Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Office of Child and Family Services
2 Anthony Ave 11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-7999; Toll Free: (877) 680-5866
TTY: Dial 711 (Maine Relay); Fax: (207) 287-6308

Child Care Affordability Program (CCAP) Application

Child Care Affordability payments to child care providers will be for child care services provided between the beginning date and end date of the award letter. The parent is responsible for any care used prior to the issuance of an award.

To Process Application:

- Use clear, legible handwriting in black ink
- Submit a completed and signed application. All questions must be answered
- Submit a copy of all required documentation (see below)
- Incomplete applications will experience a delay in processing
- For questions regarding this program and/or application email ccap.dhhs@maine.gov or call 624-7999
- If you would like information on developmental screenings, please go to the following link: https://www.cdc.gov/ncbddd/childdevelopment/screening.html

Required Documentation:
For all adults in the household responsible for children (include spouse, significant other etc.)

☐ **Proof of Citizenship for children** (birth certificate (state issued copy), passport, immigration or naturalization documents)
*Social Security cards are not acceptable proof of citizenship.

☐ **Proof of Residency for the Primary Applicant** (driver's license with the physical address, rental agreement, mortgage statement, car registration, hunting/fishing license, utility bills (electric, water, gas) dated within (1) one year of submission)
*Phone and/or internet bill is not accepted as proof of residency.

☐ **Official School Schedule for parent(s) (if applicable)** Graduate or doctorate level programs are not accepted.
For each student; provide a current official class schedule showing institution name, student name, class days/time, semester dates, and credit hours, financial aid letter, and school bill. Please attach a separate sheet with all the information above for each additional adult attending an education program/job training program.

☐ **Income Verification**
Pay stubs (**4 most recent** weeks dated within 60 days of submission) **OR** Employment information sheet (if you receive tipped/commissioned/bonus wages, you must supply pay stubs)

Self-Employment: Most recent complete copy of IRS Tax Return **OR** Most recent monthly profit and loss statement

☐ **Custody or Child Support Documentation (if applicable)** Complete copy of court ordered custody agreement/schedule and support documentation, administrative or voluntary child support order issued by the Division of Support Enforcement and Recovery, voluntary documentation indicating custody schedule and support

☐ **Provider Information Sheet** completed by the child care provider

☐ **Two-parent household, one disabled parent (if applicable)** Documented disability letter from Social Security Administration and a doctor's note indicating the disability preventing him/her from caring for the children

☐ **All Unearned Income (if applicable)** (Social Security award letter, child SSI award letter, child only TANF grant, pension/retirement statement/alimony, child support, financial aid, military benefits etc.)

☐ **Special needs documentation** determined by a qualified professional (if applicable)

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STATE OF MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Child and Family Services
Child Care Affordability Program Application

SECTION 1: Applicant(s) Information			
1. **Primary Applicant Name** (Adult Applying):			Birthdate:
Email Address:			Last Four of Social Security #:
Home Phone:		Cell Phone:	
Gender:	Primary Language:		Race:
Hispanic or Latino Origin: ☐ Yes ☐ No		Translator needed? ☐	
Are you a court appointed legal guardian? ☐ Yes **(if yes, attach proof of legal guardianship)** ☐ No			
2. Physical Address: *Proof of residency needed for the primary applicant			
Street Address:			
City:	State:	Zip:	County:
3. Mailing Address: (if different from above)			
Mailing Address/Post Office Box:			
City:	State:	Zip:	County:

SECTION 2: MUST INCLUDE **ALL** Additional Household Members **(children, spouse, partner etc.)**		
4. Name:		Birthdate:
Are you a US citizen or a qualified alien? ☐ Yes (if yes, attach documentation for children needing care) ☐ No		Last Four of Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	
5. Name:		Birthdate:
Are you a US citizen or a qualified alien? ☐ Yes (if yes, attach documentation for children needing care) ☐ No		Last Four of Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	
6. Name:		Birthdate:
Are you a US citizen or a qualified alien? ☐ Yes (if yes, attach documentation for children needing care) ☐ No		Last Four of Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	
7. Name:		Birthdate:
Are you a US citizen or a qualified alien? ☐ Yes (if yes, attach documentation for children needing care) ☐ No		Last Four of Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	

SECTION 3: Questions

8. Are all adults in the family working or attending an education/job training program? ☐ Yes ☐ No

If No to Question 8: Who in the household is not working or in an education/job training program?

