me written information regarding such indication of child abuse or maltreatment. I understand I have the right to select another provider. I agree that I have carefully considered the information on child abuse and maltreatment indications that I have been given and I am selecting this provider.

  ☐ **Yes.**
  ☐ **No.**

D. Parental Acknowledgements and Agreements

1. Parent Responsibilities to Monitor Quality of Care

- ☒ I certify that I have selected this provider to care for my child(ren).
- ☒ I have reviewed each item on the Health and Safety Checklist and the Provider Behavioral Conditions Checklist with the provider, located in the Child Care Provider Section, and all information on the checklist is true and accurate.
- ☒ I understand it is my responsibility to monitor the quality of care my child(ren) receives from the child care provider.
- ☒ I understand that these agreements apply for as long as this provider is caring for my child(ren).

2. Changes to Enrollment Information

- ☒ I will notify the enrollment agency immediately if:
  - My address or phone number changes
  - I have any concerns about the health and safety of my child(ren) in the provider's care.

3. ELIGIBILITY AND PAYMENT ISSUES

- I will immediately notify the local social services district and my provider if the hours that I need child care or other circumstances related to my need or eligibility for child care change.
- I agree to pay my family share (fee), if any, as directed by the local social services district.
- I understand a child care provider who is the child(ren)'s parent, stepparent, adoptive parent, legal guardian or other person legally responsible for that child(ren) or who lives in my same household and has a child(ren) in common with me cannot be paid.
- I understand that the provider must be accepted for enrollment with the enrollment agency before any payment can be made.
- I understand a provider is not eligible to provide child care if the provider, any volunteer who is likely to have regular contact with my child(ren), any employee, or, for family child care, any person 18 years or older who is living in the home where child care is provided:
  - Has been convicted of a crime against a child(ren) or
  - Is listed on the Sex Offender Registry.
- I understand that my provider may not be eligible to provide child care and that the local social services district may not be able to pay the provider when:
  - The provider has a history of termination of parental rights, or
  - The provider has a history of Article 10 (child protective) removal of a child(ren) by family court order, or
  - The provider had a license or registration to operate a child day care program denied, revoked and/or suspended, or
  - The provider, any volunteer who is likely to have regular contact with my child(ren), any employee, or, for family child care, any person 18 years or older who is living in the home where child care is provided, has been convicted of a crime.
- I understand that if the provider is denied enrollment or has his or her enrollment terminated, the provider will be considered ineligible to provide child care.
- The local social services district cannot pay the provider or issue payment for care given by a provider who cannot be enrolled or who is ineligible. If I choose to use an ineligible provider, I am responsible to pay for the child care myself. I understand I have the right to select another provider.

4. HEALTH AND SAFETY REQUIREMENTS

- I understand that payment cannot be made until all items marked "No" on the Health and Safety Checklist and Provider Behavioral Conditions Checklist have been corrected.
- I understand that the provider must continue to meet all the basic health and safety requirements and behavioral conditions listed on the checklists.
  - The provider and I have inspected the home, completed the Health and Safety Checklist and the Provider Behavioral Conditions Checklists together.
  - All statements on the checklists are true and accurate.
  - The provider and I will notify and provide documentation to the enrollment agency when any item on the checklists has been corrected or changed.

5. PARENT CERTIFICATION

By signing this form I certify to the best of my knowledge that:

- I have reviewed the "Child Care Provider Section" of this form.
- I understand and agree to continue to meet all conditions stated above.
- I understand the decision to enroll my provider is based on the facts provided and attested to on the enrollment form. Providing false information or deliberately concealing information may result in an inaccurate determination of my provider's eligibility to provide subsidized child care, and/or a denial or termination of enrollment. If my provider provides child care services while enrolled under false pretenses, or while he or she is an ineligible child care provider, the Local Social Services District may refuse to issue child care subsidy payments, terminate child care subsidy payments, take legal action against me or the child care provider.
- Under the penalty of perjury, I agree that to the best of my knowledge all statements made on this enrollment form and any attachments to it are true and accurate.

PARENT/CARETAKER SIGNATURE	DATE

This enrollment form is a legal agreement. Make a copy of this form for your records. Return this form and its attachments to:

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

FORMULARIO DE INSCRIPCION PARA PROVEEDORES DE SERVICIOS DE CUIDADO INFANTIL EN FAMILIA LEGALMENTE EXENTO Y DE CUIDADO INFANTIL A DOMICILIO LEGALMENTE EXENTO

Los proveedores de cuidado infantil que no están requeridos por ley del Estado de Nueva York a ser licenciados o registrados para operar un programa de cuidado diurno usan este formulario para inscribirse con una agencia de inscripción de provisión de cuidado legalmente exento para proveer cuidado infantil subsidiado.

Instrucciones: *Por favor use un bolígrafo negro/azul.*

- *Proveedor(a): Complete la "Sección del Proveedor(a) de Cuidado Infantil".*
- *Padre/madre/encargado(a): Complete la "Sección de Información del Padre/Madre".*
- *El proveedor(a) y el padre/madre/encargado(a) visitan e inspeccionan el establecimiento, revisan las secciones del formulario, luego firman y ponen la fecha donde se indica.*
- *Presente el formulario completado a la agencia de inscripción que sirve el lugar donde se provee cuidado infantil.*

I. SECCIÓN DEL PROVEEDOR(A) DE CUIDADO INFANTIL

A. PROVEEDOR(A) DE CUIDADO INFANTIL Y PROGRAMA

1. **Nombre del Proveedor(a) de Cuidado Infantil:**

☐ Sr. ☐ Sra. ☐ Srta.

Apellido Nombre IM Sufijo

Conocido por otros nombres:
Soltero(a), casado(a), alias, etc.

2. **Información de Identificación y de Contacto:**

Número de Inscripción: (Si se aplica) Tel. del Lugar: ( ) ☐ Listado ☐ No listado

Fecha de Nacimiento: / / (mm/dd/yyyy) Tel. de Casa: ( ) ☐ Listado ☐ No listado

Género (M o F): Tel. Celular: ( )

No. Seguro Social [1]: E-mail[2]: ☐ No E-mail

3. **Establecimiento o Lugar de Cuidado Infantil:** *Indique dónde se provee cuidado infantil.*

Número de Casa Calle Apto.

Dirección-Línea 2 Piso

Ciudad Estado Zona Postal Condado

4. **Dirección de Casa:** ¿Es la dirección de su casa la misma que el lugar donde provee cuidado infantil, indicado arriba?
☐ Sí. ☐ No. *Si no, provea la dirección abajo.*

Número de Casa Calle Apto.

Dirección-Línea 2 Piso

Ciudad Estado Zona Postal Condado

(For Enrollment Agency Use)	**(For Local District Use)**	☐WMS
Received Date: _____	Parent's Case No.:_____	Type: ☐Local
Complete Date:	LSSD Office/Unit/Wkr. No.: / /	

[1] El número de seguro social es **requerido** cuando el distrito de servicios sociales local emite pagos de subsidio por cuidado infantil directamente al proveedor(a) de cuidado infantil. El no proveer el número de seguro social puede retrasar el pago. El número de seguro social del proveedor(a) es **opcional** cuando el distrito de servicios sociales local emite cheques de subsidio de cuidado infantil al beneficiario del subsidio (padre/madre/encargado[a]). Si se provee el número de seguro social, éste puede ser usado por agencias federales, estatales y locales para propósito de reportes, con el fin de prevenir duplicación de servicios y fraude.

[2] La dirección electrónica dada puede ser usada por la agencia de inscripción para contactarle.

5. **Dirección de Correos:** ¿Es su dirección de correos la misma que la del lugar donde provee cuidado infantil o es la dirección de su casa provista anteriormente? ☐ **Sí,** la misma que el lugar de cuidado infantil. ☐ **Sí,** la misma que la dirección de la casa.
☐ **No.** *Si "no", provea su dirección debajo.*

Número de Casa Calle Apto.

Dirección-Línea 2 Piso

Ciudad Estado Zona Postal Condado

6. ¿Estaba usted antes inscrito como proveedor(a) de cuidado infantil legalmente exento?
☐ **Sí.** Si "sí", provea el año de inscripción, _____, y el condado donde usted vivía, _____.
☐ **No.**

7. Enumere abajo los condados/distritos que están emitiendo pagos de subsidio por el cuidado infantil que usted actualmente provee.

Distrito: ID Local/No. Vendedor[3] si tiene:

Distrito: ID Local/No. Vendedor, si tiene:

Distrito: ID Local/No. Vendedor, si tiene:

8. ¿Lee inglés? ☐ **Sí.** ☐ **No.** Si "no", ¿en qué idioma lee mejor? _____.

9. ¿Habla inglés? ☐ **Sí.** ☐ **No.** Si "no", ¿qué idioma habla mejor? _____.

10. ¿Provee otra persona cuidado infantil en el mismo lugar donde usted intenta proveer cuidado infantil?
☐ **Sí. Describa:** _____
☐ **No.**

B. TIPO DE CUIDADO INFANTIL LEGALMENTE EXENTO:

1. Escoja la declaración que describe los servicios de cuidado infantil que usted provee. *Marque ☑ A, B, ó C. Provea información adicional según se indica.*

☐ A) **Yo soy un proveedor(a) de Cuidado Infantil en el Hogar (In-Home Child Care Provider).** Yo proveo cuidado **en el hogar del niño(a)** y sólo cuido a niños **que viven en el hogar**. *(Proveedor(a) y padre/madre/encargado(a): Por favor lea el formulario OCFS-LDSS-4699.2A-S, luego complete y ADJUNTE el Acuerdo del Proveedor(a) de Cuidado Infantil en Familia Legalmente Exento (**OCFS**-LDSS-4699.2-S).*

☐ B) **Yo soy un proveedor(a) de Cuidado Infantil en Familia (Family Child Care Provider).** Yo proveo cuidado en mi propia casa, o en la de otra persona. Cuido a por lo menos un niño(a) **que no vive en el hogar donde se provee cuidado**. *(Escoja ☑ 1, 2, ó 3 abajo, el que mejor describa su situación.*

☐ 1) **Cuidado como pariente-** Soy abuelo(a), bisabuelo(a), tatarabuelo(a), tío(a), tío(a) abuelo(a), hermano(a) o primo(a) hermano(a) de **TODOS** los niños bajo cuidado; O

☐ 2) Cuido a no más de 2 niños (sin contar mis propios hijos o cualquier hijo(a) mayor de 13 años); O

☐ 3) Cuido a 3 o más niños. Sin embargo, nunca tengo más de 2 niños bajo cuidado al mismo tiempo por más de tres horas al día.

☐ C) **Otro—**Yo proveo cuidado diferente a las opciones anteriores A ó B. **Explique:** _____

_____

_____

(No puede inscribirse hasta que usted pruebe que es exento legalmente de los requisitos de licencia y registro).

[3] Proveedor(a)/ No. de Vendedor es un número asignado y usado por el distrito de servicios sociales local para identificar al proveedor(a).

2. ¿Es menor de 18 años de edad?

☐ **Sí.** Usted debe cumplir con los requisitos del Departamento de Trabajo del Estado de Nueva York. *Provea los documentos listados abajo para demostrar que usted satisface los requisitos. Marque ☑ para demostrar que se adjunta el ítem.*

☐ He **ADJUNTADO** el *Empleo de Menores de Edad* (*OCFS-LDSS-4699.1-S, Rev. 2010*).

☐ He **ADJUNTADO** una copia de mis *documentos de trabajo*, los que son requeridos si soy un menor de edad que está proveyendo **Cuidado Infantil en Familia**. (*No se requiere para proveedores de cuidado infantil en el hogar).*

☐ **No.**

C. PERSONAS PRESENTES EN EL LUGAR DE CUIDADO INFANTIL

Las personas que estén presentes en el lugar de cuidado infantil cuando se provea cuidado infantil y tengan contacto con los niños que usted cuida deben pasar por una verificación de antecedentes, según lo requieren reglamentaciones de salud y de seguridad del Estado de Nueva York. Esto se aplica a:

- Un empleado(a): Una persona que usted contrate para trabajar en el lugar de cuidado infantil.
- Un voluntario(a): Una persona que a veces está en el lugar de cuidado infantil y quien puede que tenga contacto con los niños a quienes usted cuida.
- Para cuidado infantil en familia, un miembro(a) del hogar: Una persona que vive en e el hogar donde se provee cuidado.

NOTA: El *proveedor(a) de cuidado infantil* inscrito es la persona *autorizada* para cuidar a niños que reciben subsidios. El proveedor(a) de cuidado infantil inscrito debe estar presente y debe supervisar en todo momento. Empleados, voluntarios y miembros del hogar **NO** pueden sustituir al proveedor(a) en el cuidado de niños y no pueden quedarse solos con los niños.

1. ¿Tiene algún empleado(a) o voluntario(a), como se describe anteriormente?
☐ **No.** ☐ **Sí.** *Si "sí", enumere todos en el Cuadro 1, debajo, y adjunte más hojas si es necesario.*

CUADRO 1-VOLUNTARIOS Y EMPLEADOS DEL PROVEEDOR(A) DE CUIDADO INFANTIL

NOMBRE (INCLUYA Y ESPECIFIQUE EL NOMBRE DE SOLTERO(A) Y OTROS NOMBRES ALIAS POR LOS QUE SE CONOCE A LOS VOLUNTARIOS Y EMPLEADOS)				PAPEL EMPLEADO(A) O VOLUNTARIO(A)	GENERO (M O F)	FECHA DE NACIMIENTO
A) Apellido	Nombre	IM	Sufijo			/ /
B) Apellido	Nombre	IM	Sufijo			/ /
C) Apellido	Nombre	IM	Sufijo			/ /
D) Apellido	Nombre	IM	Sufijo			/ /
E) Apellido	Nombre	IM	Sufijo			/ /

2. *Sólo los proveedores de Cuidado Infantil en Familia deben contestar la siguiente pregunta:*
¿Hay adultos de 18 años de edad o mayores (sin incluir al proveedor(a) de cuidado infantil) viviendo en la residencia donde se provee cuidado infantil? Esto incluye: miembros de la familia, miembros que no son de la familia, inquilinos compartiendo el hogar, compañeros de apartamento, adultos colocados bajo su cuidado, y cualquier otra persona adulta que viva en la residencia donde se provee cuidado infantil.
☐ **No.**
☐ **Sí.** Identifique en la Tabla 2 abajo cada persona que vive en la residencia donde se provee el cuidado. *Adjunte más hojas si es necesario.*

TABLA 2-MIEMBROS DEL HOGAR DE 18 AÑOS O MÁS, VIVIENDO EN EL ESTABLECIMIENTO DE CUIDADO INFANTIL

NOMBRE (INCLUYA Y ESPECIFIQUE EL NOMBRE DE SOLTERO(A) Y CUALQUIER OTRO NOMBRE POR EL QUE LOS MIEMBROS DEL HOGAR SEAN CONOCIDOS)	GENERO (M O F)	FECHA DE NACIMIENTO
A) Apellido / Nombre / IM / Sufijo		/ /
B) Apellido / Nombre / MI / Sufijo		/ /
C) Apellido / Nombre / MI / Sufijo		/ /
D) Apellido / Nombre / MI / Sufijo		/ /
E) Apellido / Nombre / MI / Sufijo		/ /
F) Apellido / Nombre / MI / Sufijo		/ /

D. OTRAS CUALIDADES Y CARACTERÍSTICAS DEL PROGRAMA

1. ELEGIBILIDAD DEL PROVEEDOR(A) POR CAPACITACIÓN PARA MEJORES TARIFAS

¿Ha completado 10 horas de capacitación durante los **últimos 12 meses** con la intención de mejorar la calidad de cuidado que provee?

☐ **Sí.** Si contestó "sí", puede que usted sea elegible para recibir una tarifa mejor. ***ADJUNTO*** *está el Registro de Entrenamiento para Proveedores de Cuidado Infantil Legalmente Exento (OCFS-LDSS-4699.3-S)* y sus *certificados de capacitación.*
☐ **No**.

2. PROGRAMA FEDERAL DE ASISTENCIA DE ALIMENTOS

El Programa Alimenticio para Niños y Adultos (*Child and Adult Care Food Program--CACFP*) ayuda a los programas de cuidado infantil con dinero para los gastos de comidas y bocadillos. ¿Participa actualmente en CACFP?

☐A) **No**. *Si desea información acerca de CACFP, llame al: 1(800) 942-3858.*
☐B) **Sí**. *Si "sí", provea información acerca de su participación en CACFP y ADJUNTE prueba de su participación debajo, fechada dentro de los últimos 12 meses:*

1) Nombre de la Agencia Patrocinadora: _____
2) ID de la Agencia Patrocinadora (si se conoce): _____
3) Su No. de Proveedor(a) de CACFP:_____
4) No. de Acuerdo: _____
5) Prueba de Participación:
Fecha de la Prueba: _____
Tipo de Prueba (Marque ☑ *debajo para indicar prueba adjunta)*
☐ CACFP Demanda con Talón de Reembolso
☐ CACFP Lista de Control (*Monitoring Checklist-DOH-4118*)
☐ CACFP Solicitud y Acuerdo Continuo (*Continuous Application and Agreement--DOH-3705*)

3. CANTIDAD QUE USTED COBRA

¿Cobra a los padres que reciben subsidio la misma cantidad que cobra a los padres que no reciben subsidio para los niños de la misma edad y cuidado similar?

☐A) **Sí.**

☐B) **No.** Si "no", escoja la declaración que describe la cantidad que cobra.

☐1) Cobro a los padres que reciben subsidio **menos** de lo que cobro a los otros padres.

☐2) Cobro a los padres que reciben subsidio **más** de lo que cobro a otros padres.

4. ADMINISTRACION DE MEDICAMENTOS

Las leyes del Estado de Nueva York restringen el derecho de administrar medicamentos aparte de pomadas de uso externo y venta libre, protectores solares y repelentes de insectos de venta libre y uso externo, a ciertos profesionales médicos autorizados por el estado para administrar medicamentos. Algunas personas están exentas de este requisito por su relación con el niño(a), la familia o los miembros del hogar, y están autorizadas a administrar medicamentos, incluidos:

- El padre, madre o encargado(a), padre o madre adoptivo, tutor(a) o guardián legal, o miembro del hogar del niño(a),
- El proveedor(a) de cuidado infantil empleado(a) por el padre, la madre, el tutor(a) o encargado(a) para cuidar a los niños en el hogar del niño(a),
- Miembros de la familia con relaciones de hasta el tercer grado de consanguinidad con los padres o padres adoptivos del niño(a). Esto incluye el abuelo(a), bisabuelo(a), tatarabuelo(a), tío(a) (y sus cónyuges), tío(a) abuelo(a) (y sus cónyuges), hermano(a) o primo(a) hermano(a) (y sus cónyuges).
- Los proveedores de cuidado infantil que han sido capacitados y autorizados por la Oficina de Servicios para Niños y Familias (*Office of Children and Family Services--OCFS*), bajo el Plan de Cuidado de la Salud para la Administración de Medicamentos, y aprobados por un asesor médico(a) habilitado, y quienes:
  - se desempeñen de acuerdo con las reglamentaciones del Estado de Nueva York, que incluyen capacitación sobre la administración de medicamentos.
  - hayan sido autorizados por el padre, madre o encargado(a), padre o madre adoptivo, tutor(a) o guardián legal, o miembro del hogar del niño(a) para administrar medicamentos, y
  - administren medicamentos a niños subsidiados bajo cuidado.

Para poder recibir la autorización de la OCFS para administrar medicamentos, los proveedores de cuidado infantil deben tener como mínimo 18 años y conocer el idioma en el que se redactarán las autorizaciones de los padres y las instrucciones del proveedor(a) de atención médica.

Cualquier persona que NO ESTE AUTORIZADA por las leyes del Estado de Nueva York, o que no estén exentas de este requisito legal, SOLO podrán administrar pomadas o ungüentos de uso externo y venta libre, protectores solares y repelentes de insectos de uso externo. Algunos ejemplos de los medicamentos que estos proveedores NO PUEDEN ADMINISTRAR son, entre otros: Tylenol®; Ritalin®; insulina; antibióticos; y gotas para los oídos, los ojos o la nariz.

A) ¿Tiene usted, sus empleados o voluntarios PERMISO LEGAL para administrar medicamentos a los niños cuyo cuidado es subsidiado?
Marque ☑ todas las declaraciones que se aplican a usted. Provea toda la información pertinente.

☐ 1) **Sí**. Tengo una RELACION sanguínea o por matrimonio de hasta el tercer grado con el padre/madre del niño(a) o con el padrastro o madrastra del mismo(a). Por lo tanto, tengo permiso para administrar medicamentos al niño(a) o niños, siguiendo las instrucciones del proveedor(a) de salud y las del padre/madre con respecto a permisos apropiados.

- ☐ Soy el abuelo(a) de: _____
- ☐ Soy bisabuelo(a) de: _____
- ☐ Soy tatarabuelo(a) de: _____
- ☐ Soy el tío(a) (y su cónyuge) de: _____
- ☐ Soy tío(a)/abuelo(a) (y su cónyuge) de: _____
- ☐ Soy primo(a) hermano(a) (y su cónyuge) de: _____
- ☐ Soy el hermano(a) de _____

☐ 2) **Sí.** Estoy PROVEYENDO CUIDADO EN EL HOGAR de los siguientes niños: _____ _____. Por lo tanto, tengo PERMISO para administrar medicamentos a estos niños con el permiso apropiado del padre/madre y siguiendo las instrucciones del proveedor(a) de cuidado de salud.

☐ 3) **Sí.** Soy profesional médico en el Estado de Nueva York AUTORIZADO POR EL DEPARTAMENTO DE EDUCACION DEL ESTADO DE NUEVA YORK (NYSED) para administrar medicamentos. Por lo tanto, tengo permiso para administrar medicamentos a niños bajo mi cuidado con el permiso apropiado del padre/madre y siguiendo las instrucciones del proveedor(a) de cuidado.

a) Mi profesión es *(marque ☑ una)*:
- ☐ Enfermera(o) Registrada(o)
- ☐ Enfermero(a) Practicante
- ☐ Médico(a)
- ☐ Médico(a) Asistente

b) Número de Licencia: _____
- ☐ He adjuntado una copia de mi actual licencia médica profesional del Estado de Nueva York. *(Requerido)*

☐ 4) **Sí**. TENGO un *Plan de Salud para la Administracion de Medicamentos (OCFS-LDSS-7000-S)* aprobado dentro de los dos últimos años. Por lo tanto, el administrador(a) calificado de medicamentos mencionado abajo está AUTORIZADO POR OCFS para administrar medicamentos a niños subsidiados bajo mi cuidado, de acuerdo a las instrucciones del proveedor(a) de salud y las del padre/madre con respecto a permisos apropiados.

a) Fecha de aprobación del plan: _____
- ☐ He adjuntado una copia de la **primera página y la página de aprobación** de mi *Plan de Salud para la Administración de Medicamentos (OCFS-LDSS-7000-S).*

b) Nombre del Administrador(a) de Medicamentos calificado: _____.
c) Nombre del Asesor(a) de Salud: _____.
d) Profesión del Asesor(a) de Salud *(marque ☑ una)*:
- ☐ Enfermera(o) Registrada(o)
- ☐ Enfermera(o) Practicante
- ☐ Médico(a)
- ☐ Médico(a) Asistente

e) Número de Licencia: _____.

