



# DELAWARE OPPORTUNITIES INC.

35430 STATE HIGHWAY 10, HAMDEN, NY 13782

PHONE (607) 746-1600 • FAX (607) 746-1605

email: [info@delop.org](mailto:info@delop.org)

website: [www.delawareopportunities.org](http://www.delawareopportunities.org)

SERVING  
DELAWARE COUNTY

HEAD START  
DEVELOPMENTAL DISABILITIES  
BIG BUDDY  
PARENT EDUCATION  
DAY CARE  
RESOURCE/REFERRAL

(Registration)  
(Subsidies)  
(USDA Sponsor)  
(Inspections)

HEALTHY FAMILIES

SENIOR DINING

SAFE AGAINST VIOLENCE

(Domestic Violence)  
(Rape Crisis)

(Office of Victim Services)  
(Child Advocacy)

JOBS WORK CREW  
WORK IN PROGRESS

EMPLOYMENT AND TRAINING

COMMUNITY FOOD AND NUTRITION

WEATHERIZATION

(Serving both Delaware and  
Sullivan Counties)

HOUSING ASSISTANCE AND  
COMMUNITY DEVELOPMENT

(Housing Development)  
(Homeownership/Tenant Counseling)  
(Rental Assistance)  
(Housing Rehabilitation)

HEAP

FAMILY DEVELOPMENT

FAMILY RESIDENCES

INDEPENDENT LIVING SKILLS

WIC

(Women, Infants and Children)  
(Car Seat Safety)

FOOD BANK SERVICES AND  
CLOTHING/HOUSEHOLD GOODS

EMERGENCY FOOD  
AND SHELTER

HOMELESS ASSISTANCE

TRANSPORTATION

YOUTH ENGAGEMENT

HOME CARE SERVICES

SUPPLIES FOR LIFE

Dear Delaware County Parent:

To apply for day care assistance, you will need to do the following:

You will need to fill out all the enclosed forms in the packet. If you have any questions about the forms please call 607-746-1620 or come in Monday thru Friday, 8:00am to 3:30pm and we will be happy to assist you.

Child care can only be claimed when the child is physically in the provider's care and the parent is at WORK.

You must include the following copies of documents:

1. Copies of Birth Certificates for all family members.
2. Copies of Social Security cards for all family members.
3. Proof of Income, if you get paid weekly, we will need 8 weeks of current pay stubs and if you get paid bi-weekly we will need 4. If you are newly employed and don't have pay stubs yet, have your employer write a letter which needs to state the amount of hours you work per week and your rate of pay, it should be signed and dated by your employer with a phone number and address. If you are self employed, please fill out the enclosed form and your most recent tax return.
4. Confirm your place of residency by sending a piece of mail with your physical mailing address on it. (ex. Junk mail or a utility bill)
5. Divorce or Separation papers
6. Custody papers

Please send all of the above to the mailing address at the above address. Incomplete applications can only be held for 30 days before they are denied. Failure to return all the required documents will result in the application not being processed quickly, and the parent will be responsible to pay the provider.

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## 2023 Guidelines / Child Care Assistance Program

To qualify for this program, your gross income must fall below the 85% of the State Median Income. The following are the standards to be used effective October 1, 2023 to determine eligibility for services provided.

Family Size	85% of the SMI
2	\$67,490.17
3	\$83,370.21
4	\$99,250.25
5	\$115,130.29
6	\$131,010.33
7	\$133,987.84
8	\$136,965.35

For more information, contact the Child and Family Development Division, Delaware Opportunities, Inc. @ (607) 746-1620.

Cc: Shelly Bartow Executive Director  
Janelle Montgomery, CFD Director



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## Child Care Subsidy Survey

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Delaware Opportunities Inc. Child Care Subsidy Program

Strives to support the families we serve. Please fill out and return the survey form to give us feedback on our performance.

1. The staff were knowledgeable and able to answer questions I had.  
1. Strongly agree 2- agree 3. Neither agree or disagree  
4. Disagree 5. Strongly disagree
2. The service I received satisfied the needs that I had when coming to Delaware Opportunities.  
1. Strongly agree 2- agree 3. Neither agree or disagree  
4. Disagree 5. Strongly disagree
3. I would recommend Delaware Opportunities to other individuals in need of services.  
1. Strongly agree 2- agree 3. Neither agree or disagree  
4. Disagree 5. Strongly disagree
4. I was treated with dignity and respect at all times while receiving services. 1. Strongly agree 2- agree 3. Neither agree or disagree  
4. Disagree 5. Strongly disagree
5. What could be done to improve upon the services you received?  
( short answer )

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Date \_\_\_\_\_

Dear Delaware County Parent:

Day Care Assistance can only be applied to care used during Working hours or while traveling to and from work. To help us assess the number of hours you will be utilizing day care, please fill in the information below.

