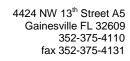
		T								
		AT-RISK CHILD CARE APPLICATION AND AUTHORIZATION								
	<b>Authorization</b> <i>If update, change in:</i>			INITIAL AUTHORIZATION Hours Children			REDETERMINATION UPDATE Address Custody			
				bility Ext	ension	Termination of		Worker/Uni	t	
Early Learning Coalition	n	FROM (Worker Name):			E	mail Address:				
of Alachua County 4424 NW 13 <sup>th</sup> Street A5 Gainesville FL 32609		Unit Number & Address:								
		City		State			Zip Code			
SECTION A: CLIE	ENT/	I FAMILY INFO	RMATION I	f address fo	or parent/guard	lian is a PO Box, ente	er street address i	in "Comments	" below.	
Social Security Number	Last Na			First Nan		MI	Date of		Race	
Spouse or other Parent, if applicable, Last Name		First Name			MI	Date of	Birth Sex	Race		
Social Security Number										
Address	City			State Zip		Day Time Phone N	o. E	Evening Phone No.		
If there is No spouse, enter the			Single	Single First Name		Widowe		Separated		
Parent (if different from above):	Last Na	ne	First f	Name	MI	Social Security Numb	er Date of Birt	h Sex	Race	
Address	City			State		Day Time Phone N	o. I	Evening Phone No.		
SECTION B: ELIGIBILITY										
I. STATUS		Assistance	Non –Assistar		Rilya Wils Diversion		s 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 Eligib	ole <1	00%		Eligible 1	50% - 200%		TANF "Chil	•		
Income Eligib			Other PROTECTIO	)N			TANF (Rela	tive Caregiv	ver)	
III. PRIMARY PURPOSE OF CARE: PROTECTION  Secondary Purpose of Care: Emergency Therapeutic Plan TANF At Risk (RCG)										
			nployment	yment 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 tran							_			
					Minimum	FAHIS	FOR COA	LITION USI	E ONLY	
Name		Social Security Number	Birth Date	Race/ Gender	Hours of Care/Work	Investigation Intake #	Centered/Home Placed	Date Enrolled	Assessed Fee	
Tvanio		rvamoer	Bitti Bate	Gender	Curcy Work	maxe "	Traccu	Date Emoned	100	
							+			
Gross Monthly Family	Incon	201 \$	Attach Inco	ma Doau	montation (if	angilahla)				
Gross Monthly Family Income: \$ Attach Income Documentation (if available).										
CARE AUTHORIZATION FROMTHROUGH(Not to exceed a 6-month period)  Comments:										
	пОр	IZING SIGNAT	FIIDE(C). 11.		ifo, that tha i	u forma ation muoni	dad ahana ia a	~~~ a a 4		
SECTION D: AUTHORIZING SIGNATURE(S): I hereby certify that the information provided above is correct.										
Applicant Signature:						Dar				
Authorizing Worker:							Date:			
Supervisory Approval:				Tel.:		Da	te:			
Coalition:						Da	te:			





## **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 base	ed on the reporte	ed 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:								