☐ 5) **No.** Ninguno de los permisos mencionados anteriormente se aplica a mi persona. Yo no estoy autorizado por OCFS o NYSED. Comprendo que **no puedo administrar medicamentos** a niños bajo mi cuidado, excepto: pomadas o ungüentos de uso externo y venta libre, protectores solares y repelentes de insectos de uso externo cremas.

B) ¿Está interesado(a) en obtener autorización para administrar medicamentos a niños subsidiados bajo su cuidado?

☐ **Sí**. Deseo conocer el proceso. Por favor envíeme el *Plan de Salud para la Administración de Medicamentos para Proveedores Legalmente Exentos (OCFS-LDSS-7007-S).*

☐ **No**. No buscaré autorización para administrar medicamentos en este momento.

C) Estoy de acuerdo. Administraré medicamentos cumpliendo la Ley del Estado de Nueva York y sólo hasta el límite permitido por la ley, lo que he indicado como selección anteriormente.
☐ **Sí.** ☐ **No.**

D) Si tengo empleados o voluntarios, me aseguraré de que cada uno administre medicamentos de acuerdo con la Ley del Estado de Nueva York y sólo hasta el límite permitido por la ley.
☐ **Sí.** ☐ **No.**

5. HORAS DE OPERACIÓN

¿Cuáles son las horas en las que generalmente provee cuidado infantil? *Marque ☑ todo lo que se aplique.*

☐ Mañanas ☐ Tardes ☐ Anochecer ☐ Por la noche
☐ Antes de la escuela ☐ Después de la escuela ☐ Sustituto Solamente
☐ Fin de semana ☐ Sábado ☐ Domingo
☐ Día de semana ☐ Lunes ☐ Martes ☐ Miércoles ☐ Jueves ☐ Viernes

E. VERIFICACIÓN DEL ESTATUS LEGALMENTE EXENTO

1. HORARIOS DE CUIDADO INFANTIL

A) Para cada **niño(a) que recibe subsidio** bajo su cuidado o a quien planea cuidar, provea TODA la información requerida.

B) Para cada **niño(a) que no recibe subsidio provea la misma información,** excepto el APELLIDO del nombre del niño(a).

INFORMACION DEL NIÑO(A) Y HORARIOS DE CUIDADO									
	NOMBRE DEL NIÑO(A):			NOMBRE DEL NIÑO(A):			NOMBRE DEL NIÑO(A):		
	EDAD DEL NIÑO(A):			EDAD DEL NIÑO(A):			EDAD DEL NIÑO(A):		
	NOMBRE DEL PADRE/MADRE:			NOMBRE DEL PADRE/MADRE:			NOMBRE DEL PADRE/MADRE:		
	RELACIÓN DEL PROVEEDOR(A) CON EL NIÑO(A):			RELACIÓN DEL PROVEEDOR(A) CON EL NIÑO(A):			RELACIÓN DEL PROVEEDOR(A) CON EL NIÑO(A):		
	¿CASO DE SUBSIDIO? ☐SÍ ☐NO			¿CASO DE SUBSIDIO? ☐SÍ ☐NO			¿CASO DE SUBSIDIO? ☐SÍ ☐NO		
	HORARIO DE CUIDADO INFANTIL			HORARIO DE CUIDADO INFANTIL			HORARIO DE CUIDADO INFANTIL		
	DEJAR	RECOGER	HRS / DÍA	DEJAR	RECOGER	HRS / DÍA	DEJAR	RECOGER	HRS / DÍA
LUNES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
MARTES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
MIÉRCOLES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
JUEVES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
VIERNES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
SABADO	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
DOMINGO	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
	TOTAL DE HORAS POR SEMANA			TOTAL DE HORAS POR SEMANA			TOTAL DE HORAS POR SEMANA		

INFORMACION DEL NIÑO(A) Y HORARIOS DE CUIDADO									
	NOMBRE DEL NIÑO(A):			NOMBRE DEL NIÑO(A):			NOMBRE DEL NIÑO(A):		
	EDAD DEL NIÑO(A):			EDAD DEL NIÑO(A):			EDAD DEL NIÑO(A):		
	NOMBRE DEL PADRE/MADRE:			NOMBRE DEL PADRE/MADRE:			NOMBRE DEL PADRE/MADRE:		
	RELACIÓN DEL PROVEEDOR(A) CON EL NIÑO(A):			RELACIÓN DEL PROVEEDOR(A) CON EL NIÑO(A):			RELACIÓN DEL PROVEEDOR(A) CON EL NIÑO(A):		
	¿CASO DE SUBSIDIO? ☐SÍ ☐NO			¿CASO DE SUBSIDIO? ☐SÍ ☐NO			¿CASO DE SUBSIDIO? ☐SÍ ☐NO		
	HORARIO DE CUIDADO INFANTIL			HORARIO DE CUIDADO INFANTIL			HORARIO DE CUIDADO INFANTIL		
	DEJAR	RECOGER	HRS / DÍA	DEJAR	RECOGER	HRS / DÍA	DEJAR	RECOGER	HRS / DÍA
LUNES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
MARTES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
MIÉRCOLES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
JUEVES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
VIERNES	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
SABADO	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
DOMINGO	AM PM	AM PM		AM PM	AM PM		AM PM	AM PM	
	TOTAL DE HORAS POR SEMANA			TOTAL DE HORAS POR SEMANA			TOTAL DE HORAS POR SEMANA		

2. LOS NIÑOS BAJO EL CUIDADO DEL PROVEEDOR(A)

A) ¿A cuántos de sus niños cuida en este establecimiento durante las horas de cuidado? *Provea datos abajo. No deje espacios en blanco. Escriba "cero" donde se aplique.*

1) Entre recién nacido y los 4 años de edad: _____.

2) Entre los 5 y los 12 años de edad: _____.

B) ¿Cuida a niños, sin contar los suyos, que **NO** están recibiendo subsidios para el cuidado infantil?

1) ☐ **Sí.** *Si "sí", indique el número de niños sin subsidio, sin contar a los suyos, abajo.*

a) Número de niños de parientes sin subsidio:_____.

a) Número de niños sin subsidio de personas sin parentesco: _____.

Nota: Todos los niños sin subsidio bajo cuidado DEBEN ser listados en la página anterior.

2) ☐ **No.**

C) ¿Ha comenzado a proveer cuidado infantil para todos los niños cuyos horarios se indican anteriormente?

1) ☐ **Sí.**

2) ☐ **No**. *Si "no",* ¿cuándo se iniciará el cuidado?

_____

NOTA: Si hay algunos cambios en el número de niños que usted cuida, las horas durante las que usted provee cuidado y el lugar donde lo provee puede afectar su elegibilidad como proveedor(a) legalmente exento y/o requerir que obtenga una licencia o se inscriba para operar un programa de cuidado diurno. Tales cambios deben reportarse a la agencia encargada de la inscripción inmediatamente.

F. LISTA DE VERIFICACIÓN DE SALUD Y SEGURIDAD

El proveedor(a) y el padre/madre/encargado(a) inspeccionan el lugar del establecimiento de cuidado infantil y completan la sección de abajo juntos.

Yo satisfago y estoy de acuerdo en continuar satisfaciendo los requisitos básicos de salud y seguridad indicados abajo.
Marque ☑ una respuesta para cada ítem de abajo.

SI	NO	El proveedor(a) satisface los siguientes requisitos básicos de salud y seguridad antes de cuidar a los niños:
☐	☐	1. Yo y todos los niños tienen dos salidas separadas y distantes para salir del edificio en caso de emergencias.
☐	☐	2. Las habitaciones de los niños tienen buena calefacción, están bien iluminadas y están bien ventiladas.
☐	☐	3. Mi establecimiento de cuidado infantil está libre de áreas no seguras (como piscinas, zanjas de desagüe abiertas, pozos de agua, hoyos, estufas a leña o a carbón, chimeneas y calentadores de ambiente a gas). Si hay áreas que no son seguras, las mismas están rodeadas por barreras resistentes que impiden que los niños se acerquen.
☐	☐	4. Si se provee cuidado infantil en pisos superiores, existen barandas o cerrojos en las ventanas para evitar que los niños se caigan.
☐	☐	5. El suministro de agua es seguro. Los baños funcionan. Hay agua corriente, caliente y fría, en todo momento.
☐	☐	6. Yo, todos los empleados y voluntarios que pueden tener contacto regular con los niños están físicamente, emocionalmente y mentalmente aptos para atender a los niños.
☐	☐	7. Yo, todos los empleados y voluntarios que pueden tener contacto regular con los niños no padecemos de ninguna enfermedad contagiosa que pueda poner en riesgo la salud y la seguridad de los niños bajo cuidado. Si yo, un empleado(a) o voluntario(a) que pueda tener contacto regular con los niños tiene una enfermedad contagiosa, yo debo obtener una declaración del médico(a) de esa persona que indique que la presencia de una enfermedad contagiosa no pone en riesgo la salud y la seguridad de los niños bajo cuidado. ☐ He ADJUNTADO una declaración de un médico, si yo, un empleado(a) o voluntario(a) que pueda tener contacto regular con los niños tiene una enfermedad contagiosa, y esa enfermedad no pone en riesgo la salud y la seguridad de los niños bajo cuidado.
☐	☐	8. Mi establecimiento de cuidado infantil está libre de condiciones peligrosas o inseguras que podrían lastimar a los niños. Esto incluye, pero no se limita a: • Los cuchillos y otros objetos cortantes están fuera del alcance de los niños. • Los tapetes, las alfombritas o alfombras continuas, y los cables eléctricos están sujetos para que los niños no se tropiecen. • Los cables eléctricos no corren por debajo de los muebles o las alfombras y están fuera del alcance de los niños pequeños. • Los cables de extensión no están sobrecargados. • Las pistolas y otras armas de fuego están descargadas y guardadas bajo llave, y la llave se mantiene en un lugar seguro. La munición se guarda por separado. • Las cuerdas de las persianas y cortinas de las ventanas están fuera del alcance de los niños. • Los líquidos calientes están fuera del alcance de los niños. • Los artículos pequeños con los que los niños podrían sofocarse están fuera de su alcance. • Los detectores de monóxido de carbono están instalados donde los niños que cuido duermen o descansan y en cada piso del hogar donde se provee cuidado.
☐	☐	9. Los fósforos, encendedores, medicamentos/drogas, artículos de limpieza, detergentes, aerosoles y otros materiales venenosos o tóxicos están almacenados en sus envases originales. Se presta la debida atención para que éstos no entren en contacto con los niños, no estén donde se preparan los alimentos o en otro sitio que pudiese ser riesgoso para los niños. Todos estos materiales se guardan en un lugar seguro, fuera del alcance de los niños.
☐	☐	10. Cada niño(a) recibirá las comidas y los bocadillos acordados entre el padre, la madre, el tutor(a) o encargado(a) y el proveedor(a).
☐	☐	11. Yo refrigeraré la leche, la leche de fórmula y otros alimentos que se echan a perder si se dejan afuera.

SI	**NO**	**El proveedor(a) satisface los siguientes requisitos básicos de salud y seguridad antes de cuidar a los niños:**
☐	☐	12. Yo no calentaré la leche de fórmula, la leche materna y demás alimentos para lactantes en hornos de microondas.
☐	☐	13. Yo siempre permitiré que el padre, la madre o el tutor(a) o encargado(a) con custodia tenga acceso ilimitado a su(s) niño(s) bajo cuidado, al lugar del programa mientras el/los niño(s) permanezca(n) allí, y a los registros escritos relacionados con el niño(a).
☐	☐	14. Yo llevaré a cabo simulacros o ejercicios de evacuación con los niños por lo menos una vez al mes para que ellos sepan qué hacer en caso de emergencias.
☐	☐	15. Tengo un teléfono que funciona O puedo conseguir uno rápidamente en caso de emergencias. Los números de teléfono del departamento de bomberos, de la policía local o estatal o alguacil de policía o "sheriff", del centro de toxicología y del servicio de ambulancias se encuentran cerca del teléfono y son fáciles de ver.
☐	☐	16. Usaré cubiertas de enchufe, protectores o instalaré dispositivos de seguridad en todos los enchufes eléctricos que un niño(a) podría alcanzar cuando cuide a un niño(a) menor de 5 años de edad.
☐	☐	17. La pintura y el yeso de las paredes están en buen estado, de modo que no hay peligro de que los niños se lleven trocitos de yeso o de pintura a la boca ni de que éstos caigan en los alimentos.
☐	☐	18. Tengo como mínimo un detector de humo en funcionamiento en cada ambiente de la vivienda. Lo controlaré periódicamente para asegurarme de que todos los detectores funcionen.
☐	☐	19. Tengo un botiquín de primeros auxilios portátil en mi establecimiento de cuidado infantil de fácil acceso en caso de emergencias y mis abastecimientos de primeros auxilios están en un recipiente limpio, fuera del alcance de los niños. Tiene los elementos necesarios para tratar las lesiones y los problemas infantiles comunes. Reemplazaré los abastecimientos del botiquín de primeros auxilios a la brevedad posible, después de haberlos usado o de que venzan.
☐	☐	20. He RECIBIDO del padre/madre/encargado(a) del niño(a) o de los niños un(a): • Comprobante firmado de un médico(a) u otro proveedor(a) de atención médica que: el/los niño(s) han recibido todas las inmunizaciones apropiadas para la edad del/de los/ niño(s); **O** • Comprobante que una o más de las inmunizaciones causarían daño a la salud del/de los niño(s); **O** • Declaración indicando que el/los niño(s) no han sido inmunizados debido a las creencias religiosas del padre/madre/encargado(a) del/de los niño(s).
☐	☐	21. Las gradas, barandas, terrazas y los balcones están en buenas condiciones.

Sólo los proveedores de **Cuidado Infantil en Familia** deben responder las preguntas *número* 22 más abajo.

SI	**NO**	**El proveedor(a) satisface los siguientes requisitos de salud y seguridad antes de cuidar a los niños:**
☐	☐	*22.* Todas las personas que viven en el hogar donde se provee cuidado están libres de enfermedades contagiosas. Si una persona que vive en el hogar tiene una enfermedad contagiosa, debo tener una declaración del proveedor(a) de atención médica de esa persona indicando que la presencia de una enfermedad contagiosa no pone en riesgo la salud o la seguridad de los niños bajo mi cuidado. *23.* ☐ He adjuntado una declaración del médico(a), si alguna persona que vive en el hogar tiene una enfermedad contagiosa, indicando que esa enfermedad no pone en riesgo la salud de los niños bajo mi cuidado.

G. CONDICIONES DE COMPORTAMIENTO DEL PROVEEDOR(A)

Todos los proveedores de cuidado infantil deben responder estas preguntas.

SI	NO	El proveedor(a) satisface y está de acuerdo en cumplir con los siguientes requisitos básicos de salud y seguridad antes de cuidar al niño(s):
☐	☐	1. Yo comprendo y estoy de acuerdo que nunca usaré el castigo corporal o permitiré que otros usen castigo físico mientras el niño(a) o los niños estén bajo mi cuidado. El castigo físico significa hacer daño directamente al cuerpo del niño(a) para castigarlo, como ser: • Pegar, morder, dar palmetazos o bofetadas, sacudir, retorcer, dar apretones; • Hacer que el niño(a) haga ejercicios físicos en exceso; • Forzar a que el niño(a) se quede quieto por largos períodos de tiempo; • Hacer que el cuerpo del niño(a) permanezca en posiciones dolorosas y extrañas; • Bañar al niño(a) en agua extremadamente fría o caliente; y • Forzar a que el niño(a) coma o tenga en su boca jabón, comida, especies o condimentos picantes, substancias extrañas.
☐	☐	2. Yo comprendo y estoy de acuerdo de que nunca usaré o estaré bajo la influencia del alcohol o las drogas mientras los niños estén bajo cuidado y me aseguraré de que los niños bajo mi cuidado no estén en contacto con personas que usan drogas o alcohol.
☐	☐	3. Yo comprendo y estoy de acuerdo en que no fumaré o permitiré que se fume dentro de un lugar o en áreas cerradas, tales como automóviles o vehículos, cuando los niños estén presentes.
☐	☐	4. Yo comprendo y estoy de acuerdo que nunca dejaré a los niños solos o sin supervisión.
☐	☐	5. Yo comprendo y estoy de acuerdo de que SIEMPRE estaré presente cuando los niños estén bajo el cuidado de mis empleados y voluntarios y miembros del hogar, en los casos en que se provea cuidado en un hogar diferente al hogar del niño(a).

H. HISTORIAL RELEVANTE – PERSONAS EN EL LUGAR DE CUIDADO INFANTIL

1. PROVEEDORES SOLAMENTE

A) TERMINACIÓN DE LOS DERECHOS PATERNOS/MATERNOS DEL PROVEEDOR(A)

Yo certifico y atestiguo que *(marque ☑ uno)*:

1) ☐ **Nunca** se me han anulado o cancelado mis derechos de padre/madre bajo la Ley de Servicios Sociales 384-b o una autoridad legal equivalente.
2) ☐ **Se me han anulado o cancelado** mis derechos de padre/madre bajo la Ley de Servicios Sociales 384-b o una autoridad legal equivalente.
   ☐ He **ADJUNTADO** el formulario de *Historial de Terminación de Derechos Paternos/Maternos y/o Retiro del Niño(a)/Niños por Orden del Tribunal según Articulo 10 y Reconocimiento Paterno/Materno* [4] (*OCFS-LDSS-4917-S)*.

B) RETIRO DE NIÑOS DEL PROVEEDOR(A) POR ORDEN DEL TRIBUNAL, ARTÍCULO 10

Yo certifico y atestiguo que *(marque ☑ uno)*:

1) ☐ **Nunca** se retiraron niños de mi cuidado por orden del tribunal, en un proceso legal bajo el Artículo 10 (protección de menores) de la Ley del Tribunal de la Familia.
2) ☐ **Se retiraron** niños de mi cuidado por orden del tribunal, en un proceso legal bajo el Artículo 10 (protección de menores) de la Ley del Tribunal de la Familia.
   ☐ He **ADJUNTADO** el formulario de *Historial de Terminación de Derechos Paternos/Maternos y/o Retiro del Niño(a)/Niños por Orden del Tribunal según Articulo 10 y Reconocimiento Paterno/Materno* [5] (*OCFS-LDSS-4917-S)*.

[4] Si necesita una copia de este formulario, por favor contacte a su distrito local de servicios sociales o a su agencia encargada de inscribir a proveedores de cuidado infantil legalmente exentos.
[5] Si necesita una copia de este formulario, por favor contacte a su distrito local de servicios sociales o a su agencia encargada de inscribir a proveedores de cuidado infantil legalmente exentos.

C) CUMPLIMIENTO DE RESPONSABILIDADES DEL PROVEEDOR(A) DE CUIDADO DIURNO

Nota: Un programa de "cuidado diurno" incluye centros de cuidado infantil licenciados o registrados, al igual que hogares de cuidado diurno en familia u hogares de cuidado diurno de un grupo en familia, o centros pequeños de cuidado infantil y/o programas de cuidado para niños en edad escolar.

1) Yo certifico y atestiguo que *(marque ☑: uno)*:

☐ **Se me ha negado** una solicitud para una licencia o registro para operar un programa de cuidado infantil diurno.

☐ **No se me ha negado una solicitud** para una licencia o registro para operar un programa de cuidado infantil diurno.

2) Yo certifico y atestiguo que (*marque ☑: uno*):

☐ **Se me ha revocado o suspendido** la licencia o el registro para operar un programa de cuidado diurno.

☐ **No se me ha revocado o suspendido** la licencia o el registro para operar un programa de cuidado diurno.

3) Si se le ha **negado** una licencia o un registro para operar un programa de cuidado diurno infantil o si se le ha **revocado** o **suspendido** una licencia o registro para operar un programa de cuidado infantil, complete lo siguiente:

a) **Nombre del Programa y Lugar:**_____

b) ☐ He **ADJUNTADO** el formulario de *Historial de Ejecutoria de Cuidado Diurno y Reconocimiento del Padre/Madre,*[4] *(OCFS-LDSS-4916-S).*

2. PROVEEDOR(A), EMPLEADOS, VOLUNTARIOS Y MIEMBROS DEL HOGAR

A) HISTORIAL CRIMINAL

1) He listado en la subsección I. C de este formulario a: TODOS los empleados, voluntarios y, si proveo cuidado en un hogar distinto al del hogar del niño(a), a todos los miembros del hogar de 18 años de edad o más que puedan tener contacto regular con los niños bajo cuidado:

☐ **Sí.**

☐ **No.**

2) Si proveo cuidado en un hogar distinto al hogar del niño(a), también he listado a todos los miembros del hogar en la subsección I. C de este formulario.

3) Certifico que he preguntado a las siguientes personas si **han sido sentenciadas o declarado culpables por un crimen**:

- Cada persona que está viviendo en el hogar (a diferencia del hogar propio de los niños) que tienen 18 años de edad o más,
- Cada voluntario que pueda tener contacto regular con los niños bajo cuidado, y
- Cada empleado(a).

☐ **Sí.**

☐ **No.**

4) ¿Ha sido usted, su empleado(a) o su voluntario(a) **sentenciado alguna vez por un crimen** en el Estado de Nueva York o cualquier otro lugar?

☐ **Sí.** Provea los nombres de las personas sentenciadas _____.

☐ He **ADJUNTADO** un formulario completo de *Historial de Convicciones Criminales y Reconocimiento del Padre/Madre (OCFS-LDSS-4915-S),* para cada persona con un historial criminal.

☐ **No.**

5) Para proveedor(a) tipo Cuidado Infantil en Familia únicamente: ¿ha sido sentenciada por un crimen en el Estado de Nueva York u otro lugar alguna persona que vive en el hogar donde se provee cuidado infantil y tiene 18 años o más de edad?

☐ **Sí.** Provea los nombres de las personas sentenciadas _____.

☐ He **ADJUNTADO** un formulario completo de *Historial de Convicciones Criminales y Reconocimiento del Padre/Madre,(OCFS-LDSS-4915-S), para cada persona con un historial criminal.*

☐ **No**.