### WORK SCHEDULE: (PLEASE SPECIFY AM or PM)

Monday: \_\_\_\_\_

Tuesday: \_\_\_\_\_

Wednesday: \_\_\_\_\_

Thursday: \_\_\_\_\_

Friday: \_\_\_\_\_

Saturday: \_\_\_\_\_

Sunday: \_\_\_\_\_

Days and times vary: (please explain) \_\_\_\_\_

### Form of Transportation: (please check one)

Car \_\_\_\_\_

Walking \_\_\_\_\_

Other \_\_\_\_\_ Please explain: \_\_\_\_\_

### Hours traveling to and from work:

To work: \_\_\_\_\_

From work: \_\_\_\_\_

My legal Day Care Provider's Name is \_\_\_\_\_

### Place of employment:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Signature: \_\_\_\_\_

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Days and times vary: (please explain) \_\_\_\_\_

### Form of Transportation: (please check one)

Car \_\_\_\_\_

Walking \_\_\_\_\_

Other \_\_\_\_\_ Please explain: \_\_\_\_\_

### Hours traveling to and from work:

To work: \_\_\_\_\_

From work: \_\_\_\_\_

My legal Day Care Provider's Name is \_\_\_\_\_

### Place of employment:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Signature: \_\_\_\_\_



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## REGISTERED FAMILY DAYCARE/ DAYCARE CENTER

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Date \_\_\_\_\_

Parent Name \_\_\_\_\_

Child's Name / Age \_\_\_\_\_

Does this child have any special needs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

The child care provider I have chosen is:

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

County \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

Social Security # / Tax ID # \_\_\_\_\_

Provider's Charge: Weekly \_\_\_\_\_ Hours Child in Care \_\_\_\_\_

Daily \_\_\_\_\_

Part Day \_\_\_\_\_

Date Child began or will begin child care \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Provider Signature

## **CHILD CARE ASSISTANCE PROGRAM (CCAP): CLIENT RIGHTS & RESPONSIBILITIES**

*\*Delaware Opportunities Day Care Department staff hopes you find this program beneficial. If you need further information or have any questions, please call us at (607) 746-1620\**

### **RIGHTS:**

At the time that you apply for child care assistance; Delaware Opportunities Inc. is advising you:

- About the various child care programs available and the requirements of the child care program for which you may be eligible;
- That you may arrange care with any regulated or informal child care provider located in any county that participates and accepts CCAP;
- That you will need to pay a weekly family share for child care services, which is determined by total household gross income;
- About factors to consider when selecting a child care provider;
- What documents or other information you must submit in order for Delaware Opportunities Inc. CCAP to determine whether you are eligible for financial assistance;
- That you have the right to have child care services provided without discrimination based on race, religion, national origin, sex, disability, political belief or any other protected class;
- That you have the right to change childcare providers or close your CCAP case for any reason.
- That CCAP funds are available for temporary public assistance recipients (Temporary Assistance for Needy Families [TANF]); and
- That CCAP funds are available for up to 80 absence days per child per provider per year, regardless of the reason for the absence

### **RESPONSIBILITIES:**

- Return to Delaware Opportunities Inc. a *completed and signed* application packet along with additional required documentation that will be used to determine your continued eligibility;
- Notify Delaware Opportunities Inc. within 10 days of any change in household income, work schedule, household composition (i.e. birth of child, divorce, marriage, etc.), living arrangements, written verification of new employment, child care provider or other changes which may affect your continued eligibility;
- Pay directly to child care provider your pre-determined family share on a weekly basis;
- Parents must sign the attendance voucher at the end of the month. Your signature verifies that the recorded days and hours are an accurate account of your work schedule. (Blank vouchers may not be signed in advance);
- Attendance vouchers must be received by Delaware Opportunities Inc. by the fourth day of each month;

**I have read, understood and agree with the rights and responsibilities of the Child Care Assistance Program**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**FAILURE TO MEET THESE RESPONSIBILITIES MAY RESULT IN THE TERMINATION OF YOUR CHILD CARE ASSISTANCE FUNDING**



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## CHILD SUPPORT FORM

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**TO BE APPROVED FOR THE DAYCARE SUBSIDY PROGRAM YOU MUST BE DOING ONE OF THE FOLLOWING ! COURT DOCUMENTATION MUST BE SENT IN WITH THIS FORM.**

- Child (1) \$ \_\_\_\_\_ per- week, bi-weekly, monthly. (please circle one)  
Child (2) \$ \_\_\_\_\_ per- week, bi-weekly, monthly. (please circle one)  
Child (3) \$ \_\_\_\_\_ per- week, bi-weekly, monthly. (please circle one)  
Child (4) \$ \_\_\_\_\_ per- week, bi-weekly, monthly. (please circle one)  
Child (5) \$ \_\_\_\_\_ per- week, bi-weekly, monthly. (please circle one)

**Please submit proof of legal documentation.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have private legal representation to pursue child support.

**Please submit proof of legal documentation.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I am currently working with the Department of Social Services Child Support Collection Unit. **Please submit proof of documentation.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- If you are not receiving or pursuing child support, please give a brief description / reason why? **Submit proof of documentation**

\_\_\_\_\_

Signature : \_\_\_\_\_ Date : \_\_\_\_\_

**\* I hereby authorize Delaware Opportunities to release or receive confidential information from the Department of Social Services.**

Signature : \_\_\_\_\_ Date : \_\_\_\_\_

### **"IMPORTANT NEW STATE REGULATION"**

**Please Submit Documentation as proof you are working with the Department of Social Services Support Collection Unit: or Private Legal Representation and Submit a copy of the court order of the decision with the amount of Child Support to be paid ;Or have Good Cause not to pursue Child Support.**





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## LANDLORD FORM

If this form is completely filled out by your landlord, it can establish your address and the persons living with you. **If the home is owned by you, this form can be signed by two friends or neighbors.** If you are unable to obtain your landlords signature you may also have two friends or neighbors sign the form.

