



Child Care Subsidy Program (CCSP) Application

To process your application, please use black ink, submit a completed signed application along with a copy of all required documentation listed below. Incomplete applications will experience a delay in processing. Child Care Subsidy payments to child care providers will be for child care services provided between the beginning date and end date of the award letter. The parent is responsible for any care used prior to the issuance of an award.

Required Documentation: For all adults in the household responsible for children (include spouse, significant other, etc.)

- Proof of Citizenship for **children** (birth certificate (state issued copy), passport, immigration or naturalization documents) *Social Security cards are **not** acceptable proof of citizenship.
- Proof of Residency (driver's license, rental agreement, mortgage statement, car registration, hunting/fishing license, utility bills (electric, water, gas) * internet bill is not accepted as proof of residency.
- Official School Schedule for parent(s) (if applicable) with financial aid award letter and school invoice
- Income Verification
 - Pay stubs (4 most recent weeks); or
 - Employment information sheet; or
 - (if self-employed) Most recent IRS Tax Return (or) Most recent monthly profit and loss statement
- Unearned Income (if applicable)
 - Social Security award letter, child SSI award letter, child only TANF grant
 - Pension/retirement statement/alimony
 - Child support (court ordered, joint custody, parental rights/responsibilities)
 - Financial aid award letter and invoice from the school
 - Military benefits
- Special needs documentation determined by a qualified professional (if applicable)

For questions regarding this program and/or application, please contact the following:

**Department of Health and Human Services
Office of Child and Family Services
Child Care Subsidy Program
2 Anthony Avenue
11 State House Station
Augusta, ME 04333-0011
Email: CCSP.DHHS@Maine.gov**



STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Child and Family Services
Child Care Subsidy Program Application

SECTION 1: Applicant(s) Information			
1. Primary Applicant Name:		Birthdate:	
Email Address:		Last four of Social Security #:	
Home Phone:		Cell Phone:	
Gender:	Primary Language:		Race:
Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Translator needed? <input type="checkbox"/>		
Are you a court appointed legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof of legal guardianship)			
2. Physical Address:			
Street Address:			
City:	State:	Zip:	County:
3. Mailing Address: (if different from above)			
Mailing Address/Post Office Box:			
City:	State:	Zip:	County:

SECTION 2: Additional Household Member(s) Including Children			
4. Name:		Birthdate:	
Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof)		Social Security #:	
Gender:	Primary Language:		Race:
Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Applicant:		
5. Name:		Birthdate:	
Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof)		Social Security #:	
Gender:	Primary Language:		Race:
Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Applicant:		
6. Name:		Birthdate:	
Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof)		Social Security #:	
Gender:	Primary Language:		Race:
Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Applicant:		
7. Name:		Birthdate:	
Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof)		Social Security #:	
Gender:	Primary Language:		Race:
Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Applicant:		

SECTION 3: Questions	
8.	Are all adults in the family working or attending an education/job training program? <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Is this a two-parent household in which one adult works or attends an education/job training program and the other has a documented disability from SSA with a doctor's note indicating the disability preventing him/her from caring for the children? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation)
10.	Has a child been placed under the legal guardianship of an individual who has reached retirement age as defined by Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Do you have assets that are equal to or exceed \$1,000,000? <input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Are you currently experiencing homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Do you receive housing assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Have you received TANF in the past twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Please check if you currently are: <input type="checkbox"/> A member of the National Guard Unit <input type="checkbox"/> A member of the Military Reserve Unit <input type="checkbox"/> On Active Duty in U.S Military
16.	Do you have a tribal affiliation? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4: Children with Special Needs	
17.	Do any children needing care have special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation)
<p>A Child with Special Needs refers to a) a Child up to thirteen (13) years of age, for whom it has been determined by a qualified professional, that the Child has a disability as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401); is eligible for early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.); is eligible for services under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794); meets the definition of disability under the Americans with Disabilities Act (ADA) (P.L. 110-325); is considered at-risk for health and/or developmental problems as a result of identified environmental risk factors including, but not limited to, homelessness, abuse and/or neglect, lead poisoning, and prenatal drug or alcohol exposure; and/or b) a Child who is between thirteen (13) years of age and eighteen (18) years of age, who is physically or mentally incapable of caring for him or herself, or is under court supervision. In addition, you will receive a release of information request to return for provider reimbursement.</p>	

SECTION 5: Absent Parent Information (Must be completed if a single parent household) <input type="checkbox"/> N/A if a 2 parent household	
18.	Do you have shared parental rights/responsibilities for child care payment? <input type="checkbox"/> Yes <input type="checkbox"/> No *provide a copy of the court order or notarized agreement
19.	Do you have court ordered shared/joint custody? <input type="checkbox"/> Yes <input type="checkbox"/> No *provide a copy of the court order or notarized visitation schedule
20.	Are you court ordered or voluntarily receiving child support? <input type="checkbox"/> Yes <input type="checkbox"/> No *court order is income regardless of payment received
21.	Do you receive adoption assistance? <input type="checkbox"/> Yes *please provide documentation <input type="checkbox"/> No

Section 6: Parent School Information	
<p>Educational program refers to a program which is required for completion of a secondary diploma, High School Equivalency Test (HISSET), or other Department-approved high school equivalency test; Department-approved vocational program; or post-secondary undergraduate program in which the parent is earning credits toward a degree; or another Department-approved educational program. Parents attending graduate or doctorate-level educational programs are not eligible to receive Child Care Subsidy.</p>	
<p>*Please list and attach documentation about education/job training programs for all adults in the household who are students. For each student; provide a current official class schedule showing institution name, student name, class days/time, semester dates, and credit hours, financial aid letter, and school bill*</p>	
22. Student #1 Name of School:	
Degree:	Start Date: End Date:
Next Semester Start Date:	Anticipated Graduation Date:
Travel Time Needed Per Day (round trip from child care to school, in hours):	
23. Student #2 - Name of School:	
Degree:	Start Date: End Date:
Next Semester Start Date:	Anticipated Graduation Date:
Travel Time Needed Per Day (round trip from child care to school, in hours):	