B) REPORTES INDICADOS DE ABUSO Y MALTRATO INFANTIL

He pedido a TODOS los empleados, voluntarios e individuos quienes estén ayudando con el cuidado de niños o quienes tengan contacto regular con los niños y, si proveo cuidado en un hogar diferente al hogar donde residen los niños, a todos los miembros del hogar de 18 años de edad o mayores, si ellos han sido sujetos a un reporte de abuso o maltrato infantil indicado. He informado al padre/madre/encargado(a) si yo o cualesquiera de estos individuos han sido sujetos de algún informe indicado de abuso o maltrato infantil. Cuando se ha dado la existencia de una indicación de abuso o maltrato infantil, he provisto por escrito al padre/madre/encargado(a) información verdadera y correcta, incluyendo:

- Una descripción del o los incidente(s), y
- La fecha de la(s) indicación/indicaciones, y
- Cualquier otra información relevante con respecto a la(s) indicación/indicaciones.

☐ **SÍ.**

☐ **No.**

I. ACUERDOS DEL PROVEEDOR(A) Y CERTIFICACIONES

1. PRESENTANDO ACTUALIZACIONES Y CAMBIOS EN LA INFORMACIÓN DE LA INSCRIPCIÓN

- Yo presentaré inmediatamente un nuevo formulario de inscripción a la agencia de inscripción si empiezo a proveer cuidado infantil en un lugar diferente al indicado en este formulario.
- Yo informaré a la agencia inmediatamente si hay cambios en:
  - mis datos de contacto,
  - los niños que cuido o las horas en las que proveo cuidado,
  - las personas que tienen contacto con lo niños bajo mi cuidado,
  - cualquier información provista en el formulario de inscripción o cambios en los adjuntos.
- Yo informaré a la agencia encargada de la inscripción inmediatamente cuando:
  - Cualquier persona de 18 años o más se traslade al hogar donde se provea “Cuidado Infantil en Familia” o se quede más de unos días (Cuidado infantil en **Familia** solamente).
  - Cualquier niño(a) que esté viviendo en el hogar donde se provea “Cuidado Infantil en Familia” que cumpla los 18 años de edad. (Cuidado Infantil en **Familia** solamente)
  - Yo contrato o recibo ayuda para cuidar a los niños.

2. REQUISITOS DE SALUD Y SEGURIDAD

- Yo comprendo que no puedo ser inscrito y que el pago no puede efectuarse hasta que todos los ítems marcados “No” sean corregidos en la Lista de Verificación de Salud y Seguridad y la Lista de Verificación de Condiciones de Comportamiento.
- Yo continuaré satisfaciendo todos los requisitos básicos de salud y seguridad listados en las lista de verificación y
  - El padre/madre/encargado(a) y yo hemos inspeccionado el hogar y hemos completado la Lista de Verificación de Salud y Seguridad y la Lista de Condiciones de Comportamiento del Proveedor(a) juntos.
  - Yo notificaré y proveeré documentación a la agencia encargada de la inscripción cuando cualquier ítem en las listas haya sido corregido o haya cambiado.

3. COMPARTIENDO INFORMACIÓN Y LA VERIFICACIÓN DE DATOS

- Yo autorizo a la agencia encargada de la inscripción y al Programa Alimenticio para Niños y Adultos (*Child and Adult Care Food Program--CACFP*) a intercambiar información respecto a mi status de inscripción de cuidado infantil y mi participación en CACFP.
- Yo comprendo que la agencia encargada de la inscripción y el distrito de servicios sociales intercambiará información con respecto a mi estado de inscripción de cuidado infantil.
- Yo comprendo que el distrito de servicios sociales local verificará su archivo de datos de bienestar infantil para encontrar mi historial relacionado al retiro de niños ordenado por un tribunal bajo la Ley del Tribunal de la Familia (*Family Court Act--FCA*) Artículo 10 y cualquier terminación de los derechos paternales/maternales.

- Yo comprendo que la agencia encargada de la inscripción verificará información con el Registro de Ofensores Sexuales del Estado de Nueva York (*New York State Sex Offender Registry*) para determinar si yo, cualquier voluntario(a) que pueda tener contacto con niños bajo cuidado, cualquier empleado(a), y para el proveedor(a) de cuidado infantil legalmente exento en familia, cualquier persona viviendo en el hogar donde se provee cuidado infantil, de 18 años de edad o más esté listado en el Registro de Ofensores Sexuales.
- Yo comprendo que la agencia encargada de la inscripción verificará con el Sistema de Establecimientos de Cuidado Infantil del Estado de Nueva York (*New York State Child Care Facility System*) si se me ha negado alguna vez la licencia o el registro de cuidado diurno infantil o si se me ha suspendido o revocado la licencia o el registro de cuidado infantil.

4. ELEGIBILIDAD Y PAGOS

- Yo comprendo que no puedo ser pagado como proveedor(a) de cuidado infantil legalmente exento si soy el padre/madre del niño(a), padrastro/madrastra, padre/madre adoptivo(a), tutor(a) legal u otra persona responsable legalmente por los niños, o si yo vivo en el mismo hogar y tengo a un niño(a) en común con el padre o la madre.
- Yo estoy de acuerdo en colectar la cuota de la familia si el distrito de servicios sociales local me instruye hacerlo. Notificaré de inmediato al distrito de servicios sociales local si el padre/madre/encargado(a) deja de pagar la cuota requerida de la familia.
- Yo estoy de acuerdo en proveer récords de asistencia correctos, a tiempo, como lo requiere el distrito de servicios sociales local.
- Yo comprendo que el distrito de servicios sociales local no me pagará por ningún cuidado infantil provisto a niños que estén recibiendo subsidio de cuidado infantil mientras la agencia encargada de la inscripción me considere un proveedor(a) inelegible.
- Yo comprendo que debo estar inscrito(a) con la agencia encargada de inscripción antes de que se pueda emitir cualquier pago.
- Yo comprendo que puede que yo no sea elegible para proveer cuidado infantil Y que el distrito de servicios sociales local no me pague cuando:
    - Tenga un historial de retiro de niños por orden del tribunal de familia relacionado al Artículo 10 (protección de menores), o
    - Tenga un historial de terminación de derechos paternales/maternales, o
    - Tenga un historial de denegación, revocación y/o suspensión de una licencia o registro para operar un programa de cuidado infantil diurno, o
    - Yo, cualquier voluntario(a) que pueda tener contacto regular con el/los niño(s); o para cuidado infantil en familia, cualquier persona de 18 años de edad o más que esté viviendo en el hogar haya sido sentenciado por un crimen.
- Yo comprendo que <u>no soy elegible</u> para proveer cuidado infantil si yo, cualquier voluntario que pueda tener contacto regular con los niños, cualquier empleado o persona que viva en el hogar (a excepción del hogar o residencia de los niños) de 18 años o más de edad haya sido sentenciado por un crimen contra un niño(a) o esté en la lista del Registro de Ofensores Sexuales.
- Yo comprendo que si la agencia encargada de la inscripción determina que no puedo inscribirme, entonces el distrito de servicios sociales local no puede emitir pago por el cuidado que he provisto. El padre/madre/encargado(a) tiene el derecho y la responsabilidad de decidir si él/ella desea utilizar mis servicios de cuidado infantil. Si el padre/madre/encargado(a) elige usar mis servicios de cuidado infantil cuando no puedo inscribirme, el padre/madre/encargado(a) es responsable por pagarme por el cuidado infantil.

5. OTROS ACUERDOS

- Yo comprendo y estoy de acuerdo en permitir que representantes de la agencia encargada de la inscripción, el distrito de servicios sociales y el Estado de Nueva York tengan acceso a los establecimientos donde se provee cuidado infantil a niños con subsidio para confirmar que la información relativa al formulario de inscripción y/o de asistencia sea acertada, y que se estén proveyendo servicios de cuidado infantil tal como se indica en estos formularios. Comprendo que si yo no permito ese acceso, entonces yo seré considerado un proveedor(a) inelegible, se anulará o cancelará mi inscripción, y el distrito de servicios sociales local no me pagará.
- Yo comprendo que si se me niega la inscripción, puedo solicitar que la agencia encargada de inscripciones revise cualquier circunstancia extenuante para determinar si se podría hacer una excepción para permitirme proveer cuidado infantil. Si solicito una excepción, debo proveer todos los documentos o referencias requeridas por la agencia encargada de la inscripción.
- Yo comprendo y estoy de acuerdo en satisfacer todas las condiciones declaradas en este formulario, siempre y cuando esté proveyendo cuidado infantil. Comprendo que se me requiere informar a la

agencia encargada de la inscripción y al padre/madre/encargado(a) si hay un cambio en la información declarada en el formulario de inscripción.

6. CERTIFICACIÓN DEL PROVEEDOR(A)

Al firmar este formulario, yo certifico que a mi mejor conocimiento:

- Yo comprendo y estoy de acuerdo en continuar satisfaciendo todas las condiciones enumeradas anteriormente.
- He revisado la "Sección de Información para el Padre/Madre" de este formulario.
- Yo comprendo que la decisión de inscribirme se basa en los datos provistos y atestiguados en el formulario de inscripción. La provisión de información falsa o deliberadamente ocultar información puede resultar en una determinación inadecuada de mi elegibilidad para proveer cuidado infantil a niños con subsidio y/o un rechazo o denegación, o cancelación o revocación terminación de la inscripción. Si proveo servicios de cuidado infantil mientras estoy inscrito con pretensiones falsas, o mientras soy inelegible para ser proveedor(a) de cuidado infantil, el Distrito de Servicios Sociales Local puede rehusare a emitir pagos de subsidio de cuidado infantil, cancelar los pagos de subsidio de cuidado infantil, tomar acción legal contra mi persona o el padre/madre/encargado(a), y puede que se me requiera reembolsar cualquier dinero que haya recibido por servicios provistos.
- Bajo la penalidad de perjurio, estoy de acuerdo en que de acuerdo a mi mejor conocimiento, todas las declaraciones hechas en este formulario de inscripción y otros adjuntos son verdaderas y correctas.

FIRMA DEL PROVEEDOR(A):	FECHA:
X	

FORMULARIO DE INSCRIPCIÓN PARA PROVEEDORES DE SERVICIOS DE CUIDADO INFANTIL LEGALMENTE EXENTO Y DE CUIDADO INFANTIL A DOMICILIO

II. SECCIÓN DE INFORMACIÓN DEL PADRE/MADRE/ENCARGADO(A)

El padre/madre/encargado(a) que está recibiendo o solicitando un subsidio por cuidado infantil debe completar esta sección Y revisar la sección del "Proveedor(a) de Cuidado Infantil".

A. INFORMACIÓN DEL PADRE/MADRE/ENCARGADO(A)[6]

1. **Nombre del Padre/Madre/Encargado(a)**:

   ☐ Sr. ☐ Sra. ☐ Srta.

   Apellido Nombre IM Sufijo

   Otros nombres por los cuales se le conoce:
   Nombre de soltero(a), casado(a), seudónimos, etc.

2. **Información de Identificación y de Contacto**:

   Fecha de Nacimiento: / / (mm/dd/yyyy) Tel. de la Casa: ( ) ☐ Listado ☐ No publicado

   Tel. del Trabajo: ( ) Tel. Celular:( )

   Dirección Electrónica[7]: ☐ No Dirección Electrónica

3. ¿Lee inglés? ☐ **Sí.** ☐ **No.** Si "no", ¿qué idiomas lee mejor? _____.
4. ¿Habla inglés? ☐ **Sí.** ☐ **No.** Si "no", ¿qué idiomas lee mejor? _____.
5. ¿Se provee cuidado infantil en su hogar? ☐ **Sí.** ☐ **No.**
6. Provea la dirección de su casa abajo.

   Dirección de la Casa:

   Número de Casa Calle Apto.

   Dirección-Línea 2 Piso

   Ciudad Estado Zona Postal Condado/Boro

7. **Dirección de Correos**: ¿Es su dirección de correos la misma que su dirección de su casa? ☐ **Sí.** ☐ **No.**
   Si su dirección es <u>diferente</u> a la dirección de casa, por favor provea su dirección de correos abajo.

   Número de Casa Calle Apto.

   Dirección-Línea 2 Piso

   Ciudad Estado Zona Postal

8. Provea información acerca de su caso de Subsidio por Cuidado Infantil:

   Condado que Paga el Subsidio: No de Asistencia Temporal[7]:

   Número de Caso de Subsidio[8]: Número de Padre/Madre CIN[7]:

[6] Encargado(a) se refiere al padre/madre de un niño(a), tutor(a) legal, pariente encargado del niño(a) o cualquier otra persona con la que el niño(a) vive que ha asumido la responsabilidad por el cuidado diario y la custodia del niño(a).
[7] La dirección electrónica dada puede ser usada por la agencia de inscripción para contactarle.

B. SUS HIJOS BAJO CUIDADO DEL PROVEEDOR(A)

1. LISTE A SU(S) HIJO(S) QUE CUIDA EL PROVEEDOR(A)

Añada hojas adicionales si es necesario.

A) Nombre del Niño(a): _____ Fecha de Nacimiento: / /
Apellido Nombre (mm/dd/yyyy)

Relación del Proveedor(a) con el Niño(a): _____ CIN del Niño(a)[9]: _____

B) Nombre del Niño(a): _____ Fecha de Nacimiento: / /
Apellido iNombre (mm/dd/yyyy)

Relación del Proveedor(a) con el Niño(a): _____ CIN del Niño(a): _____

C) Nombre del Niño(a): _____ Fecha de Nacimiento: / /
Apellido Nombre (mm/dd/yyyy)

Relación del Proveedor(a) con el Niño(a): _____ CIN del Niño(a): _____

D) Nombre del Niño(a): _____ Fecha de Nacimiento: / /
Apellido Nombre (mm/dd/yyyy)

Relación del Proveedor(a) con el Niño(a): _____ CIN del Niño(a): _____

2. LAS NECESIDADES DE MEDICAMENTOS DE MI(S) HIJO(S)

Yo comprendo que los proveedores de cuidado infantil **no pueden** administrar medicamentos a los niños excepto de la siguiente manera:

- Cualquier proveedor(a) de cuidado infantil puede administrar únicamente pomadas de uso externo y venta libre, protectores solares y repelentes de insectos de uso externo con el permiso de los padres.
- Cuando el proveedor(a) de cuidado infantil provee cuidado en el hogar del niño(a), el proveedor(a) puede administrar medicamentos de venta libre y medicamentos prescritos con el permiso del padre/madre y siguiendo las instrucciones del médico.
- Cuando el proveedor(a) de cuidado infantil tiene parentesco con el padre/madre o padrastro/madrastra del niño(a) dentro de un tercer grado de consanguinidad (por sangre o por matrimonio), el proveedor(a) puede administrar medicamentos de venta libre y prescripciones con el permiso del padre/madre y las instrucciones del médico. El proveedor(a) de cuidado infantil debe tener una de las siguientes relaciones para ser considerado un pariente de tercer grado:
  - el abuelo(a) del niño(a),
  - el tatarabuelo(a) del niño(a),
  - el tío(a) abuelo(a) (y sus cónyuge),
  - el primo(a) hermano(a) del niño(a) (y su cónyuge)
  - el bisabuelo(a) del niño(a)
  - el tío(a) del niño(a) (y su cónyuge)
  - el hermano(a) del niño(a)
- Cuando el proveedor(a) de cuidado infantil es un médico licenciado, un médico asistente, una enfermera registrada o una enfermera practicante, el proveedor(a) puede administrar prescripciones o medicamentos de venta libre a niños cuyo cuidado es subsidiado con el permiso del padre/madre y siguiendo las instrucciones del médico.
- Cuando el programa de cuidado infantil es autorizado por OCFS y sigue un Plan de Salud de Administración de Medicamentos, el administrador(a) de medicamentos designado en el plan puede administrar medicamentos de venta libre y algunos medicamentos con prescripción a niños que reciben subsidio por cuidado infantil, con el permiso del padre/madre y siguiendo instrucciones del médico.

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[8] El número de asistencia temporal, el número de caso del subsidio y el número de identificación del cliente para los padres o CIN son opcionales Si se proveen, se utilizarán para facilitar el compartimiento de información con los distritos de servicios sociales locales con respecto a su elegibilidad y el pago por cuidado infantil.

9 El Número de Identificación del Cliente (*Client Identification Number--CIN*) es opcional. Si se lo provee, se lo utilizará para facilitar el compartimiento de información con los distritos de servicios sociales locales con respecto a su elegibilidad y el pago por cuidado infantil.

He leído las "Calificaciones del Proveedor(a) para Administrar Medicamentos" en la Sección I del Proveedor(a), y "Las Necesidades de Medicamentos de Mis Hijos", y comprendo hasta qué punto mi proveedor(a) de cuidado infantil legalmente exento está permitido administrar medicamentos a mis hijos. Mi proveedor(a) de cuidado infantil y yo estamos de acuerdo en que:

☐ El padre/madre será responsable por las necesidades de medicamentos de los siguientes niños:

_____.

☐ El proveedor(a) será responsable por las necesidades de medicamentos de los siguientes niños:

_____.

3. Las Comidas y Meriendas de Mi(s) Hijo(s)

Para cada niño(a) nombrado en la página anterior, ya sea el padre/madre o el proveedor(a) debe proveer comidas y meriendas. ¿Quién proveerá comidas y meriendas para sus hijos mientras estén bajo cuidado?

☐ El padre/madre será responsable por las comidas y las meriendas de los siguientes niños:

_____.

☐ El proveedor(a) será responsable por las comidas y las meriendas de los siguientes niños:

_____.

C. Historial Relevante del Proveedor(a) y Personas en el Establecimiento de Cuidado Infantil

1. Yo comprendo que el proveedor(a) de cuidado infantil debe informarme si las personas que puede que tengan contacto con mis hijos han sido sujetas a un informe indicado de abuso o maltrato infantil:
   - proveedor(a)
   - voluntarios que puedan tener contacto regular con los niños bajo cuidado,
   - empleados, y
   - si no se provee cuidado en mi hogar, las personas que viven en el hogar de 18 años o más.

   ☐ **Sí.**
   ☐ **No.**

- He preguntado específicamente al proveedor(a) si voluntarios que puede que tengan contacto con mis hijos, empleados y personas de 18 años o más de edad (si se provee cuidado en el hogar del proveedor[a]), han sido nombrados en un informe de abuso y maltrato infantil.
- El proveedor(a) me ha informado si existe algún informe indicado de abuso o maltrato infantil y quién fue el sujeto nombrado en el informe: el proveedor(a), empleados, voluntarios que puede que tengan contacto regular con mis hijos bajo cuidado, y personas que viven en el hogar de 18 años de edad o más (si se provee cuidado en el hogar del proveedor[a]).
- Cuando existe una indicación de abuso o maltrato infantil, el proveedor(a) me ha provisto información escrita respecto a esa indicación de abuso o maltrato infantil. Yo comprendo que tengo el derecho de escoger a otro proveedor(a). Estoy de acuerdo en que he considerado cuidadosamente la información provista sobre las indicaciones de abuso y maltrato infantil, y estoy seleccionando a este proveedor(a) teniendo en cuenta esa información.

  ☐ **Sí.**
  ☐ **No.**

D. Reconocimiento del Padre/Madre y Acuerdos

1. Responsabilidades del Padre/Madre de Controlar la Calidad del Cuidado

- Certifico que yo he seleccionado a este(a) proveedor(a) de cuidado para cuidar a mis hijos.
- He revisado cada ítem en la Lista de Verificación de Salud y Seguridad y la Lista de Condiciones de Comportamiento del Proveedor(a) con el proveedor(a) en la Sección del Proveedor(a) de Cuidado Infantil, y toda la información en la lista es verdadera y correcta.
- Comprendo que es mi responsabilidad controlar la calidad del cuidado que recibe(n) mi(s) hijo(s) por parte del proveedor(a) de cuidado infantil.
- Comprendo que estos acuerdos se aplican siempre y cuando este proveedor(a) esté cuidando a mi(s) hijo(s).

2. Cambios a la Información de Inscripción

- Yo notificaré inmediatamente a la agencia de inscripción si:
  - Mi dirección o número de teléfono cambia

- Tengo alguna preocupación acerca de la salud o seguridad de mis hijos en el establecimiento del proveedor(a) de cuidado.

3. ASUNTOS DE ELEGIBILIDAD Y PAGOS

- Yo notificaré inmediatamente al distrito de servicios sociales y a mi proveedor(a) cuando cambien las horas que necesito cuidado infantil u otras circunstancias relacionadas a mis necesidades o elegibilidad para cuidado infantil.
- Estoy de acuerdo de pagar mi cuota familiar, si se aplica, según lo dicte el distrito de servicios sociales local.
- Yo comprendo que un proveedor(a) de cuidado infantil que es el hijo(a) del padre/madre, el padrastro o madrastra, padre/madre adoptivo(a), guardián legal u otra persona responsable legalmente por ese niño(s) que vive en el mismo hogar y tiene un hijo(s) en común conmigo no puede recibir pagos.
- Yo comprendo que el proveedor(a) debe ser aceptado para ser inscrito con la agencia de inscripción antes de que se pueda emitir algún pago.
- Yo comprendo que un proveedor(a) no es elegible para proveer cuidado infantil si el proveedor(a), cualquier voluntario(a) que tiene la probabilidad de tener contacto regular con mi(s) hijo(s), cualquier empleado(a), o para cuidado infantil en familia, cualquier persona de 18 años o más que está viviendo en el hogar donde se provee cuidado infantil:
  - Ha sido sentenciado por un crimen contra algún niño(s) o
  - Está en la lista del Registro de Ofensores Sexuales.
- Yo comprendo que mi proveedor(a) puede que no sea elegible para proveer cuidado infantil y que el distrito de servicios sociales puede que no pueda pagar al proveedor(a) cuando:
  - El proveedor(a) tenga un historial de terminación de derechos paternales/maternales, o
  - El proveedor(a) tenga un historial de retiro de niños según el Artículo 10 (protección de menores) por orden del Tribunal de la Familia, o
  - Al proveedor(a) se le haya negado o revocado y/o suspendido una licencia o registro para operar un programa de cuidado infantil diurno, o
  - El proveedor(a), cualquier voluntario(a) que pueda tener contacto regular con mi(s) hijo(s), cualquier empleado(a) o para cuidado infantil en familia, cualquier persona de 18 años o más que esté viviendo en el hogar donde se provea cuidado infantil haya sido sentenciada por un crimen:
- Comprendo que si al proveedor(a) se le niega la inscripción o si se termina o cancela su inscripción, el proveedor(a) será considerado inelegible para proveer cuidado infantil.
- El distrito de servicios sociales local no puede pagar al proveedor(a) o emitir un pago por el cuidado provisto por un proveedor(a) que no esté inscrito o sea inelegible. Si elijo usar un proveedor(a) inelegible, yo soy responsable de pagar por el cuidado infantil. Comprendo que tengo el derecho de seleccionar a otro proveedor(a).