1. Name of occupant: \_\_\_\_\_

Location /address: \_\_\_\_\_

Address is in: \_\_\_\_\_ County \_\_\_\_\_

Tenant begin occupancy: \_\_\_\_\_

2. List below all persons living in this unit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(I am unable to verify this \_\_\_\_\_)

This form is for verification purposes only and does not imply any obligation on the part of this agency.

\_\_\_\_\_  
Landlord / (2) friends / neighbors      Date

Return this form to: Delaware Opportunities Inc.  
Child and Family Development Division  
35430 State Highway 10  
Hamden, NY 13782



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## DELAWARE OPPORTUNITIES, INC CONSENT FOR RELEASE OF INFORMATION

I authorize: **Delaware County Department of Social Services  
and Delaware Opportunities.**

To exchange and / or update information with Delaware  
Opportunities Inc. for the purpose of providing services for:

**Child Care Subsidy Program/ and all other programs at Delaware  
Opportunities**

\_\_\_\_\_  
(Name of person Receiving Services)

\_\_\_\_\_  
(Client's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent Guardian Signature, if applicable)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Delaware Opportunities, Inc. Representative)

\_\_\_\_\_  
(Date)



# Delaware Opportunities Inc. Agency Intake Form

**PLEASE PRINT ALL AREAS NEATLY AND LEGIBLY**

Please complete the front and back of this form to the best of your knowledge; all information provided is strictly confidential and may be shared with other programs at Delaware Opportunities Inc. with your signed consent.

Applicant signature: \_\_\_\_\_

Staff signature if unable to obtain a signature and verbal consent was obtained: \_\_\_\_\_

Program: \_\_\_\_\_ Date of visit: \_\_\_\_\_ Service site: \_\_\_\_\_

Social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

First name: \_\_\_\_\_ MI: \_\_\_\_\_ Last name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing address:

House number Apt # Street City State Zip Code Town

Physical address:

House number Apt # Street City State Zip Code Town

County: \_\_\_\_\_

Best way to reach you: (circle one) email mail home phone cell phone message phone/other

home phone number: \_\_\_\_\_ cell phone number: \_\_\_\_\_

email address: \_\_\_\_\_ message phone/other/social media name: \_\_\_\_\_

Household type, check one:

- multigenerational
- other
- single parent female
- single parent male
- single person only
- two adults only
- two parent
- unrelated adult
- unrelated adults with child
- unspecified

Housing situation, check one:

- homeless
- other
- other permanent housing
- own
- own mobile home
- own multifamily
- rent
- temp stable
- temp unstable

Information regarding gender, education, or disability is collected for statistical information only. This information will not be used to determine eligibility. Some of this information is requested by the Federal Government in order to monitor laws prohibiting discrimination against those seeking services. You are not required to furnish this information, but you are encouraged to do so.

Please turn this over to enter all information on applicant and all household members.

For office use only:

\_\_\_\_\_ Initials of staff that entered data into Captain/central intake \_\_\_\_\_ date

\_\_\_\_\_ Initials of staff that entered data into program intake \_\_\_\_\_ date

\_\_\_\_\_ Initials of staff that returned intake to program \_\_\_\_\_ date

Social security number	First Name	Middle Initial	Last Name	Date of Birth	Gender: Male (M) Female (F) Transgender (T) Unspecified (U)	Pregnant: Y or N	Marital status: see codes below	Relation to applicant; see codes	Ethnicity: Hispanic: Y or N	Race: see codes below	Education: see codes below	Health Insurance: see codes below	Veteran: Y or N (If Active; A)	Disabled: Y or N	Work status: See codes below	Farmer: Y or N	Disconnected youth: see codes	Benefits received by participant
APPLICANT from front page	JOHN	J	SMITH	01/01/2010	M	N	A	A	Y	E	E	H	Y	N	B	N	F	D, C

**Marital Status**

- A. Single
- B. Married
- C. Widowed
- D. Separated
- E. Divorced
- F. Other
- G. Unspecified

**Relation to Applicant**

- A. Applicant
- B. Mother
- C. Mother figure
- D. Father
- E. Father figure
- F. Child
- G. Sister
- H. Brother
- I. Guardian
- J. Friend
- K. Spouse
- L. Grandparent
- M. Foster parent
- N. Foster child
- O. Grandchild
- P. Other
- Q. Other related
- R. Partner
- Q. Relative
- S. Stepfather
- T. Stepmother

**Race**

- A. Native American
- B. Asian
- C. Caucasian/White
- D. African American/Black E. Bi-Racial/Multi Racial
- F. Hawaiian/Pacific Islander
- G. Other \_\_\_\_\_
- H. Unknown/not reported

**Education**

- A. 0-8
- B. 9-12 Non-grad
- C. High School grad
- D. GED
- E. 12+ some college
- F. 2 yr. college grad
- G. 4 yr. college grad
- H. Vocational
- U. Unspecified

