At- Risk Child Care Application and Authorization

Authorization
If update, change in:

☐ INITIAL AUTHORIZATION ☐ REDETERMINATION ☐ UPDATE
☐ Hours ☐ Children ☐ Address ☐ Custody
☐ Eligibility Extension ☐ Termination of Care ☐ Worker/Unit

TO:		FROM: (Print Worker Name)		
		Unit, Number & Address		Phone:
		City	Zip Code	Email

SECTION A: CLIENT/FAMILY INFORMATION

Social Security No.	Last Name First Name MI (Print)	Date of Birth	Sex	Race
Social Security No.	Spouse or other Parent (if applicable) (Print): Last Name First Name MI	Date of Birth	Sex	Race

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

If there is NO spouse: enter the Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Parent/ (if different from above): Last Name First Name MI (Print)	Social Security No.	Date of Birth	Sex	Race

Address	City	State	Zip	Day Time Phone No.	Evening Phone No.

SECTION B: ELIGIBILITY

I. Status: ☐ Assistance ☐ Non-Assistance **Rilya Wilson Act:** ☐ Yes ☐ No

☒ **At Risk:** ● PI ○ PS ○ FC ☐ Project Safety Net

☐ In Home ☐ Out of Home: Relative/Non-Relative ☐ Foster Care

☐ **DIVERSION PROGRAM** ☐ **QLC**

FOR COALITION USE ONLY

☐ Income Eligible <100% ☐ Income Eligible 150%-200% ☐ TANF "Child Only"
☐ Income Eligible 100% <=150% ☐ OTHER ☐ TANF (Relative Caregiver)

II. Purpose of Care

☒ Protection ☐ Therapeutic Plan ☐ TANF At Risk (RCG) ☐ Emergency
☐ Employment ☐ Work Activity ☐ Education Activity (TED)

SECTION C: AUTHORIZATION

Child care services is authorized for this client for approved activity(ies) not to exceed a total of _____ hours per week.

This total includes _____ hours per week for reasonable transportation time. Children authorized to receive care:

Name	SSN	Birth Date	Race/Sex	FSFN Person ID	FOR COALITION USE ONLY		
					Center/Home Placed	Date Enrolled	Parent Fee

Gross Monthly Family Income:_____ Attach Documentation (if available)

Care Authorization from _____ through _____ (Not to exceed a 6 month period)

Comments:_____

SECTION D: AUTHORIZING SIGNATURE(S) – I hereby certify that the information provided above is correct.

Applicant Signature:_____ Date:_____

Authorizing Worker:_____ Date:_____

Supervisory Approval:_____ Tel.:_____ Date:_____

Coalition:_____ _____ Date:_____

THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE

Copy To: 4C and Child's File