4. REQUISITOS DE SALUD Y SEGURIDAD

- Yo comprendo que el pago no puede hacerse hasta que todos los ítems marcados ““No” se corrijan en la Lista de Condiciones de Comportamiento y la Lista de Salud y Seguridad.
- Yo comprendo que el proveedor(a) debe continuar satisfaciendo tolos los requisitos básicos de salud y seguridad y la condiciones de comportamiento indicadas en las listas de verificación.
  - El proveedor(a) y o hemos inspeccionado el hogar, hemos completado la Lista de Lista de Salud y Seguridad y la Lista de Condiciones de Comportamiento juntos.
  - Todas las declaraciones en las listas de verificación son verdaderas y acertadas.
  - El proveedor(a) y yo notificaremos y proveeremos documentación a la agencia de inscripción cuando cualquier ítem en la lista de verificación se corrija o cambie.

5. CERTIFICACIÓN DEL PADRE/MADRE/ENCARGADO(A)

Al firmar este formulario, certifico de acuerdo a mi mejor conocimiento que:

- He revisado la "Sección para el Proveedor(a) de Cuidado Infantil" de este formulario.
- Comprendo y estoy de acuerdo en satisfacer todas las condiciones declaradas anteriormente.
- Comprendo que la decisión de inscribir a mi proveedor(a) se basa en los hechos provistos y atestiguados en el formulario de inscripción. La provisión de información falsa o el ocultar deliberadamente información puede resultar en una determinación incorrecta de la elegibilidad de mi proveedor(a) para proveer cuidado infantil subsidiado, y/o una negación o terminación de la inscripción. Si my proveedor(a) provee servicios de cuidado infantil mientras está inscrito bajo identidades falsas o mientras él/ella es un proveedor(a) de cuidado infantil inelegible, el Distrito de Servicios Sociales puede rehusarse a emitir pagos por subsidio, cancelar los pagos de subsidio de cuidado infantil, tomar acción legal contra mí o el proveedor(a) de cuidado infantil.
- Bajo la penalidad de perjurio, estoy de acuerdo en que de acuerdo a mi mejor conocimiento, todas las declaraciones hechas en este formulario de inscripción y otros adjuntos son verdaderas y correctas.

FIRMA DEL PADRE/MADRE/ENCARGADO(A)	FECHA

Este formulario de inscripción es un acuerdo legal. Por favor haga una copia de este formulario para sus récords. Devuelva este formulario y sus adjuntos a:

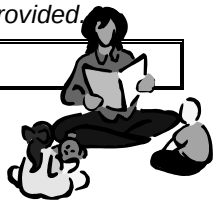
NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ENROLLMENT FORM FOR PROVIDER OF LEGALLY-EXEMPT GROUP CHILD CARE

Group child care providers, who are not required by NYS law to be licensed or registered to operate a day care program, and who are not providing "informal" child care in a residence, use this form to enroll with a legally-exempt caregiver enrollment agency to provide subsidized child care. (Regulatory reference: 18 NYCRR 415).

Instructions: *Please use black/blue pen.*

- *Provider/director must complete the "Child Care Provider Section" of this form and parent must review. Parent/caretaker must complete the "Parent Information Section" of this form and provider/program director must review.*
- *Both parent and provider/program director must sign at the end of the section.*
- *Submit the completed form to the enrollment agency serving the location where the child care is being provided.*



I. CHILD CARE PROVIDER SECTION

A. CHILD CARE PROVIDER/DIRECTOR AND PROGRAM

1. **Child Care Provider/Program Director[1] Name:**

☐ Mr. ☐ Mrs. ☐ Ms.

Last First MI Suffix

Other names known by:

Maiden, married, aliases, etc.

2. **Program Name and Federal Identification Number *(Complete only if applicable):***

DBA (Doing Business As): Federal Identification No:

Legal Name:

3. **Identifying and Contact Information:**

Enrollment Number: (If Applicable) Site Phone: ( ) ☐ Unlisted

Date of Birth: (mm/dd/yyyy) / / Home Phone: ( ) ☐ Unlisted

Gender (M or F): Cell Phone: ( ) Fax: ( )

Social Security No.[2]: E-Mail Address[3]: ☐ No E-Mail Address

4. **Child Care Location:** Give address where the child care is being provided.

Building Number Street Apt.

Address Line 2 Floor

City State Zip County/Borough

(For Enrollment Agency Use)	**(For Local District Use)**
Received Date ____/____/____	Parent's Case No. Type: Local ☐; WMS ☐
Complete Date ____/____/____	LSSD Office/Unit/Wkr. No. ____/____/____/

[1] Director means the person who has responsibility for the development and supervision of the daily activity programs for children and the administrative authority and responsibility for the daily operations of the child care program.

[2] The Social Security Number is not required when a federal identification number is present. The social security number or federal identification number is **required when the local social services district issues child care subsidy payments** directly to a child care provider/program. Failure to provide the social security or federal identification number may delay payment. Social security number of the provider or federal identification of the program is **optional** when the local social services district issues child care subsidy checks to subsidy recipient (parent/caretaker). If the social security number or federal identification is provided, it may also be used by federal, State & local agencies for federal reporting, to prevent duplication of services and to prevent fraud.

[3] The e-mail address, if given, may be used by the enrollment agency to contact you.

5. Mailing Address: Is your mailing address the same as the child care location address given on page one?
☐ **Yes**.
☐ **No**. If No, give address below.

Building Number Street Apt.

Address Line 2 Floor

City State Zip County/Borough

6. Do you read English? ☐ **Yes** ☐ **No.** If **No**, what language do you read best? _____

7. Do you speak English? ☐ **Yes** ☐ **No.** If **No**, what language do you speak best? _____

8. Operating schedule for the **program listed on page one**.

A) The program operates (choose one):
- ☐ The full calendar
- ☐ School year only
- ☐ Summers Only
- ☐ Other (please describe): _____

B) Provide information in the table below regarding the days and hours of operation for each age group and the numbers of children served.

Ages Served	Days of the Week	Daily Start and End Times	Current Number of Children	Maximum Number of Children
0-2 y				
3-4 y				
5-6 y				
7-12 y				
13+ y				

9. Does your organization operate **any other** child care program at the SAME site/location where you intend to provide child care?
☐ **No.**
☐ **Yes.** *List below all **other** child care programs operated by your organization at the same site. Attach additional papers if needed.*

PROGRAM NAME:	CHILD CARE FACILITY ID NO.: ☐ NYS License/ Registration ☐ NYS Enrolled Legally-Exempt
PROGRAM DESCRIPTION (Include numbers of children by age, hours of care, etc.):	**OTHER OVERSIGHT AGENCY:** ☐ NYC DOHMH (have Permit) ☐ None ☐ Other Agency: **RESOURCES SHARED WITH PROGRAM ON PAGE ONE:** ☐ Director ☐ Staff ☐ Space ☐ No shared resources ☐ Other resources:
PROGRAM NAME:	CHILD CARE FACILITY ID NO.: ☐ NYS License/ Registration ☐ NYS Enrolled Legally-Exempt
PROGRAM DESCRIPTION (Include numbers of children by age, hours of care, etc.):	**OTHER OVERSIGHT AGENCY:** ☐ NYC DOHMH Permit ☐ None ☐ Other Agency: **RESOURCES SHARED WITH PROGRAM ON PAGE ONE:** ☐ Director ☐ Staff ☐ Space ☐ No shared resources ☐ Other resources:

PROGRAM NAME:	CHILD CARE FACILITY ID NO.: ☐ NYS License/ Registration ☐ NYS Enrolled Legally-Exempt
PROGRAM DESCRIPTION (Include numbers of children by age, hours of care, etc.):	**OTHER OVERSIGHT AGENCY:** ☐ NYC DOHMH Permit ☐ None ☐ Other Agency:
	RESOURCES SHARED WITH PROGRAM ON PAGE ONE: ☐ Director ☐ Staff ☐ Space ☐ No shared resources ☐ Other resources:

10. Legally-exempt group child care means child care provided by a provider/program, which is *not* a legally-exempt family child care or in-home childcare provider/program, AND, which is *not required* to be licensed or registered with the Office of Children and Family Services, *or* licensed by the City of New York, but which meets all applicable State or local requirements for such child care programs. The provider/program must meet the following requirement to be enrolled as legally-exempt.

    I, the provider and/or program director, attest that my program is NOT providing child care that is required to be licensed or registered with the Office of Children and Family Services, or licensed by the City of New York.

    ☐ **Yes**. If you have supportive[4] documentation, please provide it.

    ☐ **No.**

B. TYPE OF LEGALLY-EXEMPT CHILD CARE THAT YOU PROVIDE

To be enrolled to provide subsidized child care services, the provider/program director must attest that:

- The provider/program is LEGALLY OPERATING under the auspices of another federal, State or local government agency; **OR**
- The provider/program is NOT REQUIRED to operate under the auspices of another federal, State or local government agency. These programs must meet additional health and safety requirements.

Indicate in question 1 below, whether your program <u>legally operates</u> under the authority of another federal, State, or local government, or tribal agency, or, <u>is not required</u> to do so. Your answer to question 1 will determine whether you answer question 2 or question 3, within this subsection B.

1. Choose the statement below that describes your program.

    ☐ **A)** My program legally **operates under the auspices** of another federal, State, or local government, or a tribal agency AND my program meets all State and local requirement for such program. My program is described in question B.2. PROGRAMS OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY.

    Programs operating under the auspices of another federal, State, tribal or government agency must:

    - Answer question B.2, PROGRAMS OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY, and then
    - Complete <u>only</u> the sections and questions listed immediately below.

        I. Child Care Provider Section
        A. Child Care Provider/Director and Program *(All questions.)*
        B. Type of Legally-Exempt Child Care That You Provide *(Questions 1 and 2)*
        C. Other Qualifications and Program Characteristics,
        #2) Program's Hours of Operation, *and*
        #3) Cost of Care
        F. Relevant History,
        #2) Provider, Employees and Volunteers
        G. Provider Agreements and Certification *(All questions.)*
        H. Provider Certification *(All.)*
        II. Parent Information Section
        A-D.#5. *(All questions are to completed by the parent/caretaker)*
        D. Parental Acknowledgments & Certifications,
        #6) Provider Certification

[4] Supportive documentation, issued by NYS Office of Children and Family Services, or the City of New York, may be required to establish that the provider/program is exempt from the requirement to be licensed/registered by NYS OCFS or NYC DOHMH.

☐ **B)** My program **does not** operate under the auspices of another federal, State, or local government or a tribal agency AND my program is **not legally required** to do such.

Programs that are NOT required to operate under the auspices of another federal, State, tribal or government agency, must:

- Skip question B.2 PROGRAMS OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY, on page 4, and
- Answer question B.3 PROGRAMS NOT OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY, on page 6, then
- Complete the Child Care Provider Section: ALL remaining subsections and questions.
- Complete within II. Parent Information Section, D. Parental Acknowledgements & Certifications: #6, Provider Certification, on page 19.

☐ **C)** None of the above. *Your program might not be eligible to be enrolled. Contact the enrollment agency for assistance.*

2. PROGRAMS OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY*:*

Answer this question only if your answer to question 1, above, was "A".
*Check ☑ to choose the statement A, B, C, D, E, or F, that describes your legally-exempt child care program and the **government or tribal agency under which you operate.** Answer all related questions for the selected program.*

☐ **A)** The program is operated in compliance with applicable **federal** laws and regulations and is **located on federal property**.

1) Name of Federal agency/property where located: _____

2) The type of child care provided is: *(check ☑ all that apply)*
- ☐ Day care center
- ☐ Family day care home
- ☐ Other child care program: _____

☐ **B)** The program is operated in compliance with applicable **tribal** laws and regulations and is **located on tribal property**.

1) Name of Tribe: _____

2) Name of tribal property where located: _____

3) The type of child care provided is: (*check ☑ all that apply*)
- ☐ Day care center
- ☐ Family day care home
- ☐ Other child care program:

☐ **C)** The program is operated under the auspices of the **NYS Department of Education**,
- Is **operated by** a public school district, that is providing elementary or secondary education or both, **in accordance with the compulsory education requirements** of NYS Education Law, **AND**
- Is **located on the same premises** or campus where the elementary or secondary education is provided, **AND**
- The program meets all State and local requirements for such child care programs.

1) Name of school: _____

2) Name of school district: _____

3) The type of child care provided is: (check ☑ all that apply)
- ☐ Nursery school program, providing services only to children three years of age or older
- ☐ Pre-kindergarten program, providing services only to children three years of age or older,
- ☐ School-age child care programs conducted during non-school hours.

☐ **D)** The program is a nursery school, voluntarily **registered** with the **NYS Department of Education**,

- Operating in accordance with Part 125 of NYSED regulations, **AND**
- Is operated by a nonprofit agency or organization or private proprietary organization, **AND**
- Is providing services for 3 hours or less per day, to pre-school age[5] children, **AND**
- The program meets all State and local requirements for such child care programs.

1) ☐ **I HAVE ATTACHED** a copy of my current certificate of registration *which is valid for up to 5 years*.

2) Registration Number: _____

3) Date of Certificate of Registration:

4) The program hours are: _____

☐ **E)** The program, located WITHIN New York City, is operated under Article 43 of the NYC Health Code

- Has **filed** appropriate notice with the New York City Department of Education on a form provided or approved by the NYC Department of Education, **AND**
- Is operated by a school recognized under the State Education law and which provides compulsory education for children, **AND**
- Is located within or as part of such school and has identical ownership, operation management and control of kindergarten and pre-kindergarten classes for children ages three through five and all other classes provided by the school, **AND**
- Is a pre-kindergarten or kindergarten program of instruction for children no younger than 3 years of age[6], through 5 years and serving *only* children ages 3 to 5 years, **AND**
- The program meets all State and local requirements for such child care programs.

1) Name of School: _____

2) ☐ I HAVE ATTACHED a copy of the current **Certificate of Filing** issued by the **NYC Department of Health and Mental Hygiene (DOHMH).**

3) Certificate of Filing DCID Number: _____

4) Filing Date: _____

☐ **F)** The program is a **Summer Day Camp operating under the auspices of the Department of Health AND**

- Does meet all State and local requirements for such child care programs, **AND**
- Does NOT concurrently hold a current license or registration to operate a day care program issued by the New York State Office of Children and Family Services or by the New York City DOHMH for this site and program, **AND**

1) The Summer Day Camp is operated under the jurisdiction of the: *(choose the appropriate authority)*
   ☐ New York State Department of Health (NYSDOH) in accordance with subpart 7-2 of the State Sanitary Code **OR**,
   ☐ New York City Department of Health and Mental Hygiene (NYCDOHMH).

2) The Summer Day Camp opened on or is scheduled to open on *(date)*: _____

3) Does the program have a **current year** permit, from the New York State Department of Health or the New York City DOHMH, to operate as a legally-exempt summer day camp program?

   a) ☐ **Yes.** *You must attach the permit. Check ☑ below to show you have met the requirement.*

      i) ☐ **I HAVE ATTACHED** a copy of my current year permit from the NYS DOH or the NYC DOHMH.

      ii) Permit number: _____

      iii) Expiration date: _____

[5] Per 18 NYCRR 413.2, "Preschooler" means a child who is at least three years of age and who is not yet enrolled in kindergarten or a higher grade.

[6] Programs operating under NYC Health Code Article 43 use the definition within Article 43 for *Three years of age:* A child attending an elementary school where the school year starts in September shall be deemed to be three years of age if the child's third birthday occurs or will occur on or before December 31st of the school year. In a school where the school year starts during any other month, all children in a class of three year olds shall have their third birthday within four months of the start of the school year.

b) ☐ **No**. You cannot be *fully enrolled* until you submit the current year summer camp permit from DOH. To be *conditionally enrolled* prior to the issuance of the current year's DOH summer camp permit, you must:

- Attach proof that you have completed the application to DOH for a permit to operate a summer day camp, **AND,**
- Have no outstanding compliance issues with the NYS DOH or NYC DOHMH, **AND**,
- Agree to immediately notify the enrollment agency if you are *denied* a summer camp permit by the DOH or if you withdraw your request for a summer day camp permit, **AND**,
- Agree to submit your current year's DOH summer day camp permit to the enrollment agency as soon as it is issued so that your enrollment will change from conditional enrollment to full enrollment. **Failure to submit the permit within 30 days of camp opening WILL result in a TERMINATION of enrollment.**

i) ☐ I have **ATTACHED** proof of my application for the DOH permit.

ii) I submitted the camp permit application to DOH on (date): _____

3. PROGRAMS NOT OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY:

Choose the statement, *A), B) or C),* that describes your legally-exempt child care program(s) that *does not operate under the auspices* of a federal, State, local government, or tribal agency.

☐ **A)** The program is **operated OUTSIDE OF New York City, by a private school or academy,** that is providing elementary or secondary education or both, **in accordance with the compulsory education requirements** of the NYS Education Law, **AND,**

- Is (are) **located on the same premises** or campus where the elementary or secondary education is provided, **AND,**
- Meets all State and local requirements for such child care programs.

1) Name of School: _____

2) The type of child care provided is: (check ☑ all that apply)

☐ Nursery school program or pre-kindergarten program, providing services only to children three years of age or older,

☐ A program for school-aged children conducted during non-school hours.

☐ **B)** The program is **operated WITHIN New York City, by a private school or academy,** that is providing elementary or secondary education or both, **in accordance with the compulsory education requirements** of the NYS Education Law, **AND,**

- Is (are) **located on the same premises** or campus where the elementary or secondary education is provided, **AND,**
- Meets all State and local requirements for such child care programs.

1) Name of School: _____

2) The program is for school-aged children conducted during non-school hours and the program *does not serve* any children ages 0 to 4 years of age.

☐ **C)** The program is a nursery school for children 3 years of age or older or program for preschool age children,

- Is not voluntarily registered with NYS Education Department, **AND,**
- Is operated by a non-profit agency or organization or a private proprietary agency **AND,**
- Provides services for three or less hours per day, **AND,**
- Meets all State and local requirements for such child care programs.

1) Name of Agency/Organization: _____

2) The type of child care provided is: *(check ☑ all that apply)*

☐ A nursery school

☐ A program for preschool [7]aged children, at least 3 years of age.

3) The program hours are: _____

☐ **D)** The program cares for not more than six school age children, during non-school hours, for three hours or less per day, **AND,**

- Is not located in a residence, **AND,**

Meets all State and local requirements for such child care programs.

[7] Per 18 NYCRR 413.2, "Preschooler" means a child who is at least three years of age and who is not yet enrolled in kindergarten or a higher grade.

C. OTHER QUALIFICATIONS & PROGRAM CHARACTERISTICS

1. PROVIDER'S/PROGRAM'S QUALIFICATIONS TO ADMINISTER MEDICATION

The questions pertaining to the administration of medication apply ONLY to group programs NOT operating under auspices of another government agency (Refer to pages 3-6 if you are not sure if this applies to your program.)

Note*:* *The parent's/caretaker's* plan for **who is responsible** for meeting the child(ren)'s medication needs is addressed in the Parent Information Section of this form.

NYS Law restricts the right to administer medication, other than over-the-counter topical ointments, sunscreen and topically applied insect repellent, to specific medical professionals who are authorized by New York State. A caregiver may not administer medication to any child in his or her care except to the extent that the caregiver is a medical professional authorized under the Education Law to administer medications OR both the program and the medication administrant have met the requirements for the administration of medication as defined in 18 NYCRR 418-1.11. Pursuant to 18 NYCRR 418-1.11, some child care providers/programs *may be* "permitted", to administer medications when certain requirements are met.

Legally-exempt group child care programs, NOT operating under the auspices of another government agency, may administer medication on a limited basis *only* when the following conditions are met:

- The program director is a Physician, Physician Assistant, Registered Nurse or Nurse Practitioner currently licensed by New York State Department of Education (NYSED) to administer medication

OR

- The program must be authorized by the Office of Children and Family Services (OCFS), to administer medication under a Health Care Plan for Administration of Medication, approved by a qualified health care consultant AND
  - The program's designated medications administrant must meet OCFS training requirements,
  - The program's medications administrant must be at least 18 years of age, and literate in the language in which the parental permissions and health care provider's instructions will be given,
  - The program must be operating in compliance with the NYS regulation,
  - The program's medications administrant must have permission to administer medication *to a specific child* from the child's parent/caretaker, step-parent, legal guardian, or legal custodian,
  - The program's medications administrant must follow the health care provider's instructions for administration of medication, and
  - The program's medications administrant may administer medication to *subsidized* children in care.

Any child care provider, program employee or program volunteer <u>who is not authorized</u> by NYS Law or child care regulations, *may only administer over-the-counter topical ointments, sunscreen and topical insect repellent*. Examples of medication they MAY NOT ADMINISTER include, but are not limited to: Tylenol, Ritalin, insulin, antibiotics, and ear, eye or nose drops.

A) The provider/program director agrees the provider/program director will administer medication *only as the provider/program is permitted by NYS Law, as described above.* The provider/program director will make sure that each of the program's employees and volunteers (present and future) administers medication only to the extent allowed by NYS Law.
☐ **Yes.** ☐ **No.**

B) Is the program interested in seeking OCFS authorization to administer medication to the child(ren) in subsidized care?
☐ **Yes.** The provider/program wants to learn how to start the process. Please send me the OCFS-LDSS-7007 <u>Obtaining Authorization to Administer Medication to the Child(ren) in Legally-Exempt Care</u>.
☐ **No.** The provider/program will not be seeking authorization to administer medication at this time.

C) Does this program (includes provider/director, employees, caregivers and/or volunteers) administer medication to any subsidized children in care*?*
☐ **Yes**. ☐ **No.**

D) Is the provider/program legally permitted to administer medication to the child(ren) in subsidized care? *Check ☑ statements 1 or 2. Provide all other information as it applies.*

☐ 1) **Yes.** *Complete the applicable section below, a) or b), to show the legal authority.*

☐ a) The **program director** is legally permitted to administer medication because the provider/program director is a NYS medical professional authorized by New York State Department of Education (NYSED) to administer medication. Therefore, the program director is allowed to administer medication to children in the program director's care when the program director has appropriate permissions from the parent(s) and in accordance with the health care provider's instructions.

1) Profession (*Check ☑ one):*

☐ Registered Nurse ☐ Physician
☐ Nurse Practitioner ☐ Physician Assistant

2) License number: _____

☐ I have attached a copy of the current NYS professional medical license.