**Insurance**

- P. Private
- A. Medicare
- H. Medicaid/Fidelis Based
- E. Employment
- M. Military
- C. Child Health Plus
- N. None
- U. Unspecified

**Work status**

- A. Full time
- B. Part time
- C. Retired
- D. Unemployed short term 6 months or less
- E. Unemployed long term over 6 months
- F. Unemployed/not in labor force
- G. Unknown/not reported

**Disconnected Youth**

- A. In School/Not Working
- B. In school/Working
- C. Not in school/Not Working
- D. Over 24
- E. Unknown/Not Reported
- F. Working/Not in school

**Benefits received by participant**

- I. Affordable care act/Marketplace
- H. Child care voucher/day care subsidy
- D. Housing choice voucher/Section 8
- C. HEAP
- N. None
- J. Other \_\_\_\_\_
- A. SNAP/food stamps
- K. Unknown/not reported
- B. WIC
- U. Unknown/not reported

# Delaware Opportunities Income Eligibility Worksheet

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street: \_\_\_\_\_ City/Town: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**List only ONE income source per line. If a HH member has more than one source of income, ie: wages and child support, use a separate line for each income type.**

Household member (including self)	Income source from chart below	Monthly Amount	Notes (if needed)

**Source of Income**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>A. Alimony</li> <li>B. Child Support</li> <li>C. None</li> <li>D. Other</li> <li>E. Pension</li> <li>F. Private Disability</li> <li>G. Public Assistance/TANF</li> <li>H. Rental Income</li> <li>I. Self-employed</li> </ul> | <ul style="list-style-type: none"> <li>J. Social Security</li> <li>K. SSDI</li> <li>L. SSI</li> <li>M. Unemployment Insurance</li> <li>N. Unspecified</li> <li>O. Veterans benefits</li> <li>P. Wages</li> <li>Q. Workman’s Compensation</li> <li>R. Not reported</li> </ul> |
|---|--|

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**APPLICATION FOR CHILD CARE ASSISTANCE**

This application is for you to apply for non-guaranteed Child Care Assistance only. If you want to apply for other state benefits, including guaranteed Child Care Assistance, please use the form, New York State Application for Certain Benefits and Services, LDSS-2921. You can talk to your local department of social services if you have any questions or need help.

*Please answer all questions that do not say optional. Please write clearly. Please do not write in the shaded areas.*

**Tell us about yourself.**

Full name (Please include first and last name.) \_\_\_\_\_

Aliases: \_\_\_\_\_

Street Address Street: Apt. No./Fl.: City: State: County: Zip Code:

Mailing Address (if different) Street: Apt. No./Fl.: City: State: County: Zip Code:

Phone Number ( ) - : Phone Number Type  Cell Phone  Home Phone/Landline  Work Phone

Email (This is optional.) \_\_\_\_\_

How would you like to be contacted? (This is optional.)  Phone  Email  Other (Please tell us.)

Primary Language  English  Spanish  Other (Please tell us.):

Marital Status  Single  Married  Divorced  Separated  Widowed

**Do you or any adult(s) applying with you receive any of the following benefits?**

- Medicaid
- Supplemental Nutrition Assistance Program (SNAP)
- Housing Vouchers or Assistance
- Home Energy Assistance Program (HEAP)
- Women Infants & Children Program (WIC)
- Other federal assistance programs such as Supplemental Security Income (SSI)
- Head Start/Early Head Start
- Cash Assistance from TANF
- None of these.

**Tell us about your household's circumstances.**

Do any of these apply to you or any adult(s) applying with you?

- Homeless (no fixed, regular and adequate place to stay at night)  Yes  No
- A parent is on active duty (serving full time) in the U.S. Military  Yes  No
- A parent is a member of the National Guard or Military Reserve Unit  Yes  No
- Receiving or applying for other child care funding  Yes  No
  - o If yes, please give us the agency name: \_\_\_\_\_
- Reason(s) child care is needed: \_\_\_\_\_

**Tell us about everyone in your home.**

LN	First Name and Last Name	DATE OF BIRTH (MM-DD-YY)	SEX (M/F/X)	RELATIONSHIP TO YOU	Gender Identity (This is optional. Please describe.)	SOCIAL SECURITY NUMBER (SSN) Optional	Enter Y (Yes) or N (No) if Hispanic or Latinx (Optional)				Does this child need child care? (Y/N)	FOR EACH CHILD in need of child care, answer Yes/No			
							H	A	B	P		W	Is the child a U.S. citizen/national or has satisfactory immigration status?	Does child have special needs?	Do both parents live in the home?
1		/ /		SELF											
2		/ /													
3		/ /													
4		/ /													
5		/ /													
6		/ /													
7		/ /													
8		/ /													

\* Racial Affiliation Codes: H – Hispanic, I – Native American or Alaskan Native, A – Asian, B – Black or African American, P – Native Hawaiian or Pacific Islander, W – White  
 If you need more room or there is more information you think we might need, you can use extra pages.

**Tell us about parent(s) that do not live in the home.**

List all the children who need child care, whose parent does not live in the home.

