

Federal ID #:

Department of Early Education and Care Child Care Subsidy Application and Fee Agreement

Last Name	First Name
Street Address	P.O. Box
City/Town	Zip
Home Phone #	Work Phone #
Primary Parent SSN	Second Parent SSN

Parent Type One Parent Two Parent Grandparent Foster Parent
 Guardian Teen Parent DOB: _____

Service Need: Primary / Second Parent

- | | |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Employment |
| <input type="checkbox"/> | <input type="checkbox"/> Job Search |
| <input type="checkbox"/> | <input type="checkbox"/> Training |
| <input type="checkbox"/> | <input type="checkbox"/> High School |
| <input type="checkbox"/> | <input type="checkbox"/> GED / College |
| <input type="checkbox"/> | <input type="checkbox"/> Maternity Leave |
| <input type="checkbox"/> | <input type="checkbox"/> Parent Incapacity |
| <input type="checkbox"/> | <input type="checkbox"/> Child with Special Needs |

Income Detail:
(Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Employment | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Self-Employment | <input type="checkbox"/> Housing Assistance (cash only) |
| <input type="checkbox"/> TANF / TAFDC | <input type="checkbox"/> Alimony |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Other (SSI) |
| <input type="checkbox"/> Former TAFDC Recipient | |

Total Household Income (from Application Worksheet): \$ _____

Fee Level: _____ **Family Size:** _____

Eligibility: Initial Continuing: (include code) _____

Continuity Codes: C1: continuing, no change C4: return < 3 months
C2: sibling C5: transfer program, same funding
C3: SA child, summer only C6: transfer funding

Authorization Start Date: _____ **End Date:** _____ **Reassessment Date:** _____

Federal ID #:

Primary Parent SSN# _____

Children in Subsidized Care

Date of Birth: _____ Age Order _____ First Name: _____ Supportive?
 Last Name: _____ Sex _____ Foster Child?
 Child's SSN: _____ DSS Referral #: _____ Disability?
 Slot # _____ Contract and MMARS Line # _____ Daily Fee : _____

Race / Ethnicity: Check all that apply: American Indian / Alaskan Native Hispanic / Latino
 Black / African American Asian Native Hawaiian / Pacific Islander White Other

Date of Birth: _____ Age Order _____ First Name: _____ Supportive?
 Last Name: _____ Sex _____ Foster Child?
 Child's SSN: _____ DSS Referral #: _____ Disability?
 Slot # _____ Contract and MMARS Line # _____ Daily Fee : _____

Race / Ethnicity: Check all that apply: American Indian / Alaskan Native Hispanic / Latino
 Black / African American Asian Native Hawaiian / Pacific Islander White Other

Date of Birth: _____ Age Order _____ First Name: _____ Supportive?
 Last Name: _____ Sex _____ Foster Child?
 Child's SSN: _____ DSS Referral #: _____ Disability?
 Slot # _____ Contract and MMARS Line # _____ Daily Fee : _____

Race / Ethnicity: Check all that apply: American Indian / Alaskan Native Hispanic / Latino
 Black / African American Asian Native Hawaiian / Pacific Islander White Other

Non-Subsidized Children in Family (exclude foster children)

Name	Disability Y/N	DOB	Relationship Documentation

Federal ID #:

Wage Conversion Calculation

$\frac{\text{Gross weekly} \times 4.33}{\text{Gross weekly} \times 4.33} = \text{Gross Monthly}$
 $\frac{\text{Gross every two weeks} \times 2.17}{\text{Gross every two weeks} \times 2.17} = \text{Gross Monthly}$

$\frac{\text{Gross twice monthly} \times 2}{\text{Gross twice monthly} \times 2} = \text{Gross Monthly}$
 $\frac{\text{Gross quarterly divided by 3}}{\text{Gross quarterly divided by 3}} = \text{Gross Monthly}$

Monthly Income Calculation

Total Gross Monthly Income

Application or Reassessment (circle one)

_____ 1. TAFDC Grant

_____ 2. SSI

_____ 3. Child Support / Alimony Rec'd.

_____ 4. Parents' Gross Monthly Wages/
Income from Self-employment)

_____ 5. Other Cash Assistance
(specify source)

_____ **Total Gross Monthly Income**

Adjusted Gross Monthly Income (if applicable)

Application or Reassessment (circle one)

_____ 1. Gross Monthly Income

-- _____ 2. Child Support /Alimony Paid

-- _____ 3. TAFDC Rental Allowance (when applicable)

-- _____ 4. Other Federal or State Housing Assistance (include
(Cash Only)

-- _____ 5. Employer's Benefit \$ (when applicable)

_____ **Total Adjusted Monthly Income**

Circle Total Allowable Income Level From Below – Effective 7/1/06

Family Size	2	3	4	5	6	7	8	9
50% SMI	\$2,338	\$2,890	\$3,441	\$3,991	\$4,542	\$4,645	\$4,748	\$4,851
85% SMI	\$3,978	\$4,913	\$5,849	\$6,785	\$7,720	\$7,896	\$8,071	\$8,246
100% SMI	\$4,679	\$5,780	\$6,881	\$7,982	\$9,084	\$9,289	\$9,495	\$9,701

Weekly Fee Computation

Application or Reassessment (Circle One)

Child Daily Fee _____ x # Days _____ = Weekly Fee _____

1st _____ x _____ = _____

2nd _____ x _____ = _____

3rd _____ x _____ = _____

Total weekly fee _____

x 2 = 1st payment _____

All information on this application and supporting documentation will be used to determine eligibility for child care and may be shared with EEC contracted or other authorized agency personnel for billing and/or other administrative purposes. Eligibility determination will include computer matches with other government agencies, and/or authorized contracted agency personnel. When waitlisted, certain information will be exchanged for needs assessment purposes as mandated by State law. ALL information will be used in confidence as required under Massachusetts statutes and regulations.

I certify under penalty of perjury that the information provided is correct and complete to the best of my knowledge. I will report to this agency within five (5) business days any change in income, family size, or service need. I agree to pay all weekly fees to the authorized child care provider. I will also pay an initial deposit equal to one week's fees. (Initial deposits will be adjusted accordingly when there are changes to the assessed weekly fee amounts.) I agree to pay the assessed fees for the provider's EEC-approved closings, and for absences and vacations of my child/ren. I have reviewed a schedule of the child care provider's holidays/closures and the snow day policy. I understand that I am not required to pay fees for unauthorized provider closings. I understand that I have the right to request an EEC Review Process should my child care services be reduced or terminated. I agree to continue to pay uncontested fees while awaiting a Review Process decision and I agree to pay any parent fee owed as a result of a Review Process decision. I certify that I am not receiving more than 50 hours of subsidized child care per week from any source. **I understand that providing false or misleading information in connection with this application and/or failure to report within two weeks any change in circumstances that might impact my eligibility or fee may result in termination of the child care subsidy, ineligibility for any future EEC subsidy, an obligation to repay the cost of child care, and / or the assessment of a civil fine.**

Signature of Parent or Guardian / date

Signature of Agency Staff / date