☐ b) The program's **medication administrant**, designated in the Health Care Plan for the Administration of Medication, is legally permitted to administer medication because the provider/program has an OCFS-LDSS-7000, Health Care Plan for the Administration of Medication approved within the past 2 years and the designated **medication administrant** has met all basic and training requirements. The medications administrant named below is authorized to administer medication to subsidized children in the program's care when there are appropriate permissions from the parent, and, in accordance with the Health Care Plan for the Administration of Medication and the health care provider's instructions.

i) Approval date for Health Care Plan for the Administration of Medication: _____

☐ I have attached a copy of the first page AND the approval page of my Health Care Plan for the Administration of Medication (OCFS-LDSS-7000).

ii) Name of the qualified **medication administrant**: _____

iii) Health Care Consultant (HCC) name: _____

iv) Health Care Consultant Profession (*Check ☑ one):*

☐ Registered Nurse ☐ Physician
☐ Nurse Practitioner ☐ Physician Assistant

v) License Number: _____

☐ 2). **No.** None of the above permissions apply to the provider/program. The provider/program is not authorized by OCFS or NYSED. The program, **cannot administer** medication to child(ren) in care, **except**: over-the-counter topical ointments, sunscreen, and topically applied insect repellent.

2. PROGRAM'S PERIODS OF OPERATION

(All programs must answer.)

Indicate when the program is operating by *checking ☑ all that apply.*

☐ Full Year (school year and summer)
☐ School Year
☐ Summer Only (June-September)

3. COST OF CARE

Do you charge parents receiving subsidy *the same amount or less* than you charge for non-subsidy child(ren) of the same age and similar care?

☐ **Yes.**

☐ **No.** I charge parents receiving subsidy **more** than I charge other parents.

D. HEALTH AND SAFETY CHECKLIST

The Health and Safety Checklist questions must be answered by group programs that are <u>not</u> under auspices of another government agency as explained in Subsection I B.

The provider/director and parent/caretaker must walk through and inspect the site, then complete the health and safety checklist together.

Check ☑ an answer for each item below:

YES	NO	The provider/program director agrees the program meets and will continue to meet the following basic health and safety requirements.
☐	☐	1. The provider and all children have two separate & remote ways to leave the building in an emergency.
☐	☐	2. The rooms for the child(ren) at the program site are well-heated, well-lighted and well-ventilated.
☐	☐	3. The child care premises is free of unsafe areas (such as swimming pools, open drainage ditches, wells, holes, wood or coal burning stoves, fireplaces, and gas space heaters). If there are unsafe areas, sturdy barriers are in place around those areas that keep children from getting to them.
☐	☐	4. If child care is provided above the first floor, there are barriers or locks on the windows so the child(ren) cannot fall out.
☐	☐	5. The water supply at the child care premises is safe. There are working toilets and there is hot and cold running water all the time.
☐	☐	6. The provider, all employees, and volunteers who are likely to have regular contact with the child(ren) are physically, emotionally and mentally able to provide child care.
☐	☐	7. The provider, all employees, and volunteers who are likely to have regular contact with the child(ren) are free from any communicable diseases that pose a risk to the health and safety of the child(ren) in care. If the provider, any employee, or volunteer who is likely to have regular contact with the child(ren) has a communicable disease, the provider/program, must have a statement from such person's health care provider that indicates that the presence of a communicable disease does not pose a risk to the health and safety of the child(ren) in care. ☐ The provider/program has ATTACHED a doctor's statement, if the provider, any employee, or volunteer who is likely to have regular contact with the child(ren) has a communicable disease and that such disease does not pose a risk to the health and safety of the child(ren) in care.
☐	☐	8. The child care premises is free of any dangerous or unsafe conditions that could hurt the child(ren). This includes but is not limited to: • Knives and other sharp objects are out of the reach of the child(ren). • Small rugs, runners, and electrical cords are held in place so the child(ren) won't trip. • Electrical cords do not run under furniture or rugs and are out of the reach of the small child(ren). • Extension cords are not overloaded. • Cords to window blinds and shades are out of the reach of the child(ren). • Hot liquids are out of the reach of the child(ren). • Small items that the child(ren) could choke on are out of the child(ren)'s reach. • To the extent that a legally-exempt group program provides cribs, those cribs must be in compliance with the federal requirements. • A carbon monoxide detector is installed on each floor where a carbon monoxide source is located and/or where the child(ren) sleep or nap.
☐	☐	9. All matches, lighters, medicines/drugs, cleaning materials, detergents, aerosol spray cans and other poisonous or toxic materials are stored in their original containers. Care is taken so that they do not come in contact with the child(ren), where food is prepared, or otherwise may be a danger to the child(ren). The provider/program stores all of these potentially unsafe materials in an inaccessible area safely away from the child(ren).
☐	☐	10. The provider/program staff will give the child(ren) meals and snacks according to what the parent/caretaker and I have agreed.
☐	☐	11. The provider/program staff will refrigerate milk, formula and perishable food that goes bad if left out.
☐	☐	12. The provider/program staff will not heat formula, breast milk and other food items for infants in a microwave oven.
☐	☐	13. The provider/program staff will always allow the custodial parent/caretaker or caretaker to have unlimited access to his/her child(ren) in care, to the program site while the child(ren) is in care, and to any written records concerning the child(ren).

YES	NO	The provider/program director agrees the program meets and will continue to meet the following basic health and safety requirements.
☐	☐	14. The provider/program staff will hold fire/evacuation drills monthly with the child(ren) during hours that the child(ren) are in care so that the child(ren) and I will know what to do in the case of an emergency.
☐	☐	15. The provider/program has a working telephone OR can get to one very quickly in an emergency. Emergency telephone numbers for the fire department, local or State police or sheriff's department, poison control center and ambulance service are posted near the phone and are easy to see.
☐	☐	16. The provider/program will use protective caps, covers or permanently installed safety devices on all electrical outlets that the child(ren) could reach when I am caring for the child(ren) under 5 years old.
☐	☐	17. Paint and plaster are in good repair so that there is no danger of the child(ren) putting paint or plaster chips in their mouths or of it getting into food.
☐	☐	18. The child care premises has at least one operating smoke detector on each floor of the program site. I will check regularly to make sure all detectors work.
☐	☐	19. The provider/program has a portable first aid kit at the program site that is easy to get to in an emergency and my first aid supplies are kept in a clean container or cabinet away from the child(ren). It is stocked to treat common childhood injuries and problems. I will always replace things in the first aid kit as soon as possible after something has been used or is too old to be used.
☐	☐	20. The provider/program director has RECEIVED from the child(ren)'s parent/caretaker: • signed proof from a doctor or other health care provider that: the child(ren) has received all of the immunizations appropriate for the child(ren)'s age; OR • proof that one or more of the immunizations would harm the child(ren)'s health; OR • a statement saying that the child(ren) has not been immunized due to the parent/caretaker's religious beliefs.
☐	☐	21. The stairs, railings, porches and balconies are in good repair.

E. PROVIDER/PROGRAM BEHAVIORAL CONDITIONS

The Provider/Program Behavioral Conditions Checklist questions must be answered by group programs that are *not operating under auspices* of another government agency as explained in Subsection I B.

YES	NO	The provider/program director agrees the program meets and will continue to meet the following basic health and safety requirements before caring for children:
☐	☐	1. The provider/program director understands and agrees that the provider, program staff and program volunteers will never use physical punishment or let others use physical punishment while child(ren) are in their care. Physical punishment means doing things directly to the child(ren)'s body to punish them, such as: • Spanking, biting, slapping, shaking, twisting, or squeezing; • Making the child(ren) do physical exercises beyond what is normal; • Forcing the child(ren) to stay still for long periods of time; • Making the child(ren) stay in positions that hurt the child(ren) or are bizarre; • Bathing the child(ren) in unusually hot or cold water; and • Forcing child(ren) to eat or have in the child(ren)'s mouth soap, foods, hot spices or foreign substances.
☐	☐	2. The provider/program director understands and agrees that provider, program staff and program volunteers will never use or be under the influence of alcohol or drugs while the child(ren) are in care and will make sure that the child(ren) being cared for do not have contact with people using drugs or alcohol.
☐	☐	3. The provider/program director understands and agrees that provider, program staff and program volunteers will not smoke or allow smoking in indoor areas or other enclosed areas, such as cars or other vehicles, when the child(ren) are present.
☐	☐	4. The provider/program director understands and agrees that provider, program staff and program volunteers will never leave the child(ren) alone or unsupervised.

F. RELEVANT HISTORY

1. PROVIDER'S HISTORY

The questions in F.1.(A-C), must be answered only by Group Programs that are not operating under auspices of another government agency as explained in Subsection I B.

A) PROVIDER/ DIRECTOR TERMINATION OF PARENTAL RIGHTS

I certify and attest that *(Check☑one):*

☐ I have **never had** my parental rights terminated under Social Services Law 384-b or equivalent legal authority.

☐ I **have had** my parental rights terminated under Social Services Law 384-b or equivalent legal authority.

☐ I have **ATTACHED** the OCFS-LDSS-4917[8], History of Court-Ordered Removal Of A Child And/or Termination of Parental Rights.

B) PROVIDER/DIRECTOR COURT ORDERED ARTICLE 10 REMOVAL

I certify and attest that (*Check☑one*):

☐ I **have never had** a child removed from my care by court order in a proceeding under Article 10 (child protective) of the Family Court Act.

☐ I **have had** a child removed from my care by court order in a proceeding under Article 10 (child protective) of the Family Court Act.

☐ I have **ATTACHED** the OCFS-LDSS-4917, History of Court-Ordered Removal Of A Child And/or Termination of Parental Rights.

C) PROVIDER/DIRECTOR DAY CARE ENFORCEMENT

A child "day care" program includes licensed or registered day care centers, family day care homes, group family day care homes, small day care centers and/or school age child care programs.

1) I certify and attest that *(check☑one):*

   ☐ I **have** had an application for a license or registration to operate a child day care program denied.

   ☐ I **have not** had an application for a license or registration to operate a child day care program denied.

2) I certify and attest that (*Check☑one*):

   ☐ I **have** had a license or registration to operate a child day care program revoked or suspended.

   ☐ I **have not** had a license or registration to operate a child day care program revoked or suspended.

3) If the provider/program director has been denied a license or registration to operate a child day care program, OR if provider/program director has had a license or registration to operate a child day care program revoked or suspended, complete the following:

   a) Name of the child day care program(s) for which this action occurred:

   _____

   b) Location: _____

   c) ☐ I have **ATTACHED** the OCFS-LDSS-4916, History of Day Care Enforcement and Parental Acknowledgement.

2. PROVIDER'S, EMPLOYEE'S AND VOLUNTEER'S HISTORY

These questions must be answered by ALL Group programs.

The provider/director must ask each employee and each volunteer who is likely to have regular contact with the child(ren) in care if they have been convicted of a crime.

A) Did the provider/director ask each employee and each volunteer who is likely to have regular contact with the child(ren) in care, if they have been convicted of a crime?

☐ Yes.

☐ No.

[8] If you need a copy of this form, please contact your local social services district or your legally-exempt child care provider enrollment agency.

B) Has the provider/program director and/or the program's employee(s) and/or volunteer(s) ever been convicted of a crime in New York State or any other place?

☐ **No**. *Skip to Question D.*

☐ **Yes**. *If yes, you must complete and attach the OCFS-LDSS-4915, History of Criminal Convictions And Parental Acknowledgement for person with a criminal convictions history and answer question C.*

☐ The provider/program director has ATTACHED the OCFS-LDSS-4915, History of Criminal Convictions And Parental Acknowledgement.

C) In the chart below, provide additional information on each person **with a criminal convictions history** who is present at the child care site.

ADDITIONAL INFORMATION ON CONVICTED PERSONS AT THE CHILD CARE SITE										
NAME (INCLUDE AND SPECIFY MAIDEN NAME AND ANY OTHER ALIAS NAMES BY WHICH VOLUNTEERS AND EMPLOYEES MAY BE KNOWN)						**ROLE:** EMPLOYEE, OR VOLUNTEER		**GENDER** *(M OR F)*		**DATE OF BIRTH**
1)	Last	First	MI	Suffix						/ /
2)	Last	First	MI	Suffix						/ /
3)	Last	First	MI	Suffix						/ /
4)	Last	First	MI	Suffix						/ /
5)	Last	First	MI	Suffix						/ /
	Last	First	MI	Suffix						

D) Indicated Reports Of Child Abuse Or Maltreatment

The provider/program director must ask all volunteers who are likely to have regular contact with children in care and all employees, if they have been the subject of an indicated report of child abuse or maltreatment (Child Protective).

The provider/program must provide each parent/caretaker with a true and accurate written statement, indicating whether the provider/program director, any program employee, and/or any volunteers who are likely to have regular contact with children in care, have been the subject and person responsible on any indicated report of child abuse or maltreatment, including: a description of the incident, the date of the indication and any other relevant information.

1) I, the provider/program director, have asked all volunteers and employees if they have been the subject of an indicated report of child abuse or maltreatment. When any report of child abuse or maltreatment has been indicated against the provider/program director, employee or volunteers, I have given the parent/caretaker a true and accurate written description of the incident, the indication and any other relevant information.

☐ **Yes.**

☐ **No.**

G. PROVIDER AGREEMENTS AND CERTIFICATIONS

1. RECORD KEEPING

- On a daily basis, the provider/program maintains current and accurate attendance records, at the child care program, for each child being cared for, minimally including: the date, arrival time, departure time, and if absent for the full day, a note that the child is absent.

2. SUBMITTING UPDATES AND CHANGES OF ENROLLMENT INFORMATION

- I understand that enrollment of this provider/program to provide subsidized child care will only apply to the specific provider/program located at the site specified on page one. If the program relocates temporarily or permanently to a child care location different from the one given on this form, this enrollment will end. To remain eligible to provide subsidized child care I must submit a new enrollment request for the new site to the enrollment agency and begin the enrollment process anew.
- I understand that if, in the future there are new employees or volunteers, the requirements on pages 11-12 for Criminal History and Child Protective Indicated Reports apply to them.
- I understand I am required to inform the enrollment agency promptly if I add any new employees or volunteers who have a criminal conviction so their criminal history can be evaluated.

- I understand that the decision to enroll the program is based on the facts provided on the enrollment form and when there is a change to any of the information I have attested to, my eligibility to provide subsidized child care may also change. I will inform the enrollment agency immediately if there are changes in any information provided on the enrollment form or changes to the attachments.

3. INFORMATION SHARING

- I understand the enrollment agency and the local social services district will exchange information regarding the child care program's enrollment status.

4. ELIGIBILITY AND PAYMENT

- I understand that the program cannot be enrolled until all items marked "No" on the Health and Safety Checklist have been corrected.
- I understand that the program must be enrolled with the enrollment agency before any payment can be made.
- The program agrees to maintain and provide accurate attendance records as required by the local social services district.
- The program agrees to collect the family share (fee) if instructed to do so by the local social services district. The program will immediately notify the local social services district if the parent/caretaker fails to pay the required family share.
- I understand that when I, any volunteer who is likely to have regular contact with the child(ren), or any employee has been convicted of a crime, the provider must give the parent and the Enrollment Agency true and accurate information about the crime which will enable the parent and Enrollment Agency to evaluate whether the criminal background poses an unreasonable risk to the safety or welfare of the children.
- I understand that no person convicted of a felony or misdemeanor against children or, for caregivers of legally-exempt family child care, whose household includes an individual convicted of such a crime may be enrolled by a legally-exempt caregiver enrollment agency as a child care caregiver.
- I understand that no legally-exempt informal child care program or legally-exempt group child care program which employs an individual or uses a volunteer convicted of a felony or misdemeanor against children may be enrolled by a legally-exempt caregiver enrollment agency as a child care caregiver.
- I understand a legally-exempt caregiver enrollment agency may enroll a caregiver who has been convicted or whose employee, volunteer or household member has been convicted of other felony or misdemeanor offenses, consistent with guidelines issued by the office for evaluating applicants with criminal conviction records.
- I understand that if the enrollment agency determines the program cannot be enrolled, then the local social services district cannot issue payment for care provided. The program will not be paid by the local social service district for any child care that it provides to a child(ren) receiving a child care subsidy, while the program is deemed an ineligible provider by the enrollment agency. The parent/caretaker has the right and responsibility to decide whether he/she wants to use the program. If the parent/caretaker chooses to use the program when it cannot be enrolled, the parent/caretaker is responsible to pay the program for the child care.

5. ADDITIONAL REQUIREMENTS FOR PROGRAMS NOT OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY-ONLY

(This section does not apply to programs operating under the auspices of another government agency).

- I understand the program may not be eligible to provide child care AND that the local social services district may not be able to pay the program when:
  - I have a history of Article 10 (child protective) removal of a child by family court order, or
  - I have a history of termination of parental rights, or
  - I have a history of denial, revocation and/or suspension of a license or registration to operate a child day care program.
- I understand the provider/program may request, within 30 days of the Notice Date, that the enrollment agency review any extenuating circumstances, when the program's enrollment is denied or terminated based on:
  - Article 10 (child protective) removal of a child by family court order, or
  - History of termination of parental rights, OR
  - History of denial, revocation and/or suspension of a license or registration to operate a child day care program.

6. OTHER AGREEMENTS

- I agree to operate in compliance with all applicable State and local laws.
- I understand and agree the program will allow the parent/caretaker unlimited and on demand access including:
  - Access to the parent's/caretaker's child(ren),
  - The right to inspect at any time during the hours of operation, all parts of the facility used for child care or which could present a hazard to the heath and/or safety to the child(ren),
  - Access to the providers/caregivers caring for the child(ren),
  - Access to written records about the parent's/caretaker's child(ren) except when otherwise restricted by law.
- I understand and agree that the program will allow representatives of the enrollment agency, the local social services district and the State of New York access to the premises where subsidized child care is provided to confirm that information on my enrollment form and/or on attendance forms is true and accurate and that child care services are being provided as listed on these forms. I understand that if I do not allow such access, then the program will be considered ineligible, the program's enrollment will be terminated and the program will not be paid by the local social services district.
- I understand and agree to meet all of the conditions stated on this form for as long as I am providing child care. I understand that I am required to inform the enrollment agency and the parent/caretaker if there is a change in the information stated on the enrollment form.

H. CERTIFICATION

1. PROVIDER CERTIFICATION

By signing this form I certify to the best of my knowledge that:

- I understand and agree to continue to meet all conditions stated above.
- I have reviewed the "Parent Information Section" of this form.
- I understand the decision to enroll the program is based on the facts provided and attested to on the enrollment form. Providing false information or deliberately concealing information may result in an inaccurate determination of my eligibility to provide subsidized child care, and/or a denial or termination of enrollment. If I provide child care services while enrolled under false pretenses, or while I am an ineligible child care provider, the Local Social Services District may refuse to issue child care subsidy payments, terminate child care subsidy payments, take legal action against the provider/program or the parent/caretaker and the provider/program may be required to repay any money I receive for such services.
- Under the penalty of perjury, I agree that to the best of my knowledge all statements made on this enrollment form and any attachments to it are true and accurate.

PROVIDER SIGNATURE:	DATE:
X	

2. PARENT CERTIFICATION

I have reviewed the "child care provider" section of this form. Under the penalty of perjury, I agree that to the best of my knowledge all statements made on this enrollment form and any attachments to it are true and accurate.

PARENT/CARETAKER SIGNATURE:	DATE:
X	

II. PARENT INFORMATION SECTION

The parent/caretaker receiving or applying for child care subsidy must complete this section AND review the "Child Care Provider" Section. The provider must review and sign this section.

A. PARENT/CARETAKER[9] INFORMATION

1. Parent/Caretaker's Name:

☐ Mr. ☐ Mrs. ☐ Ms.

Last First MI Suffix

Other names known by:

Maiden, married, aliases, etc

2. Identifying and Contact Information:

Date of Birth: / / (mm/dd/yyyy) Home Phone: ( ) ☐ Listed ☐ Unlisted

Work Phone: ( ) Cell Phone: ( )

E-Mail Address:[10] ☐ No E-Mail Address

3. Do you read English? ☐ **Yes** ☐ **No.** If No what languages do you read best?

4. Do you speak English? ☐ **Yes** ☐ **No.** If No, what languages do you speak best?

5. Home Address:

House Number Street Apt.

Address Line 2 Floor

City State Zip County/Borough

6. Mailing Address: Is your mailing address the same as your home address? ☐ **Yes** ☐ **No.** If no, give mailing address below.

House Number Street Apt.

Address Line 2 Floor

City State Zip County/Borough

7. Parent's /Caretaker's Child Care Subsidy Case[11]:

Subsidy Paying County: Temporary Assistance No.:

Subsidy Case Number: Parent's CIN Number:

8. Child Care Provider's Name:

☐ Mr. ☐ Mrs. ☐ Ms.

Last First MI Suffix

[9] Caretaker means the child's parent, legal guardian, caretaker relative or any other person with whom a child lives and who has assumed responsibility for the day-to–day care and custody of the child.

[10] The e-mail address if given may be used by the enrollment agency to contact you.

[11] The Temporary Assistance Number, Subsidy Case Number and Parent's CIN (Client Identification Number) are optional. If given, they will be used to facilitate information sharing with the local social services district regarding your eligibility and payment for child care.

B. CHILD(REN) IN THE PROVIDER'S CARE

1. MY CHILD(REN) THAT THE PROVIDER CARES FOR.

A) Child's Name: _____
Last First

District CIN: _____ Date of Birth: / / (mm/dd/yyyy) ☐ Male ☐ Female Gender

B) Child's Name: _____
Last First

District CIN: _____ Date of Birth: / / (mm/dd/yyyy) ☐ Male ☐ Female Gender

C) Child's Name: _____
Last First

District CIN: _____ Date of Birth: / / (mm/dd/yyyy) ☐ Male ☐ Female Gender

D) Child's Name: _____
Last First

District CIN: _____ Date of Birth: / / (mm/dd/yyyy) ☐ Male ☐ Female Gender

2. MY CHILD(REN)'S MEDICATION NEEDS

A). Child care providers/programs ***can only administer medication in accordance with State Laws and regulations.***

1) OCFS does NOT oversee the administration of medication by legally-exempt group programs operating under the auspices of a federal, State or local government or tribal agency (see pages 3-5). Such programs must follow the regulations set forth by the federal, State or local government or tribal agency that the program is operating under. If your child is attending such a program, ask the program about its medication administration policies.