Names of children under 19	Is absent parent available to provide care?	If no, provide reason.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Tell us about your job and other activities.**

Do you need child care because you are working?  Yes  No

Are you about to start a new job?  Yes  No If yes, start date: / /

Are you looking for work?  Yes  No

EMPLOYER'S NAME

TOTAL HOURS WORKED PER WEEK

Does your schedule change week to week?  Yes  No

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TYPICAL WORK SCHEDULE -- If your schedule changes, enter your schedule from last week.						

Do you have more than one job?  Yes  No If yes, please use extra pages to give us more information about your other job(s).

Do you need child care because you are in a training program for work?  Yes  No

Are you about to start a training program for work?  Yes  No If yes, start date: / /

Are you looking for work?  Yes  No

TRAINING PROGRAM NAME/FACILITY

TOTAL HOURS OF TRAINING PER WEEK

Does your schedule change week to week?  Yes  No

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TYPICAL TRAINING SCHEDULE -- If your schedule changes, enter your schedule from last week.						

Do you need child care because you are going to college/taking classes?  Yes  No

Are you about to start college/taking classes?  Yes  No If yes, start date: / /

Are you looking for work?  Yes  No

SCHOOL OR COLLEGE NAME

TOTAL HOURS OF CLASSES PER WEEK

Does your schedule change week to week?  Yes  No

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TYPICAL CLASS SCHEDULE -- If your schedule changes, enter your schedule from last week.						

**Tell us about the other adult(s) applying with you and their activities.**

Whose job information is this? (Check one.)  Spouse  Other parent  Other adult

Do they have more than one job?  Yes  No If yes, please use extra pages.

Is the adult working?  Yes  No Is the adult about to start a new job?  Yes  No Start date: / /

Is the adult looking for work?  Yes  No

EMPLOYER'S NAME

TOTAL HOURS WORKED PER WEEK

Does the schedule change week to week?  Yes  No

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TYPICAL WORK SCHEDULE -- If the schedule changes, enter the schedule from last week.						

Is the adult in a training program for work?  Yes  No

Are you about to start a training program for work?  Yes  No If yes, start date: / /

Are you looking for work?  Yes  No

TRAINING PROGRAM NAME/FACILITY

TOTAL HOURS OF TRAINING PER WEEK

Does the schedule change week to week?  Yes  No

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TYPICAL TRAINING SCHEDULE -- If the schedule changes, enter the schedule from last week.						



Is the adult going to college/taking classes?  
 Yes  No

Is the adult about to start college/taking classes?  
 Yes  No If yes, start date: / /

SCHOOL OR COLLEGE NAME

TOTAL HOURS OF CLASSES PER WEEK Does the schedule change week to week?  Yes  No

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

TYPICAL CLASS SCHEDULE - If the schedule changes, enter the schedule from last week.

**Tell us about your household income.**

Let us know if you or anyone applying with you receives money from any of the following:	YES	NO	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)
Income From Work (including wages/salary, overtime, commissions, training programs, tips)	<input type="checkbox"/>	<input type="checkbox"/>						
Net Self-Employment Income	<input type="checkbox"/>	<input type="checkbox"/>						
Child Support Payments (received)	<input type="checkbox"/>	<input type="checkbox"/>						
Alimony/Spousal Support (received)	<input type="checkbox"/>	<input type="checkbox"/>						
Unemployment Insurance Benefits, Workers' Comp.	<input type="checkbox"/>	<input type="checkbox"/>						
Social Security Benefits (including SSI)	<input type="checkbox"/>	<input type="checkbox"/>						
Disability Benefits (New York State, Veterans Affairs, Private)	<input type="checkbox"/>	<input type="checkbox"/>						
Rental/Boarder/Lodger Income (received)	<input type="checkbox"/>	<input type="checkbox"/>						
Dividends/Interest - Stocks, Bonds, Savings	<input type="checkbox"/>	<input type="checkbox"/>						
Pensions/Annuities	<input type="checkbox"/>	<input type="checkbox"/>						
Public Assistance (PA) Grant, Safety Net Benefits	<input type="checkbox"/>	<input type="checkbox"/>						
Other (Please specify.)	<input type="checkbox"/>	<input type="checkbox"/>						

**Consents and Signature**

Please read the terms, check the box, and sign the application. By submitting this application, I agree that:

- I want to apply for Child Care Assistance. I have been honest on this application, and it is complete to the best of my knowledge.
- Getting assistance will not affect me or my family's immigration status. Immigration information is private and confidential.
- My family resources are not more than \$1,000,000.

I attest that the information I provided on this application is correct and complete to the best of my knowledge.

YOUR SIGNATURE X	PRINT NAME	DATE SIGNED / /
THE OTHER ADULT(S) SIGNATURE X	PRINT NAME	DATE SIGNED / /

# NYS Agency-Based Voter Registration Form



"If you are not registered to vote where you live now, would you like to apply to register here today?"

**Yes** If you checked YES, please complete the VOTER REGISTRATION APPLICATION below

**NO** because I choose not to register OR

I am already registered at my current address OR

I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please Print Name \_\_\_\_\_

### Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 양식을 원하시면 1-800-367-8683

으로 전화 하십시오.

