AT-RISK CHILD CARE APPLICATION AND AUTHORIZATION

Authorization ☐ INITIAL AUTHORIZATION ☐ REDETERMINATION ☐ UPDATE

If update, change in: ☐ Hours ☐ Children ☐ Address ☐ Custody ☐ Eligibility Extension ☐ Termination of Care ☐ Worker/Unit

TO:
Early Learning Coalition
of Alachua County
4424 NW 13th 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
						Other
Spouse or other Parent, *if applicable,* Social Security Number	Last Name	First Name	MI	Date of Birth	Sex	Race
						Other

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
							Other

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** ☐ **Diversion**

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

Custody: ☐ Under ☐ Not Under DCF Placement & Care/Custody

Medicaid Eligible: ☐ Yes ☐ No If no, is ineligibility due to citizenship? ☐ Yes ☐ No

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

Early Learning Coalition of Alachua County

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: _____

Submit Forms