2) OCFS **DOES** OVERSEE administration of medication by legally-exempt group *programs **NOT** operating under the auspices of a federal, State or local government or tribal agency* (see pages 3-6).

a) Review pages 7-8 to determine if the child care program is authorized to administer medication. When the child care program IS AUTHORIZED by OCFS and following a Health Care Plan for the Administration of Medication, the *medications administrant* designated in the Health Care Plan for the Administration of Medication may administer over-the-counter medication and some prescription medication to subsidized child(ren) with the permission of the parent and following physician's instructions.

b) When the child care program is authorized by OCFS to administer medication and following a Health Care Plan for the Administration of Medication, the child's parent/caretaker may choose to allow the program to be responsible for the medication needs of the child. When the child care program is responsible for medication administration, the parent must provide written permissions and physician's instructions to the child care program.

c) Parent/Caretaker, indicate below your decision on who will be responsible for administering medication to each of your child(ren).

I, the parent/caretaker, have read the Provider's Qualifications to Administer Medication on pages 7-8 and the section above. I understand whether this provider/program is or is not legally permitted to administer medication to my child(ren) and my plan is: (Choose the correct statement(s) below and list children's names).

☐ The Child Care Program is NOT *legally permitted* to administer medication to my children, AND, I, the *parent/caretaker* will be responsible for the medication needs of (list children's names):

_____

☐ Although, the Child Care Program is *legally permitted* to administer medication to my children; I, the *parent/caretaker* will be responsible for administering medication to my child (ren):

_____

☐ The Child Care Program is *legally permitted* to administer medications through its Health Care Plan for the Administration of Medication. The *medications administrant*(s) designated in the program's Health Care Plan for Administration of Medications will administer medication to my child(ren) in accordance with the procedures set forth in the Child Care Program's Health Care Plan for the Administration of Medication. The CHILD CARE PROGRAM[12] will be responsible for administering medication to my child (ren):

_____

3. MY CHILD(REN)'S MEALS AND SNACKS

For each of my child(ren) in the provider's care, either the parent or the provider must provide meals and snacks. Who will provide meals and snacks for your child(ren) while in care?

☐ The parent/caretaker will be responsible for the meals and snacks for the following child(ren):

_____

☐ The provider/program will be responsible for the meals and snacks for the following child(ren):

_____

C. RELEVANT HISTORY OF THE PROVIDER AND PEOPLE AT THE CHILD CARE LOCATION

1. I understand the child care provider **must tell me** whether the provider, employees and volunteers who are likely to have regular contact with child(ren) in care, have been the subject of an indicated report of child abuse or maltreatment.
   - I have specifically asked the provider if the provider, volunteers who are likely to have regular contact with child(ren) in care and/or employees, have been the subject of an indicated report of child abuse or maltreatment.
   - The provider has informed me whether any indicated reports of child abuse or maltreatment exist, which name as subject of the report: the provider, employees and/or volunteers who are likely to have regular contact with child(ren) in care.
   - When an indication of child abuse or maltreatment exists, the provider has given me **written information** regarding such indication of child abuse or maltreatment, including: **a description of the incident, the date of the indication and any other relevant information.**
   - I understand I have the right to select another provider. I agree that I have carefully considered the information on child abuse and maltreatment indications that I have been given and I am selecting this provider.
     ☐ **Yes.**
     ☐ **No.**

[12] The program may only be chosen to be responsible for medication administration when the program is legally permitted to administer medication.

D. PARENTAL ACKNOWLEDGEMENTS & CERTIFICATIONS

1. PARENT RESPONSIBILITIES TO MONITOR QUALITY OF CARE

- I understand it is my responsibility to choose a provider that meets the needs of my child(ren). I certify that I have selected this provider/program to care for my child(ren).
- My child care provider/program must give me unlimited and on demand access including:
  - Access to my child(ren),
  - The right to inspect, at any time during the hours of operation, all parts of the facility used for child care or which could present a hazard to the heath and/or safety of my child(ren),
  - Access to the provider/caregivers caring for my child(ren),
  - Access to written records about my child(ren) except when otherwise restricted by law.
- I understand the provider/program director *must provide me with a written statement* indicating whether the provider/program director, any program employee, and/or any volunteers who are likely to have regular contact with children in care has been the subject of any indicated report of child abuse or maltreatment, including: a description of the incident, the date of the indication and any other relevant information.
- I understand it is my responsibility to monitor the quality of care my child(ren) receives from the child care provider/program. I understand that these agreements apply for as long as this provider is caring for my child(ren).

2. CHANGES TO ENROLLMENT INFORMATION

- I will notify the enrollment agency immediately if:
  - My address or phone number changes,
  - I have any concerns about the health and safety of my child(ren) in the provider's care.

3. ELIGIBILITY AND PAYMENT ISSUES

- I understand that this enrollment applies ONLY to the provider/program and the location of care listed on page one. If the provider/program OR the location of care changes, this enrollment ends, and I must submit a new enrollment form for the new provider/program or the new location.
- I will immediately notify the local social services district and my provider if the hours that I need child care or other circumstances related to my need or eligibility for child care change.
- I agree to pay my family share (fee), if any, as directed by the local social services district.
- I understand that the provider/program must be accepted for enrollment with the Enrollment Agency before any payment can be made.
- I understand a provider/program may not be eligible to provide child care if the provider, any volunteer who is likely to have regular contact with my child(ren) or any employee has been convicted of a crime.
- I understand a provider/program *is not eligible* to provide child care if the provider, any volunteer who is likely to have regular contact with my child(ren), or any employee has been convicted of a *crime against a child.*
- I understand that if the provider/program is denied enrollment or has his or her enrollment terminated, the provider/program will be considered ineligible to provide child care. The local social services district cannot pay the provider/program or issue payment for care given by a provider/program who cannot be enrolled or who is ineligible.
  - If I choose to use an ineligible provider/program, I am responsible to pay for the child care myself.
  - I understand I have the right to select another provider/program.

4. PROGRAM NOT OPERATING UNDER THE AUSPICES OF ANOTHER GOVERNMENT AGENCY

- For the duration of the enrollment, the provider must meet all the basic health and safety requirements listed on the Health and Safety checklist. The provider/program director and I have inspected the program site and completed the Health and Safety checklist together. All statements on the Health and Safety checklist- located in the Child Care Provider Section-of this form are true and accurate.
- I understand, that for group child care programs not operating under the auspices of another federal, State, or local government or tribal agency, payment cannot be made until all items marked "No" on the Health and Safety Checklist have been corrected.
- The provider and I will notify and provide documentation to the enrollment agency when any item on the checklist has been corrected or changed.
- I understand that my provider/program may not be eligible to provide child care and that the local social services district may not be able to pay the provider when the provider has a history of:
  - Termination of parental rights, or
  - Article 10 (child protective) removal of a child(ren) by family court order, or
  - Denial, revocation and/or suspension of a license or registration to operate a child day care program.

5. PARENT CERTIFICATION

By signing this form I certify to the best of my knowledge that:

- I have reviewed the "Child Care Provider" section of this form.
- I understand and agree to continue to meet all conditions stated above.
- I understand the decision to enroll my provider is based on the facts provided and attested to on the enrollment form. Providing false information or deliberately concealing information may result in an inaccurate determination of my provider's eligibility to provide subsidized child care, and/or a denial or termination of enrollment. If my provider/program provides child care services while enrolled under false pretenses, or while the provider/program is an ineligible child care provider, the Local Social Services District may refuse to issue child care subsidy payments, terminate child care subsidy payments, and/or take legal action against me or the child care provider.
- Under the penalty of perjury, I agree that to the best of my knowledge all statements made on this enrollment form and any attachments to it are true and accurate.

PARENT/CARETAKER SIGNATURE:	DATE:
X	

6. PROVIDER CERTIFICATION

I have reviewed the "Parent Information Section" of this form. Under the penalty of perjury, I agree that to the best of my knowledge all statements made on this enrollment form and any attachments to it are true and accurate.

PROVIDER SIGNATURE:	DATE:
X	

This enrollment form is a legal agreement. Make a copy of this form for your records.
Return this form and its attachments to:

OCFS-LDSS-4779 (Rev. 09/2015)

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

APPROVAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE DATE:	EFFECTIVE ELIGIBILITY DATE	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
		OR Agency Conference Fair Hearing information and assistance **1-800-342-3334** Record Access Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

Your application dated _____ for child care benefits has been approved. You are eligible to receive child care benefits for child care provided on _____ through _____ while you are _____

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION

BENEFITS. Payment will be provided on behalf of the following:

Child(ren):	For this provider:	For the amount of:**	Full Time or Part Time:

***Payment may vary based on fluctuations in your approved activity and/or absences.*

Benefits will be paid: ☐ Directly to you. ☐ Directly to your provider.

Your child care provider must submit a bill and attendance sheet to your local department of social services.

FAMILY SHARE. You are responsible for paying the following fees:

☐ Effective _____, a **Weekly Family Share** must be paid to _____
in the amount of $_____ per week.

☐ Effective _____, an **Additional Family Share** must be paid to _____
in the amount of $_____ per week.

☐ Effective _____, a **Court Ordered Family Share** must be paid to _____
in the amount of $_____ per week, for the child(ren) _____.

The following information is an explanation of how your weekly family share was determined.

Family's annual gross income $_____

Minus 100% annual state income standard for a family size of _____ $_____

Remaining income $_____

Remaining income $_____ X family share % _____ % = $_____

$_____ / 52 weeks = $_____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum fee of $1 per week for all families not receiving TA.

In order to continue to receive benefits these are your responsibilities:

- Notify your caseworker immediately of any change in family income, who lives in your house, employment, child care arrangements or other changes which may affect your continued eligibility or the amount of your benefit.
- Promptly pay any family share required.

The LAW(S) AND/OR REGULATION(S) that allows us to do this is:

CLIENT/FAIR HEARINGS COPY

RIGHT TO ACCEPT OR DECLINE SERVICES: Approval of your benefits does not obligate you to accept the services. You may choose to decline the services by contacting your local department of social services.

If you disagree with your local department of social services decision you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) **Calling**: _____ (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) **Writing:** Check the box below and mail to _____

   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. You can request a fair hearing without requesting a conference.

   You may request a fair hearing by:

   (1) **Calling**: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) **Online**: To send your fair hearing request online, go to http://www.otda.ny.gov/oah, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) **Writing:** Check the box, complete the information below and mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) **Faxing**: Check the box, complete the information below and fax both sides of this form to (518) 473-6735.

   ☐ I want a fair hearing. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

   Name: _____ District: _____

   Address: _____ Case Number: _____

   _____ Phone Number: _____

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay-stubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you **only** if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

OCFS-LDSS-4779-S (Rev. 09/2015)

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

APROBACIÓN DE SU SOLICITUD PARA BENEFICIOS DE CUIDADO INFANTIL

FECHA DE LA NOTIFICACIÓN	FECHA EFECTIVA	NOMBRE Y DIRECCIÓN DE LA AGENCIA/CENTRO U OFICINA DISTRITAL
NÚMERO DE CASO	NÚMERO CIN	
NOMBRE DEL CASO (Y C/O Nombre si Presente) Y DIRECCIÓN		

NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA		
O	Conferencia con la Agencia	
	Asistencia e Información sobre Audiencias Imparciales	**1-800-342-3334**
	Acceso a Registros	
	Información sobre Asistencia Legal	

NO.DE OFICINA	NO.DE UNIDAD	NO. DE TRABAJADOR(A)	NOMBRE DE LA UNIDAD O TRABAJADOR(A)	NO. DE TELEFONO DEL TRABAJADOR(A)

Su solicitud fechada el _____ para beneficios de cuidado infantil ha sido aprobada. Usted es elegible para recibir beneficios de cuidado infantil provistos el _____ hasta el _____ mientras usted esté en _____

Comentarios:

USTED TIENE EL DERECHO A UNA CONFERENCIA Y/O AUDIENCIA IMPARCIAL PARA APELAR ESTA DECISION. LEA EL REVERSO DE ESTA NOTIFICACIÓN SOBRE CÓMO SOLICITAR UNA CONFERENCIA Y/O AUDIENCIA PARA APELAR ESTA DECISIÓN.

BENEFICIOS. El pago será provisto en nombre de los siguientes:

Niños:	Para este proveedor(a):	Para la cantidad de:**	Tiempo Completo o Tiempo Parcial:

***El pago puede variar basado en fluctuaciones en su actividad aprobada y/o ausencias.*

Los beneficios serán pagados: ☐ Directamente a usted. ☐ Directamente a su proveedor(a).

Su proveedor(a) de cuidado infantil debe presentar una factura mensual y una hoja de asistencia a su departamento local se servicios sociales.

PORCIÓN FAMILIAR. Usted es responsable de pagar las siguientes cuotas:

☐ Efectivo el _____, una **Porción Familiar Semanal** debe ser pagada a _____ en la cantidad de $_____ por semana.

☐ Efectivo _____, una **Porción Familiar Adicional** debe ser pagada a _____ en la cantidad de $_____ por semana.

☐ Efectivo _____, una **Porción Familiar Ordenada por el Tribunal** debe ser pagada a _____ en la cantidad de $_____ por semana, para los niños _____

La siguiente información es una explicación de cómo se determinó su porción familiar semanal.

Ingreso bruto anual de la familia	$	
Menos del 100% anual del ingreso estatal estándar para una familia de _____	$	
Ingreso restante	$	
Ingreso restante	$	X porción familiar ____% = $
$ / 52 semanas =	$	porción semanal de la familia

Todas las porciones se las redondea a la cifra más próxima a $0.50. Hay una tarifa mínima de $1 por semana para todas las familias que no están recibiendo Asistencia Temporal.

Para continuar recibiendo beneficios, éstas son sus responsabilidades:

- Notifique a su trabajador(a) de caso inmediatamente sobre cualquier cambio en el ingreso económico de la familia, la persona que vive en su hogar, empleo, arreglos de cuidado infantil u otros cambios que puedan afectar su elegibilidad continua o la cantidad de su beneficio.
- Pague con prontitud cualquier porción familiar requerida.

La(s) LEY(LEYES) Y/O REGULACIÓN/REGULACIONES que nos permite(n) hacer este es/son:

DERECHO A ACEPTAR O RECHAZAR SERVICIOS: La aprobación de su solicitud no le obliga a aceptar estos servicios. Usted puede declinar los servicios contactando a su departamento local de servicios sociales.

Si usted está en desacuerdo con la decisión del departamento local de servicios sociales, usted puede solicitar una conferencia y/o una audiencia imparcial.

1. CONFERENCIA: Usted tiene el derecho a solicitar una conferencia a su departamento local de servicios sociales para revisar la determinación. Si usted desea una conferencia, usted debería solicitar una lo más pronto posible, porque el resultado de la conferencia puede que impacte su decisión de solicitar una audiencia imparcial. En la conferencia, usted puede presentar información para demostrar la razón por la que usted cree que la decisión de la agencia no es correcta.

Usted puede solicitar una conferencia:

(1) **Llamando al**: _____ (POR FAVOR TENGA ESTA NOTIFICACIÓN CONSIGO CUANDO LLAME).

(2) **Escribiendo al:** Marque la casilla de abajo y envíe a _____. Por favor guarde una copia para usted.

☐ Deseo una conferencia. No estoy de acuerdo con la acción de la agencia. Usted puede explicar en un documento separado por qué está en desacuerdo, pero usted no tiene que incluir una explicación por escrito.

2. AUDIENCIA IMPARCIAL: Usted tiene el derecho a una audiencia imparcial para apelar la determinación del departamento local de servicios sociales. Si desea una audiencia imparcial, usted tiene 60 DIAS desde la FECHA DE LA NOTIFICACIÓN, localizada en la primera página, para hacer una solicitud. Usted puede solicitar una audiencia imparcial:

(1) **Llamando por teléfono: 1-800-342-3334** (POR FAVOR TENGA CONSIGO ESTA NOTIFICACION CUANDO LLAME).

(2) **Por correo electrónico:** Para enviar su solicitud en línea, visite http://www.otda.ny.gov/oah, y haga un clic en los enlaces que solicitan una audiencia imparcial utilizando el formulario en línea y siguiendo las instrucciones para completar y presentar el formulario en línea.

(3) **Escribiendo:** Marque la casilla, complete la información de abajo, firme y envíela por correo a la New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201-1930. Por favor guarde una copia para usted.

(4) **Por facsímil:** Complete la información, firme y envíe ambos lados de este formulario para solicitar una audiencia imparcial al **(518) 473-6735.**

☐ Yo deseo una audiencia imparcial. No estoy de acuerdo con la acción de la agencia. (Usted puede explicar la razón por la que está en desacuerdo debajo, pero no tiene que incluir una explicación por escrito).

Nombre:	Distrito:
Dirección:	Número de Caso:
	Teléfono:

Si usted solicita una audiencia imparcial, el estado le enviará una notificación que le indicará la hora y el lugar de la audiencia. Usted tiene el derecho de ser representado(a) por un abogado(a), un pariente, un amigo(a) u otra persona, o puede representarse a sí mismo(a). En la audiencia, usted, su abogado(a) u otro representante tendrá la oportunidad de presentar evidencia escrita u oral para explicar la razón por la que usted cree que no debería tomarse la determinada acción; similarmente, tendrá la oportunidad de hacer preguntas a cualquier persona que se presente a la audiencia. Usted también tiene derecho a traer testigos que testifiquen en su favor. Usted debería traer a la audiencia cualesquier documentos, tales como esta notificación, talones salariales, recibos, facturas de cuidado de niños, verificación médica, cartas, etc. que puedan ayudarle en la presentación de su caso.

ASISTENCIA LEGAL: Si usted cree que necesita asistencia legal gratuita, usted puede obtener esa ayuda poniéndose en contacto con la Sociedad de Ayuda Legal de su localidad u otro grupo de abogacía legal. Usted puede localizar a la Sociedad de Ayuda Legal o a un grupo de abogacía buscando en las Páginas Amarillas o "Yellow Pages" bajo la sección de "Abogados" o "Lawyers", o llamando al número indicado en la primera página de esta notificación.

ACCESO A SU ARCHIVO/REGISTRO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar el archivo/registro de su caso. Si usted nos llama o nos escribe, le proveeremos copias gratuitas de los documentos de su archivo/registro que proporcionaremos al funcionario de la audiencia para la audiencia imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo/registro, llámenos al número de teléfono de Acceso a Registros que aparece en la parte superior de la primera página de esta notificación o escríbanos a la dirección impresa que aparece en la parte superior de la primera página de esta notificación. Si usted desea copias de algunos documentos de su archivo/registro, usted debería pedirlas con anticipación. Estas se le enviarán dentro de un tiempo razonable antes de la fecha de su audiencia. Los documentos se le enviarán **solamente** si usted especifica el deseo de que se los envíe.

INFORMACIÓN: Si desea más información acerca de su caso, cómo solicitar una audiencia imparcial, cómo revisar su archivo/registro, o cómo obtener copias adicionales de documentos, llámenos a los números de teléfono que aparecen en la parte superior de la primera página de esta notificación o escríbanos a la dirección que aparece en la parte superior de la primera página de esta notificación.

OCFS-LDSS-4780 (Rev. 09/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
		OR Agency Conference
		Fair Hearing information and assistance **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

Your application dated _____ for child care benefits has been **denied** and the reason(s) your application has denied are explained below.

Comments: _____

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION

You are ineligible to receive benefits because:

☐ Your family's gross income exceeds 200% of the State Income Standard, which is the maximum income allowed by New York State regulation to be eligible for child care subsidy. Your family's monthly gross income of $ _____ exceeds the maximum monthly income of $ _____ for a family size of _____ .
(Please see the attached addendum for additional information)

☐ You have not provided us with the following documents: _____

☐ You are not programmatically eligible for child care services because: _____

☐ Due to insufficient funding the district is not opening cases at this time.

☐ Due to insufficient funding, the district is only opening cases up to _____% of the State Income Standard. Your family's monthly gross income of $ _____ exceeds the maximum monthly gross income of $ _____ for your family size. Also, your family does not meet the eligibility criteria for a child care guarantee designation. (*Please see attached addendum for additional information*)

☐ Other: _____

The LAW(S) AND/OR REGULATION(S) that allows us to do this is: _____

CLIENT/FAIR HEARINGS COPY

If you disagree with your local department of social services decision you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) **Calling**: _____ (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) **Writing:** Check the box below and mail to _____

   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. You can request a fair hearing without requesting a conference.

   You may request a fair hearing by:

   (1) **Calling**: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) **Online**: To send your fair hearing request online, go to http://www.otda.ny.gov/oah, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) **Writing:** Check the box, complete the information below and mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) **Faxing**: Check the box, complete the information below and fax both sides of this form to (518) 473-6735.

   ☐ I want a fair hearing. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

   Name: _____ District: _____

   Address: _____ Case Number: _____

   _____ Phone Number: _____

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay-stubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you **only** if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

OCFS-LDSS-4780 (Rev. 09/2015)

ADDENDUM TO DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS-FINANCIAL ELIGIBILITY CALCULATION

Effective Date: _____

Case Name: _____

Case Number: _____

We have determined that you are not eligible for child care benefits. Your family's monthly gross income is $ _____ .

This exceeds the maximum monthly gross income standard of $ _____ for a family size of _____ .

Please check the information below. If there is a mistake contact your caseworker listed on page one of this notice. If there is a mistake, it could mean that the decision made about your benefits is not correct.

There is a child with special needs residing in your household. ☐ Yes ☐ No **If you have a child with special needs, that needs child care, you may have received this notice in error. Contact your caseworker on page one of this notice to determine if you were denied child care benefits in error.**

Your family's **monthly gross income** was determined from the following sources:			
☐	Wages or salary (18 NYCRR § 404.5(b)(5)(i)) before taxes in the amount of:	$	per month.
☐	Social Security (18 NYCRR §404.5(b)(5)(iv)) in the amount of:	$	per month.
☐	Child Support (18 NYCRR §404.5(b)(5)(xi)) in the amount of:	$	per month.
☐	*Other income not listed above as defined in New York State regulation 18 NYCRR §404.5(b)(5) in the amount of:	$	per month.
	Your family's **total monthly gross income**:	$	per month.

The following information is an explanation of how your eligibility for child care benefits was determined. To determine eligibility for child care benefits, your family's monthly gross income for your family size was compared to the Social Service District's (SSD) priority level for the monthly income standard. For a family to be eligible for child care benefits, a family must make less than the Monthly Income Standard amount listed below for their family size. Below are the Monthly Income Standards used by the district to determine your eligibility for child care benefits.

Family Size	**SSD's Priority Level = ___% Monthly Income Standard**
1	
2	
3	
4	
5	
6	
7	
8	

For families with more than 8 persons, add **$** _____ for each additional person.

Your family's monthly gross income is $ _____ for a family size of _____. This exceeds the maximum of $ _____ .