1-800-367-8683

1-800-367-8683

## VOTER REGISTRATION APPLICATION (instructions on back)

I need an application for an Absentee Ballot

1	Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	2	If you answered NO, do not complete this form	
	If you answered NO to both of the prior questions, you cannot register to vote.			
3	Last Name		First Name	
	Middle Initial		Suffix	
4	Address where you live (do not give P.O. box)		Apt. No.	
	City/Town/Village		Zip Code	
5	Address where you get your mail (if different than above)		P.O. Box, Star Route, etc.	
	Post Office		Zip Code	
6	Date of Birth	7	Gender (optional)	8
	Telephone (optional)	Email (optional)		
10	The last year you voted	Your address was (give house number, street and city)		
	In county/state	Under the name (if different from your name now)		
11	Political Party			
	<input type="checkbox"/> I wish to enroll in a political party <input type="checkbox"/> Democratic party <input type="checkbox"/> Republican party <input type="checkbox"/> Conservative party <input type="checkbox"/> Working Families party <input type="checkbox"/> Other <input type="checkbox"/> I do not wish to enroll in any political party and wish to be an independent voter.			
12	Affidavit: I swear or affirm that			
	I am a citizen of the United States. I will have lived in the county, city or village for at least 30 days before the election. I will meet all requirements to register to vote in New York State. This is my signature or mark on the line below. The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years.			
9		ID Number (Check the applicable box and provide your number)		
		<input type="checkbox"/> New York State DMV number <input type="checkbox"/> Last four digits of your Social Security number <input type="checkbox"/> I do not have a New York State DMV or Social Security number		
Signature or Mark in Ink		Date		

## (Optional) Register to donate your organs and tissues

By signing below, you certify that you are:

- 16 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;

Authorizing the Board of Elections to provide your name and identifying information to NYS Donate Life Registry for enrollment;

And authorizing the Registry to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and others approved by the NYS Commissioner of Health hospitals upon your death.



Signature \_\_\_\_\_

Date \_\_\_\_\_

Last Name	
First Name	Middle Initial
Suffix	
Address	
Birth Date	Gender
Eye Color	Height
DMV or ID NYC Number	

**Qualifications for Registration**

**You Can Use This Form To:**

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment;
- pre-register to vote if you are 16 or 17 years of age.

**To Register You Must:**

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until you are 18);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in prison for a felony conviction;
- not claim the right to vote elsewhere; and
- not found to be incompetent by a court.

**Important!**

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections  
40 North Pearl St, Suite 5  
Albany, NY 12207-2729  
Telephone: 1-800-469-6872;  
TDD/TTY users contact the New York State Relay at 711;  
or visit our web site - [www.elections.ny.gov](http://www.elections.ny.gov)

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted, will remain confidential to be used only for voter registration purposes.

**Verifying your identity**

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement,

pay check, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

**To complete this form:**

**It is a crime to procure a false registration or to furnish false information to the Board of Elections.**

**Box 9:** You must make one selection. For questions refer to Verifying your identity above.

**Box 10:** If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

**Box 11:** Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state rules allow otherwise.

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**HOW TO COMPLETE THE APPLICATION FOR CHILD CARE ASSISTANCE**

**This application is for non-guaranteed Child Care Assistance only.** If you want to apply for Child Care Assistance and other state benefits, such as Public Assistance (PA), Supplemental Nutrition Assistance Program (SNAP), Home Energy Assistance (HEAP), Medicaid, or guaranteed Child Care Assistance (category 1), please use the form *New York State Application for Certain Benefits and Service, LDSS-2921*, found here: <https://ofda.ny.gov/programs/applications/2921.pdf>.

### APPLYING FOR CHILD CARE ASSISTANCE

- You are applying for category 2 Child Care Assistance. Category 2 Child Care Assistance is for families when funds are available. Category 1 Child Care Assistance is for families who are eligible for a child care guarantee, which includes families applying for or receiving PA, Child Care Assistance in lieu of PA, and transitional child care.
- You can fill out the application and turn it in the same day you get it. If you are eligible, the county you live in may give you assistance back to the date you turned in your application.
- You can turn in your application in person or by mail. If you want to turn in your application electronically by email, fax, etc., please reach out to your local department of social services for further information.
- The local department of social services will take your application if it has your name, address, and a signature. However, the application needs to be complete to determine if you are eligible to get Child Care Assistance.

### HOW TO COMPLETE THE APPLICATION

- Please complete each section. Some sections are marked "optional," and you can choose to complete them or not.
- Please write clearly on the application.
- Do not write in the shaded areas.
- If you are helping someone apply, please write the information about the person you are helping.

### WHERE TO TURN IN THE APPLICATION

- Please turn the application in to your local department of social services of the county where you live.

**Make sure the local department of social services gives you copies of:**

- LDSS-4148A, *What You Should Know About Your Rights and Responsibilities*
- LDSS-4148B, *What You Should Know About Social Services Programs*
- LDSS-4148C, *What You Should Know If You Have an Emergency*

**These booklets have important information in them about your rights and responsibilities and can be found here:**

- <https://ofda.ny.gov/programs/applications/4148A.pdf>
- <https://ofda.ny.gov/programs/applications/4148B.pdf>
- <https://ofda.ny.gov/programs/applications/4148C.pdf>

### IF YOU WANT TO WITHDRAW YOUR APPLICATION

- Give the local department of social services a written and signed request to withdraw the application you turned in.
- You can apply again at any time.

