

Kansas Department for Children and Families
Application for Foster Care Child Care Benefits

ES-3100FC
Rev. 05-19

This is your application for Foster Care Child Care (FC-CC) offered through the Department for Children and Families (DCF). Please answer all the questions truthfully, to the best of your ability. If English is not your primary language, an interpreter will be provided at no cost to you. Please be aware, you are subject to severe penalties for any false or misleading information you supply on this application.

Agency Use Only

Date Received: _____
Date Interviewed: _____
_____ Initial _____ Review
Interview completed by: _____
Case Number(s): _____

This form provides us with the information we need to determine child care eligibility for you as a foster family for the child(ren) in your temporary care. Supporting documentation for your employment or school attendance must be included with this application.

Follow These Steps to Apply

- Complete this form to apply. If you need help or have questions, call (785) 368-8594.
- Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Sign and date this form. Your application is not complete until it is signed.
- Return this form as soon as possible. If you are eligible, some benefits start from the date a signed application is received in our office.
- Mail, fax or bring this form to your child's case management provider or your child's placing agency. It may take 30 to 45 days before your application is processed.
- If an interview is required, we will contact you.

Return this form to:



A. Tell Us About Yourself and the People in Your Home

Provide the following information and sign this section of the application.

Name: _____ Signature: _____

First Name, Middle Initial, Last Name

Street Address: _____ City: _____ County: _____ Zip: _____

Mailing Address: _____ City: _____ County: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ E-mail: _____

Are You: Never Married Married Common Law Married Divorced Separated

Widowed Member of an Unmarried Couple

Who are the members of your family? (Do not include children in foster care here.)

First name, Mi, Last name	Relationship to you	Sex	DOB	SSN
	Self			

Your information is private:

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify for benefits.

B. Tell Us How to Communicate with You

We provide interpreter and translation services. Complete this section to help us meet your needs.

Do you have a primary language other than English? No Yes

If yes, write in the names of spoken and/or written language below. Also include other communication needs such as braille, relay, signed English, TDD/TTY, large print, Voice Synthesizer Program, etc.

Spoken Language	Written Language	Other needs

C. Tell Us About the Foster Children for Whom You Are Applying

Who is the child or children in foster care temporarily living with you? Attach additional pages as necessary.

You may choose not to list race or ethnic heritage, and it will not be used against you. We only ask this information for federal reporting purposes. Answers will in no way affect eligibility or benefits.

PERSON 1			
First name	Middle name	Last name	Suffix
Social Security number		Date of birth (month/day/year)	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F

Race and Ethnicity (optional) Note: For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

Disability: Is Person 1 disabled? No Yes

Ethnicity: Is Person 1 Hispanic or Latino? No Yes

Race: Check all that apply to Person 1.

- | | | | | |
|--|---|-------------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | | |

PERSON 2			
First name	Middle name	Last name	Suffix
Social Security number		Date of birth (month/day/year)	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F

Race and Ethnicity (optional) Note: For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

Disability: Is Person 2 disabled? No Yes

Ethnicity: Is Person 2 Hispanic or Latino? No Yes

Race: Check all that apply to Person 2.

- | | | | | |
|--|---|-------------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | | |

PERSON 3

First name	Middle name	Last name	Suffix
Social Security number		Date of birth (month/day/year)	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F

Race and Ethnicity (optional) Note: For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

Disability: Is Person 3 disabled? No Yes

Ethnicity: Is Person 3 Hispanic or Latino? No Yes

Race: Check all that apply to Person 3.

- | | | | | |
|--|---|-------------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | | |

PERSON 4

First name	Middle name	Last name	Suffix
Social Security number		Date of birth (month/day/year)	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F

Race and Ethnicity (optional) Note: For reporting purposes, if you choose not to select a race and/or ethnic category, a choice will be made on your behalf.

Disability: Is Person 4 disabled? No Yes

Ethnicity: Is Person 4 Hispanic or Latino? No Yes

Race: Check all that apply to Person 4.

- | | | | | |
|--|---|-------------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | | |

D. Tell Us About Your Child Care Needs

To help us determine if you can get child care benefits, tell us why you need help with child care expenses (check all that apply):

I have a job. I go to school/training.

Other - explain: _____

Do you need help finding quality child care? No Yes

Do you have enrollment fees to begin child care for your foster child? No Yes

If yes, what amount is being charged? _____

When do you need child care to start? _____

Please fill out the information below for each child who needs child care. If child care is needed for more than 4 children, please attach additional pages.