*Other income not listed above and defined in New York State regulation 18 NYCRR 404.5(b)(5) are defined as but not limited to the following: net income for non-farm self-employment, i.e. gross receipts minus expenses from one's own business, professional enterprise or partnership; or net income from farm self-employment, i.e. gross receipts minus operation expenses from the operation of a firm by a person on his own account, as owner, renter or sharecropper; or dividends, interest (on savings or bonds) income from estates or trusts, net rental income or royalties; public assistance (PA) or welfare payments include PA payments such as SSI and home relief; or pensions and annuities include pensions or retirement benefits paid to a retired person or his survivors; or unemployment compensation, workers' compensation; or alimony; or veterans' pensions.

In addition to the citations listed on the attached notice refer to the district's Child and Family Services Plan, at http://ocfs.ny.gov/main/childcare/plans/plans.asp for additional information on how the district closes cases in the event that there are insufficient funds to provide child care benefits to all eligible families and the order in which they will open new cases should funding become available.

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

DENEGACIÓN DE SU SOLICITUD DE BENEFICIOS PARA CUIDADO INFANTIL

FECHA DE LA NOTIFICACIÓN		NOMBRE Y DIRECCIÓN DE LA AGENCIA/CENTROS U OFICINA DISTRITAL
NÚMERO DE CASO	NÚMERO CIN	
NOMBRE DEL CASO (Y C/O Nombre si Presente) Y DIRECCIÓN		NO. DE TELÉFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA
		O Conferencia con la Agencia Asistencia e Información sobre Audiencias Imparciales **1-800-342-3334** Acceso a Registros Información sobre Asistencia Legal

NO. DE LA OFICINA	NO. DE UNIDAD	NO. DE TRABAJADOR(A)	UNIDAD O NOMBRE DEL TRABAJADOR(A)	NO. DE TELEFONO DEL TRABAJADOR(A)

Su solicitud fechada el _____ para beneficios de cuidado infantil ha sido **denegada** y la(s) razón/ razones por las que su solicitud ha sido denegada se explica(n) abajo.

Comentarios: _____

USTED TIENE EL DERECHO A UNA CONFERENCIA Y/O AUDIENCIA IMPARCIAL PARA APELAR ESTA DECISIÓN. LEA EL REVERSO DE ESTA NOTIFICACIÓN SOBRE CÓMO SOLICITAR UNA CONFERENCIA Y/O AUDIENCIA PARA APELAR ESTA

Usted no es elegible para recibir beneficios debido a que:

☐ El ingreso bruto de su familia excede el 200% del Ingreso Estatal Estándar, el que es el ingreso máximo permitido por la regulación del Estado de Nueva York para ser elegible para el subsidio de cuidado infantil. El ingreso bruto mensual de su familia de $ _____ excede el ingreso mensual máximo de $ _____ para el tamaño de una familia de _____ *(Vea al anexo adjunto para información adicional).*

☐ Usted no ha provisto los siguientes documentos: _____

☐ Usted no es elegible bajo el programa de servicios de cuidado infantil porque: _____

☐ Debido a insuficientes fondos, el distrito no está abriendo casos en este momento.

☐ Debido a insuficientes fondos, el distrito sólo está abriendo casos hasta el _____ % del Nivel de Ingreso Estatal Estándar. El ingreso mensual bruto de su familia de $ _____ excede el ingreso máximo mensual bruto de $ _____ para el tamaño de su familia. También, su familia no satisface el criterio de elegibilidad para una designación garantizada de cuidado infantil. *(Vea el anexo adjunto para información adicional*).

☐ Otro: _____

La(s) LEY(LEYES) Y/O REGULACIÓN/REGULACIONES que nos permite(n) hacer esto es/son: _____

Si usted está en desacuerdo con la decisión del departamento local de servicios sociales, usted puede solicitar una conferencia y/o una audiencia imparcial.

1. **CONFERENCIA:** Usted tiene el derecho a solicitar una conferencia a su departamento de servicios sociales para revisar la determinación. Si usted desea una conferencia, usted debería solicitar una lo más pronto posible, porque el resultado de la conferencia puede que impacte su decisión de solicitar una audiencia imparcial. En la conferencia, usted puede presentar información para demostrar por qué cree que la acción de la agencia no es correcta.

   Usted puede solicitar una conferencia:

   (1) **Llamando al:** _____ (POR FAVOR TENGA CONSIGO ESTA NOTIFICACION CUANDO LLAME).

   (2) **Escribiendo:** Marque la casilla de abajo y envíe a _____.

   Por favor guarde una copia para usted.

   ☐ Yo deseo una conferencia. No estoy de acuerdo con la acción de la agencia. Usted puede explicar en un documento separado por qué está en desacuerdo debajo, pero no tiene que incluir una explicación por escrito.

2. **AUDIENCIA IMPARCIAL:** Usted tiene el derecho a una audiencia imparcial para apelar la determinación del departamento local de servicios sociales. Si desea una audiencia imparcial, usted tiene 60 DÍAS desde la FECHA DE LA NOTIFICACION, localizada en la primera página, para hacer una solicitud. Usted puede solicitar una audiencia imparcial sin solicitar una conferencia.

   Usted puede solicitar una audiencia imparcial:

   (1) **Llamando por teléfono**: **1-800-342-3334** (POR FAVOR TENGA CONSIGO ESTA NOTIFICACION CUANDO LLAME).

   (2) **Por correo electrónico**: Para enviar su solicitud en línea, visite http://www.otda.ny.gov/oah, y haga un clic en los enlaces para solicitar una audiencia imparcial utilizando el formulario en línea y siguiendo las instrucciones para completar y presentar el formulario en línea.

   (3) **Escribiendo**: Complete la información de abajo, firme y envíela por correo a la New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201-1930. Por favor guarde una copia para usted.

   (4) **Por facsímil**: Marque la casilla y complete la información de abajo. Envíe ambos lados de este formulario a (518) 473-6735.

   ☐ Yo deseo una audiencia imparcial. No estoy de acuerdo con la acción de la agencia. Usted puede explicar la razón por la que está en desacuerdo debajo, pero no tiene que incluir una explicación por escrito.

Nombre: _____ Distrito: _____

Dirección: _____ Número de Caso:

_____ Teléfono: _____

Si usted solicita una audiencia imparcial, el estado le enviará una notificación que le indicará la hora y el lugar de la audiencia. Usted tiene el derecho de ser representado(a) por un abogado(a), un pariente, un amigo(a) u otra persona, o puede representarse a sí mismo(a). En la audiencia, usted, su abogado(a) u otro representante tendrá la oportunidad de presentar evidencia escrita u oral para explicar la razón por la que usted cree que no debería tomarse la determinada acción; similarmente, tendrá la oportunidad de hacer preguntas a cualquier persona que se presente a la audiencia. Usted también tiene el derecho de traer testigos que testifiquen en su favor. Usted debería traer a la audiencia cualesquier documentos, tales como esta notificación, talones salariales, recibos, facturas de cuidado de niños, verificación médica, cartas, etc. que puedan ayudarle en la presentación de su caso.

ASISTENCIA LEGAL: Si usted cree que necesita asistencia legal gratuita, usted puede obtener esa ayuda poniéndose en contacto con la Sociedad de Ayuda Legal de su localidad u otro grupo de abogacía legal. Usted puede localizar a la Sociedad de Ayuda Legal o un grupo de abogacía buscando en las Páginas Amarillas o "Yellow Pages" bajo la sección de "Abogados" o "Lawyers", o llamando al número indicado en la primera página de esta notificación.

ACCESO A SU ARCHIVO/REGISTRO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar el archivo/registro de su caso. Si usted nos llama o nos escribe, le proveeremos copias gratuitas de los documentos de su archivo/registro que proporcionaremos al funcionario de la audiencia para la audiencia imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo/registro, llámenos al número de teléfono de Acceso a Registros que aparece en la parte superior de la primera página de esta notificación o escríbanos a la dirección impresa que aparece en la parte superior de la primera página de esta notificación. También, si usted llama o nos escribe, le proveeremos copias gratuitas de otros documentos de su archivo los que puede que necesite para prepararse para su audiencia imparcial. Si usted desea copias de algunos documentos de su archivo/registro, usted debería pedirlas con anticipación. Estas se le enviarán dentro de un tiempo razonable antes de la fecha de su audiencia. Los documentos se le enviarán **solamente** si usted especifica el deseo de que se los envíe.

INFORMACION: Si desea más información acerca de su caso, cómo solicitar una conferencia o audiencia imparcial, cómo revisar su archivo/registro, o cómo obtener copias adicionales de documentos, llámenos a los números de teléfono que aparecen en la parte superior de la primera página de esta notificación o escríbanos a la dirección que aparece en la parte superior de la primera página de esta notificación.

ANEXO A LA DENEGACIÓN DE SU SOLICITUD PARA BENEFICIOS DE CUIDADO INFANTIL-CÁLCULO DE ELEGIBILIDAD FINANCIERA

Fecha Efectiva: _____

Nombre del Caso: _____ Número de Caso: _____

Hemos determinado que usted no es elegible para beneficios de cuidado infantil. El ingreso mensual bruto de su familia es $_____. Esto excede el ingreso mensual bruto máximo estándar de $_____ para una familia del tamaño de _____.

Por favor verifique la información de abajo. Si hay un error, contacte a su trabajador(a) de caso listado en la primera página de esta notificación. Si hay un error, esto podría significar que la decisión hecha acerca de sus beneficios no es correcta.

Hay un niño(a) con necesidades especiales residiendo en su hogar. ☐ Sí ☐ No **Si usted tiene un niño(a) con necesidades especiales que necesita cuidado infantil, usted puede que haya recibido esta notificación en error. Contacte a su trabajador(a) en le primera página de esta notificación para determinar si usted ha sido denegado beneficios de cuidado infantil erróneamente.**

El **ingreso mensual bruto** de su familia fue determinado por los siguiente recursos:			
☐	Sueldo o Salario (18 NYCRR § 404.5(b)(5)(i)) antes de impuestos en la cantidad de:	$	al mes.
☐	Seguro Social (18 NYCRR §404.5(b)(5)(iv)) en la cantidad de:	$	al mes.
☐	Manutención Infantil (18 NYCRR §404.5(b)(5)(xi)) en la cantidad de:	$	al mes.
☐	*Otro ingreso no indicado arriba, como se define en la regulación del Estado de Nueva York 18 NYCRR §404.5(b)(5), en la cantidad de:	$	al mes.
	El ingreso total mensual bruto de su familia:	$	al mes.

La siguiente información es una explicación de cómo se determinó su elegibilidad para los beneficios de cuidado infantil. Para determinar la elegibilidad de beneficios de cuidado infantil, el ingreso mensual bruto para el tamaño de su familia fue comparado con el nivel de prioridad del Distrito de Servicios Sociales (Social Services District—SSD) para el ingreso mensual estándar. Para que una familia sea elegible para beneficios de cuidado infantil, una familia debe ganar menos que la cantidad de Ingreso Mensual Estándar listada abajo para el tamaño de su familia. Abajo están los Estándares de Ingreso Mensual utilizados por el distrito para determinar su elegibilidad para beneficios de cuidado infantil.

Tamaño de la Familia	**Nivel de Prioridad de SSD = ____% Ingreso Mensual Estándar**
1	
2	
3	
4	
5	
6	
7	
8	

Para familias con más de 8 personas, aumente $_____ para cada persona adicional.

El ingreso mensual bruto de su familia es $_____ para el tamaño de una familia de _____.

Esto excede el máximo de $_____

*Otro ingreso no listado arriba y definido en la regulación del Estado de Nueva York 18 NYCRR 404.5(b)(5) se define como, pero no se limita a: ingreso neto para empleo propio no agrícola. Por ejemplo, recibos brutos menos gastos del negocio de una persona, empresa profesional o asociación; o ingreso neto por empleo propio agrícola. Por ejemplo, recibos brutos menos gastos administrativos de la operación de una firma por una persona en su propia cuenta, como propietario(a), inquilino(a) o aparcero(a); o dividendos, ingreso de interés (sobre ahorros u bonos) de estados o fideicomisos, ingreso neto por alquiler o regalías; asistencia pública (PA) o pagos de bienestar social, incluyendo pagos de PA tales como SSI y relevo en el hogar; o pensiones y anualidades, incluyendo pensiones o beneficios por retiro pagados a una persona retirada o a sus sobrevivientes; o compensación por desempleo, compensación del trabajador(a); o pensión alimenticia; o pensiones de veteranos.

Además de las citaciones listadas en la notificación adjunta, refiérase al Plan de Servicios para Niños y Familias del distrito en http://ocfs.ny.gov/main/childcare/plans/plans.asp para información adicional sobre cómo el distrito cierra casos en el caso de que haya fondos insuficientes para proveer beneficios de cuidado infantil a todas las familias elegibles y el orden en el que ellos abrirán nuevos casos si existiera la disponibilidad de fondos.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTICE OF INTENT TO DISCONTINUE CHILD CARE BENEFITS

NOTICE DATE:	EFFECTIVE CLOSING DATE	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
		OR Agency Conference
		Fair Hearing information and assistance **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

This notice is to inform you that your child care benefit case will be closed on (date) ___/___/___. You are not eligible for child care benefits for services provided after _____

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION

The reason for this action is:

☐ Your family's gross income exceeds 200% of the State Income Standard, which is the maximum income allowed by New York State regulation to be eligible for child care subsidy. Your family's monthly gross income of $ _____ exceeds the maximum monthly income of $ _____ for a family size of _____.

(Please see the attached addendum for additional information)

☐ Due to insufficient funding, the district is closing cases at or above _____% of the State Income Standard. Your family's monthly gross income of $ _____ exceeds the maximum monthly gross income of $ _____ for your family size. Also, your family does not meet the eligibility criteria for a child care guarantee designation. *(Please see the attached addendum for additional information)*

☐ You are not programmatically eligible for child care services because: _____

☐ You did not provide the following documentation or the following documentation was not adequate: _____

☐ Other _____

The LAW(S) AND/OR REGULATION(S) that allows us to do this is: _____

CLIENT/FAIR HEARINGS COPY

If you disagree with your local department of social services decision you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. If you want a fair hearing and your child care benefit to remain unchanged (aid continuing) until the fair hearing decision is issued you must request a fair hearing before the EFFECTIVE CLOSING DATE on the front page of this notice. A request for a conference alone will not result in your benefits being continued. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) **Calling**: _____ (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) **Writing:** Check the box below and mail to _____
   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. If you do not want your child care benefit to change until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE CLOSING DATE listed on the front page of this notice. You do not have to request a conference before requesting a fair hearing.

   You may request to keep your child care benefit until a fair hearing decision has been issued. If you request your benefit to be continued until a fair hearing decision has been issued, and you lose the fair hearing, you will have been overpaid. The local department of social services will seek to recover the overpayment from you by reducing future child care benefits, by collecting a lump sum payment or installment payments, or through legal action.

   You may request a fair hearing by:

   (1) **Calling**: **1-800-342-3334**. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

   (2) **Online**: To send your fair hearing request online, go to http://www.otda.ny.gov/oah, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) **Writing:** Check the box and complete the information below. Mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) **Faxing**: Check the box and complete the information below. Fax both sides of this form to (518) 473-6735.

   ☐ I want a fair hearing. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

   Select one.

   ☐ Do **NOT** stop my child care benefit until a fair hearing decision has been issued.

   ☐ Stop my child care benefit on the effective date listed on this notice, pending the fair hearing decision.

   Name: _____ District: _____

   Address: _____ Case Number: _____

   _____ Phone Number: _____

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay-stubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you **only** if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

OCFS-LDSS-4782 (Rev 09/2015)

ADDENDUM TO NOTICE OF INTENT TO DISCONTINUE CHILD CARE BENEFITS-FINANCIAL ELIGIBILITY CALCULATION

Effective Date: _____

Case Name: _____ Case Number: _____

We have determined that you are no longer eligible for child care benefits. Your family's monthly gross income is $ _____.

This exceeds the maximum monthly gross income standard of $ _____ for a family size of _____.

Please check the information below. If there is a mistake contact your caseworker listed on page one of this notice. If there is a mistake, it could mean that the decision made about your benefits is not correct.

There is a child with special needs residing in your household. ☐ Yes ☐ No **If you have a child with special needs, that needs child care, you may have received this notice in error. Contact your caseworker listed on page one of this notice to determine if your case was closed in error.**

Your family's **monthly gross income** was determined from the following sources:			
☐	Wages or salary (18 NYCRR § 404.5(b)(5)(i)) before taxes in the amount of:	$	per month.
☐	Social Security (18 NYCRR §404.5(b)(5)(iv)) in the amount of:	$	per month.
☐	Child Support (18 NYCRR §404.5(b)(5)(xi)) in the amount of:	$	per month.
☐	*Other income not listed above as defined in New York State regulation 18 NYCRR §404.5(b)(5) in the amount of:	$	per month.
	Your family's **total monthly gross income**:	$	per month.

The following information is an explanation of how your eligibility for child care benefits was determined. To determine eligibility for child care benefits, your family's monthly gross income for your family size was compared to the Social Service District's (SSD) priority level for the monthly income standard. For a family to be eligible for child care benefits, a family must make less than the Monthly Income Standard amount listed below for their family size. Below are the Monthly Income Standards used by the district to determine your eligibility for child care benefits.

Family Size	**SSD's Priority level = ____% Monthly Income Standard**
1	
2	
3	
4	
5	
6	
7	
8	

For families with more than 8 persons, add **$** _____ for each additional person.

Your family's monthly gross income is $ _____ for a family size of _____ .

This exceeds the maximum income of $ _____ .

*Other income not listed above and defined in New York State regulation 18NYCRR 404.5(b)(5) are defined as but not limited to the following: net income for non-farm self-employment, i.e. gross receipts minus expenses from one's own business, professional enterprise or partnership; or net income from farm self-employment, i.e. gross receipts minus operation expenses from the operation of a firm by a person on his own account, as owner, renter or sharecropper; or dividends, interest (on savings or bonds) income from estates or trusts, net rental income or royalties, public assistance (PA) or welfare payments include PA payments such as PA, SSI and home relief; or pensions and annuities include pensions or retirement benefits paid to a retired person or his survivors; or unemployment compensation, workers' compensation; or alimony; or veterans' pensions.

In addition to the citations listed on the attached notice refer to the district's Child and Family Services Plan, at http://ocfs.ny.gov/main/childcare/plans/plans.asp for additional information on how the district closes cases in the event that there are insufficient funds to provide child care benefits to all eligible families and the order in which they will open new cases should funding become available.

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

NOTIFICACIÓN DEL INTENTO DE DISCONTINUAR LOS BENEFICIOS DE CUIDADO INFANTIL

FECHA DE LA NOTIFICACIÓN	FECHA EFECTIVA DEL CIERRE	NOMBRE Y DIRECCIÓN DE LA AGENCIA/CENTRO U OFICINA DISTRITAL
NÚMERO DE CASO	NÚMERO CIN	
NOMBRE DEL CASO (Y C/O Nombre si Presente) Y DIRECCIÓN		NO. DE TELÉFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA
		O Conferencia con la Agencia
		Asistencia e Información sobre Audiencias **1-800-342-3334**
		Acceso a Registros
		Información sobre Asistencia Legal

NO. DE OFICINA.	NO. DE UNIDAD	NO. DEL TRABAJADOR(A)	NOMBRE DE LA UNIDAD O TRABAJADOR(A)	NO. DE TELÉFONO DEL TRABAJADOR(A)

Esta notificación es para informarle que sus beneficios de cuidado infantil serán cancelados el (DATE) ___/___/_____

Usted no es elegible para recibir beneficios de cuidado infantil a partir del _____

Comentarios:

USTED TIENE EL DERECHO A UNA CONFERENCIA Y/O AUDIENCIA IMPARCIAL PARA APELAR ESTA DECISION. LEA EL REVERSO DE ESTA NOTIFICACIÓN SOBRE CÓMO SOLICITAR UNA CONFERENCIA Y/O AUDIENCIA PARA APELAR ESTA DECISIÓN.

La razón de esta acción es:

☐ El ingreso bruto de su familia excede el 200% del Ingreso Estatal Estándar, el que es el ingreso máximo permitido por la regulación del Estado de Nueva York para ser elegible para el subsidio de cuidado infantil. El ingreso bruto mensual de su familia de $_____ excede el ingreso mensual máximo de $_____ para el tamaño de una familia de _____

(Vea al anexo adjunto para información adicional)

☐ Debido a fondos insuficientes, el distrito está cerrando casos en o por encima del _____% del Ingreso Estatal Estándar. El ingreso mensual bruto de su familia de $_____ excede el ingreso mensual bruto máximo de $_____ para el tamaño de su familia. También, su familia no satisface el criterio para una designación garantizada de cuidado infantil. *(Vea el anexo adjunto para más información)*

☐ Usted no es programáticamente elegible para servicios de cuidado infantil debido a que: _____

☐ Usted no proveyó la siguiente documentación o la siguiente documentación no fue adecuada: _____

☐ Otro: _____

La(s) LEY/LEYES Y/O LA(S) REGULACION/REGULACIONES que nos permite(n) hacer esto es/son: _____

COPIA DEL CLIENTE/AUDIENCIA IMPARCIAL

Si usted está en desacuerdo con la decisión de su departamento local de servicios sociales, usted puede solicitar una conferencia y/o una audiencia imparcial.

1. **CONFERENCIA:** Usted tiene el derecho a solicitar una conferencia a su departamento local de servicios sociales para revisar la determinación. Si usted desea una conferencia, usted debería solicitar una lo más pronto posible, porque el resultado de la conferencia puede que impacte su decisión de solicitar una audiencia imparcial. Si desea una audiencia imparcial y sus beneficios de cuidado infantil permanecen sin cambio alguno (la ayuda continúa, hasta que se emita la decisión de la audiencia imparcial, usted debe solicitar una audiencia imparcial antes de la FECHA EFFECTIVA DEL CIERRE, en la primera página de esta notificación. El solicitar sólo una conferencia no resultará en la continuación de sus beneficios. En la conferencia, usted puede presentar información que demuestre la razón por la que cree que la acción de la agencia no es correcta.

   Usted puede solicitar una conferencia:

   (1) **Llamando al**: _____ (POR FAVOR TENGA ESTA NOTIFICACIÓN CONSIGO CUANDO LLAME).

   (2) **Escribiendo al:** Marque la casilla de abajo y envíe a _____
   Por favor guarde una copia para usted.

   ☐ Deseo una conferencia. No estoy de acuerdo con la acción de la agencia. Usted puede explicar en un documento separado por qué está en desacuerdo, pero usted no tiene que incluir una explicación por escrito.