SECTION 7: Employment **Not Applicable**

Please submit employment information for all adults in the household. Please submit four (4) weeks of current paystubs for all working adults or an employment information sheet can be submitted. Self-employed individuals must submit a copy of their most current taxes or most recent monthly profit and loss statement. Please provide all sources of unearned income. If adults have more than two jobs, please attach a separate sheet with all the information listed below for each additional position, in addition to all supporting documentation referenced above

24. Job #1 – Traditional Self-employed Seasonal Per diem

Employee Name: _____ Job Title: _____

Name of Employer: _____ Work Phone: _____

Hire/Start Date: _____ Travel time (one-way), work to child care in hours: _____

Work Schedule: (example: 8am – 5pm) *Note: If your schedule varies, please indicate your work schedule for the past four (4) weeks*

Week Beginning/end dates (mm/dd/yr. – mm/dd/yr.)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

25. Job #2 – Traditional Self-employed Seasonal Per diem

Employee Name: _____ Job Title: _____

Name of Employer: _____ Work Phone: _____

Hire/Start Date: _____ Travel time, work to child care in hours: _____

Work Schedule: (example: 8am – 5pm) *Note: If your schedule varies, please indicate your work schedule for the past four (4) weeks*

Week Beginning/end dates (mm/dd/yr. – mm/dd/yr.)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

INFORMATION

If you would like information on developmental screenings, please go to the following link:
<https://www.cdc.gov/ncbddd/childdevelopment/screening.html>

Signature Required-Please sign, date and return

I certify under penalty of perjury that to the best of my knowledge the above information is true. I understand that this information will be provided to the Department of Health and Human Services (DHHS) for use in administration of this program. I authorize the agency to verify this information by whatever means necessary. I agree to notify the DHHS, Child Care Subsidy Program (CCSP) within ten (10) days of any cessation of work or attendance at an educational or job training program and/or change of child care provider and/or if family income exceeds over eighty-five percent (85%) of State Median Income (SMI).

The application review process may take the Department up to 30 days.

Primary Applicant Signature: _____ (typed signature is not accepted) Date: _____

Preparer Signature: _____ Date: _____

Employer Information Sheet

Please have your supervisor or human resources staff complete this form

Employer Responsible for Completion

Not Applicable

1. Employer Name:		
2. Name of Employee:		
3. Hourly Wage/Salary:	4. Date of Hire:	5. Date of Rehire:
6. Does the schedule include a 30 min unpaid break?	7. Are you paid weekly, bi-weekly or monthly?	
8. If you receive tips, how much do you receive in tips per week? (Please provide documentation)		

Employee's Work Schedule: (example: 8am – 5pm)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

Note: If the employee's schedule varies, please indicate work schedule for the past four (4) weeks. If the employee has not been employed for a full four (4) weeks, please estimate expected hour for the remaining weeks

Week Beginning/end dates (mm/dd/yr. – mm/dd/yr.)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

I certify under penalty of perjury that to the best of my knowledge the above information is true.

Supervisor/Human Resources Staff Name (Print): _____

Supervisor/Human Resources Staff Signature: _____ Date: _____

Email Address: _____ Phone: _____



STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Child and Family Services

Child Care Subsidy Program – Child Care Provider Information Sheet

Please have your Child Care Provider complete this form

Child Care Provider Responsible for Completion
1. Parent Name:
2. Child(ren's) Name(s):
3. When is the child expected to attend your program?

Provider Information	
1. Business Name: Laugh & Learn Academy	2. Provider hours of operation: 6:00AM-5:15PM
3. Name of Contact Person: Kaitie Gilmour	4. Phone Number: 207-521-5090
5. Address: 18 High St. Houlton Me. 04730	
6. Email Address: Kaitie@LaughandLearnAcademy.me	
7. Do you currently participate in the Maine's Quality Ratings and Improvement System? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
8. Provider Type: (select below)	
<input checked="" type="checkbox"/> Licensed License Number/CCSP Billing Number: 762369	
<input type="checkbox"/> License Exempt Provider *Background check paperwork may take up to 45 days to process* *Additional paperwork will be sent for completion*	
<ul style="list-style-type: none"> Must be 18 years old and may not reside at the same address as the child(ren); and Can only watch a maximum of two (2) children Must be a Maine resident for 6 months 	
Check one:	
In <u>Providers</u> Home: <input type="checkbox"/> Unrelated <input type="checkbox"/> Related (must indicate relationship to child) _____	
In <u>Child's</u> Home: <input type="checkbox"/> Unrelated <input type="checkbox"/> Related (must indicate relationship to child) _____	
School Age Program/Recreational <input type="checkbox"/>	
9. What is your QRIS Step Level: 1	

By signing below you acknowledge that the **Child Care Subsidy Program does not pay retroactively** and the parent is responsible for all payments until you receive an award letter. If you are a new provider to the Child Care Subsidy Program you will be receiving additional paperwork that needs to be completed.

Providers Name (Print): Kaitie Gilmour Preferred Language: English
 Provider's Signature: Date: _____

***Signature Required-Please sign, date and return to the following address:**

Department of Health and Human Services
 Office of Child and Family Services
 Child Care Subsidy Program
 2 Anthony Avenue
 11 State House Station
 Augusta, ME 04333-0011