Provide the following for each child	Child's name	Child's name	Child's name	Child's name
List child care provider information below each child's name				
Provider's name				
Address				
Phone number				
Parent's work/ school schedule (daily work/school schedule)	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM
	Mon	Mon	Mon	Mon
	Tue	Tue	Tue	Tue
	Wed	Wed	Wed	Wed
	Thur	Thur	Thur	Thur
	Fri	Fri	Fri	Fri
	Sat	Sat	Sat	Sat
	Sun	Sun	Sun	Sun
Child's school schedule (daily school schedule)	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM
	Mon	Mon	Mon	Mon
	Tue	Tue	Tue	Tue
	Wed	Wed	Wed	Wed
	Thur	Thur	Thur	Thur
	Fri	Fri	Fri	Fri
	Sat	Sat	Sat	Sat
	Sun	Sun	Sun	Sun
Child's grade and name of school/ headstart				

Please Read This Information Before Signing

Rights, responsibilities and penalties

- I have read and understand my rights and responsibilities on this form.
- I understand the questions on this application form.
- I understand the penalties for hiding information.
- I understand the penalties for giving false information.

Changes you must report

- I agree to report changes such as changes in my address, changes in choice of child care provider, and/or changes in hours of child care needed/used (other than hours needed for school age children for times that school is not in session). This includes when child care is no longer being used or has not been used for an entire calendar month for any or all children receiving assistance.
- I understand I will be notified about the changes I am required to report.
- I will tell my foster care worker of any changes that would impact my eligibility.

We will verify the information you give us

- I understand you will verify the information I provide on this application form.
- I understand you may contact other agencies such as federal, state, local officials, employers, medical providers, businesses, financial organizations and child care providers to verify information.
- I understand you will use the information you verify and that it could affect my eligibility or benefit level.

Fraud Penalties

Child Care Assistance – If you or any adult member of your foster care child care household intentionally break any of the following rules or are otherwise found to have committed fraud (civil, criminal or administrative), in child care, all adults in your household are permanently ineligible for child care assistance. If you would be eligible in the future or currently are receiving TANF benefits, you would become permanently ineligible as well.

- Do not lie, make misleading statements, hide information or fail to report changes, as required, to get benefit that your household should not get.
- Do not use or have in your possession Kansas Benefits Cards that are not yours.
- Do not trade or sell Benefits Cards.

The remainder of your foster care child care household can get benefits if they are otherwise eligible. Adults in the household will still be responsible for paying the amount of any benefits overpayment that was received by the person disqualified.

DCF Rights

DCF has a right to:

- Verify the alien status of applicant household members by submitting information from the application to the U.S. Citizenship and Immigration Service (USCIS). The information received may affect the household's eligibility and amount of benefits.
- Deny benefits to your household if you do not provide requested information.
- Disclose the information on your application to other federal and state agencies for official examination, and to law enforcement officials for the purpose of arresting people who are running from the law.
- Refer the information on this application to federal and state agencies, as well as private claims agencies, for claims collection if overpayments arise against your household.
- Conduct a full investigation of your eligibility, including contacting employers, child care providers, banks, doctors or by visiting your home.
- Deny your application or prosecute you for fraud if you knowingly give us false information so you can receive assistance.

Your Responsibilities

You have a responsibility to:

- Report changes as required;
- Pay your child care provider for services;
- Cooperate with Quality Assurance staff if your case is reviewed;
- Cooperate with a fraud investigation.

Your Rights

You have a right to:

- Have an interpreter provided at no cost if English is not your primary language;
- Have information given to DCF kept confidential, unless directly related to the administration of DCF programs;
- Withdraw your application at any time;
- Request a fair hearing within 30 days for child care assistance;
- Have your benefits determined from the date this application is received by DCF.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Foster Care Case Management or Child Placing Agency

My signature on this application certifies that the foster child(ren) for whom child care assistance is requested are in the custody of the Secretary of the Kansas Department for Children and Families (DCF). It also certifies that child care is needed due to the foster family's verified work or school schedule, and that the below stated agency has obtained verification of the citizenship and date of birth for each child whom child care assistance is requested. All documentation must be maintained and cannot be destroyed until after the child care assistance case has been closed for 36 months and must be made available to DCF in the event of an audit.

Name of Foster Care Case Management/Child Placing Agency

Name of Case Management/Agency Representative (Printed)

Signature of Case Management/Agency Representative

Date

Permission to Release Information and Signature

My signature on this application authorizes employers, child care providers, health care providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to Kansas Department for Children and Families (DCF) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program (including Child Support Services) for which I applied.

I authorize DCF to share medical information for administrative purposes with other agencies and contractors.

I understand all information provided on this application and all information provided to DCF staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge, including the information concerning citizenship and alien status. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person to obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 21-5801 and amendments, which could be a felony offense punished by imprisonment, fine, or both, and the offender may also be subject to prosecution under other applicable state and federal law.

Your Signature (required)

Date

Your Spouse's Signature or Another Adult in Your Home (not required)

Date

Signature of First Witness (required if you cannot sign your name)

Date

Signature of Second Witness (required if you cannot sign your name)

Date

Signature of Court-Appointed Guardian/Conservator (if applicable)

Date