**Tell us about yourself.**

Please fill out the information about yourself. If you are helping someone apply, please fill out this information about the person you are helping (the applicant):

- **Full Name**  
Please tell us your legal name, both your first and last name. Please include any aliases.
- **Street Address**  
Please tell us the full street address, including apartment number/floor, city, county, state, and Zip Code, of where you are living now.
- **Mailing Address**  
If you get mail somewhere other than where you live, please tell us that address here.
- **Phone Number**  
Please tell us your phone number, with the area code. Check  the box if this is a cell phone, home phone, or work phone.
- **Email**  
If you want to be reached by email, please tell us your email address. *This is optional.*
- **Contact**  
Please check  the box that tells us how you want someone reach you. If you check "other," please tell us the best way to reach you. *This is optional.*
- **Primary Language**  
Please check  the box that tells us the language that you speak most often in your home. If you check "other," please tell us the language you prefer.
- **Marital Status**  
Please check  the box to tell us your current legal marital status.

**Do you or any adult(s) applying with you receive any of the following benefits?**

The questions in this section are for you **AND** any other adult household members who are applying for Child Care Assistance with you – this means your spouse who lives with you, the child's parent who lives with you, individuals temporarily absent from the home who must contribute toward the needs of the household, or any other adult living in the home who is legally responsible for the child(ren).

- If you and/or any of the listed adults above get any of the benefits that are on the list, please check  each one that is received. If no one is receiving any of these benefits, please check  the box, "None of these."

**Tell us about your household's circumstances.**

The questions in this section are for you **AND** any other adult(s) applying with you.

- **Homeless**  
Please check  Yes or No to tell us if your family has a fixed, regular, adequate place to stay at night.
- **U.S. Military**  
Please check  Yes or No to tell us if an adult in the home is on active duty, serving full-time in the U.S. Military.
- **Military Reserve**  
Please check  Yes or No to tell us if an adult in the home is a member of the National Guard, or Military Reserve Unit
- **Child Care Funding**  
Please check  Yes or No to tell us if an adult in home is receiving/applying for other child care funding. If you check  Yes, please tell us the agency name.
- **Need Reason**  
Please tell us the reason(s) child care is needed. For example, to work, to attend substance abuse treatment, etc.

**Tell us about everyone in your home.**

List the information for everyone who lives with you, even if they are not applying with you.

- **Full Name**  
Please write your full name on line 1 and then write the names of the other people who live with you on each line under yours.
- **Date of Birth**  
Please tell us each person's date of birth.
- **Sex**  
New York State will make sure that you can access state benefits and/or services regardless of your sex, gender identity, or expression. Please write the sex of all the people who live with you as male, female, or X to match what is on file with the United States Social Security Administration.

- **Relationship**  
Please tell us each person's relationship to you. For example, spouse, other parent, biological child, foster child, friend, roommate, grandparent, etc.
- **Gender Identity**  
Your gender identity is how you see yourself and what you call yourself. Your gender identity can be the same as your sex. You do not have to tell us any of this information if you do not want to. If you choose to write your gender identity, please only tell us your own in the space provided. Giving us your gender identity is your choice and will not change your eligibility for Child Care Assistance or the amount of assistance you will be given by this agency.
- **Social Security Number**  
You can add your Social Security number if you would like to. Social Security numbers may be used by federal, state, and local agencies to make sure the services you are given are not duplicated, may be used to catch or stop fraud, and may be used for federal reporting. *This is optional.*
- **Hispanic/Latinx**  
Please enter **Y** (Yes) or **N** (No) for each person if they are Hispanic, Latinx, or not. Giving us ethnicity information is your choice and will not change your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.
- **Race**  
Please enter **Y** (Yes) or **N** (No) for each of the race codes (below). Giving us race information is your choice and will not change your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.  
**H** – Hispanic, **I** – Native American or Alaskan Native, **A** – Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White
- **Child Care Need**  
Please enter **Y** (Yes) or **N** (No) to tell us if each child needs child care.
- **Citizenship**  
Please enter **Y** (Yes) or **N** (No) to tell us if each child is a *United States citizen, United States national, or a person with satisfactory immigration status*. If you are not sure, please talk to your local department of social services. The citizenship or immigration status of the adults or children who do not need child care will not change your eligibility for Child Care Assistance or the amount of assistance that you will be given by this agency.
- **Special needs**  
Please enter **Y** (Yes) or **N** (No) to tell us if each child has special needs. A child with special needs is a child who cannot take care of themselves and has one or more of the following diagnoses:  
  - (1) Visual impairment
  - (2) Deafness or other hearing impairment
  - (3) Orthopedic impairment
  - (4) Emotional disturbance
  - (5) Intellectual disability
  - (6) Learning disability
  - (7) Speech or language impairment
  - (8) Health impairment
  - (9) Autism
  - (10) Multiple disabilities
  - (11) Traumatic brain injury
  - (12) Deaf-blindness
  - (13) Other health impairment
- **Parents in the home**  
*For the full definition of a child with special needs, please see NYCRR Title 18 Part 415.1(c).*  
Please enter **Y** (Yes) or **N** (No) for each child to tell us if both parents live in the home.

