Iowa Department of Human Services

Child Care Assistance Application

Tell Us About the People in Your Home

If both parents/step-parents or caretakers are in the home, include information for both.

Parent/step-parent or caretaker name	Birth Date	Social Security Number	Phone ( )	
Parent/step-parent or caretaker name	Birth Date	Social Security Number	Phone ( )	
Street		City	State	Zip

List all children needing child care.

We have to ask the ethnicity and race of each child, but you don't have to answer. Your answer will not affect your eligibility for child care. If you answer, use the following coding:

Ethnicity:
H = Hispanic or Latino
N = Not Hispanic or Latino

Race: (choose all that apply)
W = White
B = Black or African American
A = Asian
I = American Indian or Alaskan Native
N = Native Hawaiian or other Pacific Islander

Name (First, Last)	Relationship to you	Birth Date	Social Security Number	Sex	Name of School	Race	Ethnicity	Citizen Yes/No	If Alien, Status

Are any of your children listed above identified as having special needs? ❑ Yes ❑ No

If yes, attach a statement from your doctor or the professional who made the diagnosis to verify special needs.

List all other people living in your home.

Name	Relationship to you

Child Care Provider Information

Provider name		Phone ( )	
Street	City	State	Zip

Will your provider watch your children in your own home? ❑ Yes ❑ No

Need for Service

Parent/Guardian:			**Parent/Guardian:**		
Are you working? ❑ Yes ❑ No			Are you working? ❑ Yes ❑ No		
How many hours a week?			How many hours a week?		
What is your hourly wage?			What is your hourly wage?		
Employer name:			Employer name:		
Phone:			Phone:		
List the start and end times of the days you work.	Start	End	List the start and end times of the days you work.	Start	End
Sunday			Sunday		
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Are you a full-time student? ❑ Yes ❑ No			Are you a full-time student? ❑ Yes ❑ No		
Enrolled in graduate school? ❑ Yes ❑ No			Enrolled in graduate school? ❑ Yes ❑ No		
School name:			School name:		

In order to determine your need for child care assistance, attach your pay stubs from the last 30 days or a letter from your employer stating your wage and hours. If you are a student, attach a copy of your class schedule.

List other reasons you need child care (hospitalizations, job search, etc.).

_____

Monthly Family Income

List your family income below. If you are not the parent/step-parent of the child needing care, list only the child's income.

Gross Wages (before taxes)	$	SSI	$
FIP Benefits	$	Social Security	$
Child Support or Alimony	$	Other	$

If you are receiving Food Assistance, FIP, or medical assistance please write your worker's name here _____.

Signature	Date

Iowa Department of Human Services

Employer's Statement of Earnings

Date: _____
Case #: _____
Worker #: _____

Dear _____:

Please complete this form and send or fax it back by _____. The employee has given permission for you to give us this information. Only the checked sections need to be completed. Please attach another sheet of paper if you need more space. Thank you.

Employee Permission

I give my employer permission to share information about my job. I will not take legal action against them for sharing this information. This permission will stop the last day of the sixth month after the month signed.

Employee Last Name	First	SSN	Employee Signature	Date
			X	X

☐ **Starting Employment** Date started:_____ Date of first check: _____

Rate of pay $_____ per ☐ hour ☐ day ☐ week ☐ month ☐ year

Pay period ends on:_____ (day of week) paid _____ days later on _____ (day of week)

Employee is paid: ☐ weekly ☐ biweekly ☐ monthly ☐ semimonthly ☐ other _____

Hours of work per week: _____ Average hours of overtime per week: _____

Does employee get tips? ☐ Yes ☐ No Estimated monthly tips: $_____

Does employee get commissions? ☐ Yes ☐ No Estimated monthly commission: $_____

Title of employee: _____ Is health insurance available? ☐ Yes ☐ No

☐ **Ending Employment** Reason ended: ☐ quit ☐ fired ☐ laid off ☐ other _____

Last date of employment:_____ Date of last check:_____ Gross amount $_____

Is this job still available? ☐ Yes ☐ No Would you rehire this person? ☐ Yes ☐ No

☐ **Amount of Pay** Please list the gross amount of pay that the employee will get or has gotten for the time period listed. For future income, please estimate the gross amount.

Time period requesting information for: _____ to _____

Date pay period ends	Date pay received	Gross amount–before taxes/deductions	Hours worked

Is any of the gross amount Earned Income Tax Credit? ☐ Yes ☐ No If yes, amount $_____

☒ **Employer Information**

Employer/Representative Signature	Phone	Date

Employer's Name	Address

Questions??? Please contact:

Worker Name	Phone Number	Fax Number	E-mail Address

Mailing Address

You Have the Right to Appeal

You or the person helping you may request a hearing in writing if you do not agree with any action taken on your case. You may contact your county DHS office about legal services that are available based on your ability to pay. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

You Will Not Be Discriminated Against

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to: Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.