2. **AUDIENCIA IMPARCIAL:** Usted tiene el derecho a una audiencia imparcial para apelar la determinación del departamento local de servicios sociales. Si desea una audiencia imparcial, usted tiene 60 DIAS desde la FECHA DE LA NOTIFICACIÓN, localizada en la primera página, para hacer la solicitud. Si usted no desea que sus beneficios de cuidado infantil cambien hasta que se emita la decisión de la audiencia imparcial, usted debe solicitar una audiencia imparcial antes de la FECHA EFECTIVA DEL CIERRRE, listada en la primera página de esta notificación. Usted no tiene que solicitar una conferencia antes de solicitar una audiencia imparcial.
   Usted puede solicitar que se mantengan sus beneficios de cuidado infantil hasta que se emita la decisión de la audiencia imparcial. Si usted solicita que su beneficio continúe hasta que se emita una audiencia imparcial, y usted pierde la audiencia imparcial, usted habrá recibido pagos en exceso. El departamento local de servicios sociales tratará de recobrar el exceso de pago reduciendo sus futuros beneficios de cuidado infantil, recobrando el pago ya sea en una suma única o en pagos a plazos, o a través de una acción legal.

   Usted puede solicitar una audiencia imparcial:

   (1) **Llamando por teléfono: 1-800-342-3334** (POR FAVOR TENGA CONSIGO ESTA NOTIFICACION CUANDO LLAME).
   (2) **Por correo electrónico:** Para enviar su solicitud en línea, visite http://www.otda.ny.gov/oah, y haga un clic en los enlaces para solicitar una audiencia imparcial utilizando el formulario en línea y siguiendo las instrucciones para completar y presentar el formulario en línea.
   (3) **Escribiendo:** Complete la información de abajo, firme y envíela por correo a la New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201-1930. Por favor guarde una copia para usted.
   (4) **Por facsímil:** Marque la casilla y complete la información de abajo. Envíe ambos lados de este formulario a **(518) 473-6735.**
   ☐ Yo deseo una audiencia imparcial. No estoy de acuerdo con la acción de la agencia. Usted puede explicar, en una página aparte, la razón por la que está en desacuerdo, pero no tiene que incluir una explicación por escrito.

   Marque uno:

   ☐ **NO** detenga mi beneficio de cuidado infantil hasta que se emita una decisión en la audiencia imparcial.

   ☐ Detenga mi beneficio de cuidado infantil a partir de la fecha listada en esta notificación, pendiente la decisión de la audiencia imparcial.

Nombre: _____ Distrito: _____

Dirección: _____ Número de Caso: _____

_____ Número de Teléfono: _____

Si usted solicita una audiencia imparcial, el estado le enviará una notificación que le indicará la hora y el lugar de la audiencia. Usted tiene el derecho de ser representado(a) por un abogado(a), un pariente, un amigo(a) u otra persona, o puede representarse a sí mismo(a). En la audiencia, usted, su abogado(a) u otro representante tendrá la oportunidad de presentar evidencia escrita u oral para explicar la razón por la que usted cree que no debería tomarse la determinada acción; similarmente, tendrá la oportunidad de hacer preguntas a cualquier persona que se presente a la audiencia. Usted también tiene el derecho de traer testigos que testifiquen en su favor. Usted debería traer a la audiencia cualesquier documentos, tales como esta notificación, talones salariales, recibos, facturas de cuidado de niños, verificación médica, cartas, etc. que puedan ayudarle en la presentación de su caso.

ASISTENCIA LEGAL: Si usted cree que necesita asistencia legal gratuita, usted puede obtener esa ayuda poniéndose en contacto con la Sociedad de Ayuda Legal de su localidad u otro grupo de abogacía legal. Usted puede localizar a la Sociedad de Ayuda Legal o un grupo de abogacía buscando en las Páginas Amarillas o "Yellow Pages" bajo la sección de "Abogados" o "Lawyers", o llamando al número indicado en la primera página de esta notificación.

ACCESO A SU ARCHIVO/REGISTRO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar el archivo/registro de su caso. Si usted nos llama o nos escribe, le proveeremos copias gratuitas de los documentos de su archivo/registro que proporcionaremos al funcionario de la audiencia para la audiencia imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo/registro, llámenos al número de teléfono de Acceso a Registros que aparece en la parte superior de la primera página de esta notificación o escríbanos a la dirección impresa que aparece en la parte superior de la primera página de esta notificación. También, si usted llama o nos escribe, le proveeremos copias gratuitas de otros documentos de su archivo los que puede que necesite para prepararse para su audiencia imparcial. Si usted desea copias de algunos documentos de su archivo/registro, usted debería pedirlas con anticipación. Estas se le enviarán dentro de un tiempo razonable antes de la fecha de su audiencia. Los documentos se le enviarán **solamente** si usted especifica el deseo de que se los envíe.

INFORMACION: Si desea más información acerca de su caso, cómo solicitar una audiencia imparcial, cómo revisar su archivo/registro, o cómo obtener copias adicionales de documentos, llámenos a los números de teléfono que aparecen en la parte superior de la primera página de esta notificación o escríbanos a la dirección que aparece en la parte superior de la primera página de esta notificación.

OCFS 4782-S (Rev. 09/2015)

ANEXO DE LA NOTIFICACION DEL INTENTO DE DISCONTINUAR LOS BENEFICIOS DE CUIDADO INFANTIL-CÁLCULO DE ELEGIBILIDAD FINANCIERA

Fecha Efectiva: _____

Nombre del Caso: _____ No. del Caso: _____

Hemos determinado que usted ya no es elegible para beneficios de cuidado infantil. El ingreso mensual bruto de su familia es:

$ _____ Esto excede el ingreso mensual bruto máximo estándar de $ _____ para el tamaño de una familia de _____.

Por favor verifique la información de abajo. Si hay un error, contacte a su trabajador(a) de caso listado en la primera página de esta notificación. Si hay un error, esto podría significar que la decisión hecha acerca de sus beneficios no es correcta.

Hay un niño(a) con necesidades especiales que reside en su hogar. ☐ Sí ☐ No **Si usted tiene un hijo(a) con necesidades especiales que necesita cuidado infantil, usted puede que haya recibido esta notificación en error. Contacte a su trabajador(a) listado en la primera página de esta notificación para determinar si su caso fue cerrado erróneamente.**

El **ingreso mensual bruto** de su familia fue determinado por los siguientes recursos:			
☐	Sueldo o salario (18 NYCRR § 404.5(b)(5)(i)) antes de impuestos en la cantidad de:	$	al mes.
☐	Seguro Social (18 NYCRR §404.5(b)(5)(iv)) en la cantidad de:	$	al mes.
☐	Manutención Infantil (18 NYCRR §404.5(b)(5)(xi)) en la cantidad de:	$	al mes.
☐	*Otro ingreso no indicado arriba, como se define en la regulación del Estado de Nueva York 18 NYCRR §404.5(b)(5), en la cantidad de:	$	al mes.
	El ingreso total mensual bruto de su familia:	$	al mes.

La siguiente información es una explicación de cómo se determinó su elegibilidad para los beneficios de cuidado infantil. Para determinar la elegibilidad de beneficios de cuidado infantil, el ingreso mensual bruto para el tamaño de su familia fue comparado con el nivel de prioridad del Distrito de Servicios Sociales (Social Services District—SSD) para el ingreso mensual estándar. Para que una familia sea elegible para beneficios de cuidado infantil, una familia debe ganar menos que la cantidad de Ingreso Mensual Estándar listada abajo para el tamaño de su familia. Abajo están los Estándares de Ingreso Mensual utilizados por el distrito para determinar su elegibilidad para beneficios de cuidado infantil.

Tamaño de la Familia	**Nivel de Prioridad de SSD = ____% Ingreso Mensual Estándar**
1	
2	
3	
4	
5	
6	
7	
8	

Para familias con más de 8 personas, aumente **$** _____ para cada persona adicional.

El ingreso mensual bruto de su familia es de $ _____ **para el tamaño de una familia de** _____ **.**

Esto excede el ingreso máximo de $ _____ **.**

*Otro ingreso no listado arriba y definido en la regulación del Estado de Nueva York 18 NYCRR 404.5(b)(5) se define como, pero no se limita a: ingreso neto para empleo propio no agrícola. Por ejemplo recibos brutos menos gastos del negocio de una persona, empresa profesional o asociación; o ingreso neto por empleo propio agrícola. Por ejemplo, recibos brutos menos gastos administrativos de la operación de una firma por una persona en su propia cuenta, como propietario(a), inquilino o aparcero; o dividendos, ingreso de interés (sobre ahorros u bonos) de estados o fideicomisos, ingreso neto por alquiler o regalías; asistencia pública (PA) o pagos de bienestar social, incluyendo pagos de PA tales como SSI y relevo en el hogar; o pensiones y anualidades, incluyendo pensiones o beneficios por retiro pagados a una persona retirada o a sus sobrevivientes; o compensación por desempleo, compensación del trabajador(a); o pensión alimenticia; o pensiones de veteranos.

Además de las citaciones listadas en la notificación adjunta, refiérase al Plan de Servicios para Niños y Familias del distrito en http://ocfs.ny.gov/main/childcare/plans/plans.asp para información adicional sobre cómo el distrito cierra casos en el caso de que haya fondos insuficientes para proveer beneficios de cuidado infantil a todas las familias elegibles y el orden en el que ellos abrirán nuevos casos si existiera la disponibilidad de fondos.

OCFS-LDSS-4784 (Rev. 09/2015)

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

APPROVAL OF YOUR REDETERMINATION FOR CHILD CARE BENEFITS

NOTICE DATE:	EFFECTIVE DATE	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
		OR Agency Conference
		Fair Hearing information and assistance **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

Your application dated _____ for child care benefits has been approved. You are eligible to receive child care benefits for child care provided on _____ through _____ while you are _____.

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION

BENEFITS. Payment will be provided on behalf of the following:

Child(ren):	For this provider:	For the amount of:**	Full Time or Part Time:

***Payment may vary based on fluctuations in your approved activity and/or absences.**

Benefits will be paid: ☐ Directly to you. ☐ Directly to your provider.

Your provider must submit a bill and attendance sheet to your local department of social services.

FAMILY SHARE. You are responsible for paying the following fees:

☐ Effective _____, a **Weekly Family Share** must be paid to _____
in the amount of $_____ per week.

☐ Effective _____, an **Additional Family Share** must be paid to _____
in the amount of $_____ per week.

☐ Effective _____, a **Court Ordered Family Share** must be paid to _____
in the amount of $_____ per week, for the child(ren) _____.

The following information is an explanation of how your weekly family share was determined.

Family's annual gross income $_____

Minus 100% annual state income standard for a family size of _____ $_____

Remaining income $_____

Remaining income $_____ X family share %_____ % = $_____

$_____ / 52 weeks = $_____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum fee of $1 per week for all families not receiving TA.

In order to continue to receive benefits these are your responsibilities:

- Notify your caseworker immediately of any change in family income, who lives in your house, employment, child care arrangements or other changes which may affect your continued eligibility or the amount of your benefit.
- Promptly pay any family share required.

The LAW(S) AND/OR REGLATIONS(S) that allows us to do this is:

CLIENT/FAIR HEARINGS COPY

RIGHT TO ACCEPT OR DECLINE SERVICES: Approval of your benefits does not obligate you to accept the services. You may choose to decline the services by contacting your local department of social services.

If you disagree with your local department of social services decision you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. If you want a fair hearing and your child care benefit to remain unchanged (aid continuing) until the fair hearing decision is issued you must request a fair hearing before the EFFECTIVE DATE on the front page of this notice. A request for a conference alone will not result in your benefits being continued. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) **Calling**: _____ (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) **Writing:** Check the box below and mail to _____

   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. If you do not want your child care benefit to change until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE DATE listed on the front page of this notice. You can request a fair hearing without requesting a conference.

   You may request to keep your child care benefit unchanged until a fair hearing decision has been issued. If you request your benefit not to be changed until a fair hearing decision has been issued, and you lose the fair hearing, you will have been overpaid. The local department of social services will seek to recover the overpayment from you by reducing future child care benefits, by collecting a lump sum payment or installment payments, or through legal action.

   You may request a fair hearing by:

   (1) Calling: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) Online: To send your fair hearing request online, go to http://www.otda.ny.gov/oah, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box, complete the information below and mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box, complete the information below and fax both sides of this form to (518) 473-6735.

   ☐ I want a fair hearing. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

   Select one.

   ☐ Do **NOT** change my child care benefit until a fair hearing decision has been issued.

   ☐ Change my child care benefit on the effective date listed on this notice, pending the fair hearing decision.

Name: _____ District: _____

Address: _____ Case Number: _____

_____ Phone: _____

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay-stubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you **only** if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

OCFS-LDSS-4784-S (Rev. 09/2015)

ESTADO DE NUEVA YORK

OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

APROBACIÓN DE SU REDETERMINACIÓN PARA BENEFICIOS DE CUIDADO INFANTIL

FECHA DE LA NOTIFICACIÓN	FECHA EFECTIVA	NOMBRE Y DIRECCIÓN DE LA AGENCIA/CENTRO U OFICINA DISTRITAL
NÚMERO DE CASO	NÚMERO CIN	
NOMBRE DEL CASO (Y C/O Nombre si Presente) Y DIRECCIÓN		NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA
		O Conferencia con la Agencia
		Asistencia e Información sobre Audiencias **1-800-342-3334**
		Acceso a Registros
		Información sobre Asistencia Legal

NO. DE OFICINA	NO. DE UNIDAD	NO. DE TRABAJADOR(A)	NOMBRE DE LA UNIDAD O DEL TRABAJADOR(A)	NO. DE TELEFONO DEL TRABAJADOR(A)

Su solicitud fechada el _____ para beneficios de cuidado infantil ha sido aprobada. Usted es elegible para recibir beneficios de cuidado infantil para cuidado infantil provistos el _____ hasta _____ mientras usted esté en _____.

Comentarios:

USTED TIENE EL DERECHO A UNA CONFERENCIA Y/O AUDIENCIA IMPARCIAL PARA APELAR ESTA DECISIÓN.
LEA EL REVERSO DE ESTA NOTIFICACIÓN SOBRE CÓMO SOLICITAR UNA CONFERENCIA Y/0 AUDIENCIA PARA APELAR ESTA DECISIÓN.

BENEFICIOS. Se proveerán pagos en nombre de las siguientes personas:

Niño(s):	Para este proveedor(a):	Para la cantidad de:*	Tiempo Completo o Parcial:

El pago puede variar basado en fluctuaciones en su actividad aprobada y/o ausencias.

Los beneficios se pagarán: ☐ Directamente a usted. ☐ Directamente a su proveedor(a).
Su proveedor(a) debe presentar una cuenta y una hoja de asistencia a su departamento local de servicios sociales.

PORCIÓN FAMILIAR. Usted es responsable por pagar las siguientes cuotas:

☐ A partir de _____, una **Porción Semanal Familiar** debe pagarse a _____ en la cantidad de $_____ por semana.

☐ A partir de _____, una **Porción Familiar Adicional** debe pagarse a _____ en la cantidad de $_____ por semana.

☐ A partir de _____, una **Porción Familiar Ordenada por el Tribunal** debe pagarse a _____ en la cantidad de $_____ por semana, para los niños _____

La siguiente información es una explicación de cómo se determinó su porción familiar semanal.

Ingreso bruto anual de la familia $_____

Menos el 100% del Ingreso Estatal Estándar anual para una familia del $_____

Ingreso restante $_____

Ingreso restante $_____ X % de la porción familiar ____% = $_____

$_____ / 52 semanas = $_____ porción semanal de la familia

Todas las cantidades de las porciones familiares se redondean al $0.50 más cercano. Hay una cuota mínima de $1 por semana para todas las familias que no estén recibiendo Asistencia Temporal (Temporary Assistance-TA).

Para continuar recibiendo beneficios, estas son sus responsabilidades:

- Notifique a su trabajador(a) de caso inmediatamente sobre cualquier cambio en el ingreso de la familia, quién vive en su hogar, empleo, arreglos de cuidado infantil u otros cambios que puede que afecten su elegibilidad continua o la cantidad de su beneficio.
- Pagar con prontitud cualquier porción familiar requerida.

La(s) LEY/LEYES Y/O LA(S) REGU.ACION/REGULACIONES que nos permite(n) hacer esto es/son:

DERECHO A ACEPTAR O RECHAZAR SERVICIOS: La aprobación de sus beneficios no le obliga a aceptar los servicios. Usted puede escoger declinar los servicios contactando a su departamento local de servicios sociales.

Si usted está en desacuerdo con la decisión del departamento local de servicios sociales, usted puede solicitar una conferencia y//o una audiencia imparcial.

1. **CONFERENCIA:** Usted tiene el derecho a solicitar una conferencia a su departamento local de servicios sociales para revisar la determinación. Si usted desea una conferencia, usted debería solicitar una lo más pronto posible, porque el resultado de la conferencia puede que impacte su decisión de solicitar una audiencia imparcial. Si desea una audiencia imparcial y su beneficio de cuidado infantil permanece sin cambio alguno (la ayuda continúa) hasta que se emita la decisión de la audiencia imparcial, usted debe solicitar una audiencia imparcial antes de la FECHA EFECTIVA indicada en la primera página de esta notificación. Una solicitud para una conferencia solamente no resultará en la continuación de sus beneficios. En la conferencia, usted puede presentar información para demostrar por qué usted cree que la acción de la agencia no es correcta.

   Usted puede solicitar una conferencia:

   (1) Llamando al _____ (POR FAVOR TENGA CONSIGO ESTA NOTIFICACION CUANDO LLAME).

   (2) Escribiendo al: Marque la casilla de abajo y envíe a _____
   Por favor guarde una copia para usted.

   ☐ Deseo una conferencia. No estoy de acuerdo con la acción de la agencia. Usted puede explicar en un documento separado por qué está en desacuerdo, pero usted no tiene que incluir una explicación por escrito.

2. **AUDIENCIA IMPARCIAL:** Usted tiene el derecho a una audiencia imparcial para apelar la determinación del departamento local de servicios sociales. Si desea una audiencia imparcial, usted tiene 60 DIAS desde la FECHA DE LA NOTIFICACIÓN, localizada en la primera página, para hacer la solicitud. Si usted no desea que sus beneficios de cuidado infantil cambien hasta que se emita la decisión de la audiencia imparcial, usted debe solicitar una audiencia imparcial antes de la FECHA EFECTIVA indicada en la primera página de esta notificación. Usted puede solicitar una audiencia imparcial sin solicitar una conferencia.

   Usted puede solicitar que se mantengan sus beneficios de cuidado infantil sin cambio alguno hasta que se emita la decisión de la audiencia imparcial. Si usted solicita que su beneficio no cambie hasta que se emita la decisión de la audiencia imparcial, y usted pierde la audiencia imparcial, usted habrá recibido pagos en exceso. El departamento local de servicios sociales tratará de recobrar el exceso de pago reduciendo sus futuros beneficios de cuidado infantil, recobrando el pago ya sea en una suma única o en pagos a plazos, o a través de una acción legal.

   Usted puede solicitar una audiencia imparcial:

   (1) Llamando por teléfono: 1-800-342-3334 (POR FAVOR TENGA CONSIGO ESTA NOTIFICACION CUANDO LLAME).

   (2) Por correo electrónico: Para enviar su solicitud en línea, visite http://www.otda.ny.gov/oah, y haga un clic en los enlaces para solicitar una audiencia imparcial utilizando el formulario en línea y siguiendo las instrucciones para completar y presentar el formulario en línea.

   (3) Escribiendo: Complete la información de abajo, firme y envíela por correo a la New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201-1930. Por favor guarde una copia para usted.

   (4) Por facsímil: Marque la casilla y complete la información de abajo. Envíe ambos lados de este formulario a **(518) 473-6735**.

   ☐ Yo deseo una audiencia imparcial. No estoy de acuerdo con la acción de la agencia. Usted puede explicar la razón por la que está en desacuerdo debajo, pero no tiene que incluir una explicación por escrito.

   Marque uno:

   ☐ Yo **NO** deseo cambiar mi beneficio de cuidado infantil hasta que se emita una decisión en la audiencia imparcial

   ☐ Cambie mi beneficio de cuidado infantil en la fecha efectiva indicada en esta notificación, pendiente de la decisión de la audiencia imparcial.

Nombre: _____ Distrito: _____

Dirección: _____ Número de Caso: _____

_____ Número de Teléfono: _____

Si usted solicita una audiencia imparcial, el estado le enviará una notificación que le indicará la hora y el lugar de la audiencia. Usted tiene el derecho de ser representado(a) por un abogado(a), un pariente, un amigo(a) u otra persona, o puede representarse a sí mismo(a). En la audiencia, usted, su abogado(a) u otro representante tendrá la oportunidad de presentar evidencia escrita u oral para explicar la razón por la que usted cree que no debería tomarse la determinada acción; similarmente, tendrá la oportunidad de hacer preguntas a cualquier persona que se presente a la audiencia. Usted también tiene el derecho de traer testigos que testifiquen en su favor. Usted debería traer a la audiencia cualesquier documentos, tales como esta notificación, talones salariales, recibos, facturas de cuidado de niños, verificación médica, cartas, etc. que puedan ayudarle en la presentación de su caso.

ASISTENCIA LEGAL: Si usted cree que necesita asistencia legal gratuita, usted puede obtener esa ayuda poniéndose en contacto con la Sociedad de Ayuda Legal de su localidad u otro grupo de abogacía legal. Usted puede localizar a la Sociedad de Ayuda Legal o a un grupo de abogacía buscando en las "Páginas Amarillas" o "Yellow Pages" bajo la sección de "Abogados" o "Lawyers", o llamando al número indicado en la primera página de esta notificación.

ACCESO A SU ARCHIVO/REGISTRO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar el archivo/registro de su caso. Si usted nos llama o nos escribe, le proveeremos copias gratuitas de los documentos de su archivo/registro que proporcionaremos al funcionario(a) de la audiencia para la audiencia imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo/registro, llámenos al número de teléfono de Acceso a Registros que aparece en la parte superior de la primera página de esta notificación o escríbanos a la dirección impresa que aparece en la parte superior de la primera página de esta notificación. También, si usted llama o nos escribe, le proveeremos copias gratuitas de otros documentos de su archivo los que puede que necesite para prepararse para su audiencia imparcial. Si usted desea copias de algunos documentos del archivo de su caso, usted debería pedirlas con anticipación. Estas se le enviarán dentro de un tiempo razonable antes de la fecha de su audiencia. Los documentos se le enviarán **solamente** si usted especifica el deseo de que se los envíe.

INFORMACION: Si desea más información acerca de su caso, cómo solicitar una conferencia o audiencia imparcial, cómo revisar su archivo/registro, o cómo obtener copias adicionales de documentos, llámenos a los números de teléfono que aparecen en la parte superior de la primera página de esta notificación o escríbanos a la dirección que aparece en la parte superior de la primera página de esta notificación.