

AT-RISK CHILD CARE APPLICATION AND AUTHORIZATION

Authorization	INITIAL AUTHORIZATION	REDETERMINATION	UPDATE
<i>If update, change in:</i>	Hours	Children	Address
	Eligibility Extension	Termination of Care	Custody Worker/Unit

TO: Early Learning Coalition of Alachua County 4424 NW 13 th Street A5 Gainesville FL 32609	FROM (Worker Name): _____ Email Address: _____
	Unit Number & Address: _____
	City _____ State _____ Zip Code _____

SECTION A: CLIENT/FAMILY INFORMATION If address for parent/guardian is a PO Box, enter street address in "Comments" below.

Social Security Number	Last Name	First Name	MI	Date of Birth	Sex	Race
Spouse or other Parent, <i>if applicable</i> , Social Security Number	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	Social Security Number	Date of Birth	Sex Race
Address		City	State	Zip	Day Time Phone No.	Evening Phone No.

SECTION B: ELIGIBILITY

I. STATUS	Assistance At Risk	Non –Assistance PI	Non –Assistance PS	FC	Rilya Wilson Act: Diversions	Yes	No
Placement Location:		In Home	Out of Home: Relative/Non-Relative		Foster Care		
II. FOR COALITION USE ONLY							
Income Eligible <100%		Income Eligible 150% - 200%			TANF "Child Only"		
Income Eligible 100% <=150%		Other			TANF (Relative Caregiver)		
III. PRIMARY PURPOSE OF CARE: PROTECTION							
Secondary Purpose of Care:		Emergency	Therapeutic Plan		TANF At Risk (RCG)		
		Employment	Work Activity		Education Activity (TED)		

SECTION C: AUTHORIZATION

Child care services are authorized for this client for approved activity(ies). The minimum hours of care per child includes _____ hours per week for reasonable transportation time. *Children authorized to receive care:*

						FOR COALITION USE ONLY		
Name	Social Security Number	Birth Date	Race/ Gender	Minimum Hours of Care/Work	FAHIS Investigation Intake #	Centered/Home Placed	Date Enrolled	Assessed Fee

Gross Monthly Family Income: \$_____ Attach Income 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 TEN (10) CALENDAR DAYS FROM AUTHORIZATION DATE



4424 NW 13th Street A5
 Gainesville FL 32609
 352-375-4110
 fax 352-375-4131

Request for Fee Reduction

Caregiver Name:

Phone:

Address:

Is this caregiver a foster parent or an out of home placement caregiver? Yes No

No fee waiver/reduction requested

Special circumstance that may warrant reduced or waived fees (check one):

- Child's parent/guardians are in prison;
- Child's parent/guardians are in residential treatment;
- Child's parent/guardians are incapacitated;
- Death of child's parents/guardians;
- Homeless shelter/living arrangements;
- Child's parent/guardians experienced a natural disaster (storm, earthquake, etc.);
- Child's parent/guardians experienced an emergency situation such as fire or robbery; or
- Other:

I, _____, request that based on the reported hardship the

Parent fee be: reduced waived

Current Marital Status of the Caregiver: single married separated divorced widowed

Is the caregiver a student? Yes No

Is the caregiver receiving child support for any of the children? Yes No

Family size (only of the family unit being served):

Person(s) that work:

Name: _____ Employer: _____

Gross Monthly \$ _____

Name: _____ Employer: _____

Gross Monthly \$ _____

Additional Income Received: Other than employment & child support, Such as (SSI, TANF/AFDC, Wages Assistance, Relative Care Giver Assistance, Veterans benefits, Unemployment Benefits, Adoption Subsidy, Cash Income, Financial Aid, etc.). Yes No

Authorizing Worker:

Date:

Supervisory Approval:

Date:

Decision: **Approval** of reduction waiver **Denied**

Coalition Staff: _____ Date: _____