**Tell us about parent(s) that do not live in the home.**

*This information is about the parent who does not live in the home.*

- Please write the name(s) of the child(ren) who are applying for Child Care Assistance and are under the age of 19, whose parent does not live in your home.
- Please check  Yes or No to tell us if the parent who does not live in the home is available to provide care. If they are not, please tell us the reason (for example: they are working, attending rehabilitation, in jail, there is a safety issue, visitation agreement, etc.).

**Tell us about your job and other activities.**

*Please fill out the information if you are working. If you are not working, are not about to start a new job, and are not looking for work, please check  "No" and go to the next section on the application.*

- Please check  Yes or No to tell us if you need child care because you are working, if you are about to start a new job, or you are looking for work. If you are about to start a new job, please tell us your start date.
- Employer/Job Information: Please write the name of where you work, the total number of hours you work or will be working each week, your schedule, and tell us if your schedule changes each week. If your schedule changes each week, please write the hours you worked last week. If you are about to start a new job, please tell us what your schedule will be. If you have more than one job, please check  Yes or No and use extra pages and tell us the above information.

*Please fill out the information if you are in a training program for work. If you are not in a training program or are about to start one, please check  "No" and go to the next section on the application.*

- Please check  Yes or No to tell us if you need child care because you are in a training program for work or are about to start one. If you are about to start a training program, please tell us your start date.
- Training Program Information: Please write the name of the training program or facility, the total number of hours you are at the training program or will be each week, your training schedule, and tell us if your training schedule changes each week. If your schedule changes each week, please write the hours you attended the training program last week. If you are about to start a training program, please tell us what your schedule will be.

*Please fill out the information if you are going to college/taking classes. If you are not going to college/taking classes or are about to start, please check  "No" and go to the next section on the application.*

- Please check  Yes or No to tell us if you need child care because you are going to college/taking classes or about to start college/classes.
- School/College Information: Please write the name of the school or college, the day you started going or will be starting college/taking classes, the total number of hours you are taking classes or will be taking each week, your class schedule, and tell us if your schedule changes each week. If your schedule changes each week, please write the hours you attended classes last week. If you are about to start college/classes, please tell us what your schedule will be.

**Tell us about the other adult(s) applying with you and their activities.**

*Please fill out the information about the other adult(s) applying with you.*

- Please check  whose job information this is (your spouse, other parent, or other adult). Please check  Yes or No to tell us if the adult has more than one job. If yes, please use extra pages and tell us the below information. Please tell us if they are working, about to start a new job, or looking for work. If they are about to start a new job, please tell us their start date.
- Employer/Job Information: Please write the name of where they work, the total number of hours they work or will be working each week, their job schedule, and tell us if their schedule changes each week. If the schedule changes each week, please write the hours they worked last week.

Please fill out the information if the other adult is in a training program for work. If the adult is not in a training program for work or about to start one, please check  "No" and go to the next section on the application.

- Please check  Yes or No to tell us if the adult is in a training program for work or about to start one. If they are about to start one, please tell us their start date.
- Training Program Information: Please write the name of the training program or facility, the total number of hours they are at the training program or will be each week, their training schedule, and tell us if their schedule changes each week. If their schedule changes each week, please write the hours they attended the training program last week.

Please fill out the information if the other adult is going to college/taking classes. If the adult is not going to college/taking classes or is about to start college/classes, please check  "No" and go to the next section on the application.

- Please check  Yes or No to tell us if the adult is going to college/taking classes or about to start.
- School/College Information: Please write the name of the school or college, the day they started or will be starting college/taking classes, the total number of hours they are taking classes or will be each week, their class schedule, and tell us if their class schedule changes each week. If their schedule changes each week, please write the hours they attended classes last week.

### **Tell us about your household income.**

In this section, please check  Yes or No for you and anyone applying with you for each type of income.

- For each "Yes" answer, please write the name of the person who earns the income, the dollar amount or value, and how often the person gets paid (for example: weekly, monthly, biweekly, etc.).

### **Consents and Signature.**

Please read this section or have someone read it to you. Please check  the box. By checking the box, you are agreeing that everything on the application is correct and complete.

- **SIGNATURE**  
Please sign your name and write the date. If you have filled out this application for someone else, sign your own name. If you are giving this application to the local department of social services electronically, an electronic signature (e-signature) is allowed.  
Please write your full name, first and last.
- **PRINT NAME**  
If your spouse lives with you or the other parent lives with you or individuals temporarily absent from the home who must contribute toward the needs of the household or another adult lives with you who is legally responsible for the child(ren) in need of child care, you **both** must sign the application.
- **SIGNATURE OF OTHER ADULT(S)**  
Please write your full name, first and last, if you are the spouse/other parent or other adult that lives in the home who is legally responsible for the child(ren) in need of child care.
- **PRINT NAME**  
Once you have completed the application, please give the application to the local department of social services of the county where you live.

**NOTE:** The last page of the Application for Child Care Assistance is an application to register to vote. If you want help filling out the voter registration form, please ask your local department of social services. Applying to register to vote will not change your eligibility for Child Care Assistance or the amount of assistance you will be given by this agency.