9. Is this a two-parent household in which one adult works or attends an education/job training program and the other has a documented disability from SSA with a doctor's note indicating the disability preventing him/her from caring for the children?
☐ Yes **(if yes, attach documentation)** ☐ No

10. Has a child been placed under the legal guardianship of an individual who has reached retirement age as defined by Social Security? ☐ Yes ☐ No

11. Do you have assets that are equal to or exceed $1,000,000? ☐ Yes ☐ No

12. Are you currently experiencing homelessness? ☐ Yes ☐ No

13. Do you receive housing assistance? ☐ Yes ☐ No

14. Have you received TANF in the past twelve (12) months? ☐ Yes ☐ No

15. Are you an employee of a Licensed Child Care? ☐ Yes ☐ No

16. Are you currently receiving child care assistance with the HOPE program? ☐ Yes ☐ No

17. Do you receive adoption assistance? ☐ Yes *please provide documentation ☐ No

18. Please check if you currently are:
☐ A member of the National Guard Unit ☐ A member of the Military Reserve Unit ☐ On Active Duty in U.S Military

19. Do you have a tribal affiliation? ☐ Yes ☐ No

20. Do you Home School ☐ Yes ☐ No

SECTION 4: Children with Special Needs

21. Do any children needing care have special needs? ☐ Yes **(if yes, attach documentation)** ☐ No

A Child with Special Needs refers to a) a Child up to thirteen (13) years of age, for whom it has been determined by a qualified professional, that the Child has a disability as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401); is eligible for early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.); is eligible for services under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794); meets the definition of disability under the Americans with Disabilities Act (ADA) (P.L. 110-325); is considered at-risk for health and/or developmental problems as a result of identified environmental risk factors including, but not limited to, homelessness, abuse and/or neglect, lead poisoning, and prenatal drug or alcohol exposure; and/or b) a Child who is between thirteen (13) years of age and eighteen (18) years of age, who is physically or mentally incapable of caring for him or herself, or is under court supervision. In addition, you will receive a release of information request to return for provider reimbursement.

SECTION 5: Absent Parent Information ☐ **Not Applicable if a 2-parent household**

Must be completed for a single parent household

22. Do you have shared parental rights/responsibilities for child care payment?
☐ Yes *provide a copy of the court order or notarized agreement ☐ No

23. Do you have a court ordered shared/joint custody?
☐ Yes *provide a copy of the court order or notarized visitation schedule ☐ No

24. Are you court ordered or voluntarily receiving child support?

☐ Yes * Provide complete copy of court order. For Voluntary payments indicate how much you receive weekly $_____/per week

☐ No, I receive no financial support from the other parent

25. Do you pay child support? ☐ Yes *please provide documentation ☐ No

SECTION 6: Parent School Information ☐ **Not Applicable**

Educational program refers to a program which is required for completion of a secondary diploma, High School Equivalency Test (HISET), or other Department-approved high school equivalency test; Department-approved vocational program; or post-secondary undergraduate program in which the parent is earning credits toward a degree; or another Department-approved educational program. **Parents attending graduate or doctorate-level educational programs are not eligible to receive Child Care Affordability.**

26. Parent Student Name:	School Name:	
Degree:	Start Date:	End Date:
Next Semester Start Date:	Anticipated Graduation Date:	
Travel time (one-way), school to child care in hours:	☐ **N/A if online classes**	

SECTION 7: Employment ☐ **Not Applicable**

Submit employment information for all adults in the household. Please provide all sources of unearned income. If adults have more than two jobs, please attach a separate sheet with all the information listed below for each additional position

27. Job #1 – ☐ Traditional ☐ Self-employed ☐ Seasonal ☐ Per diem

Employee Name:	Job Title:
Name of Employer:	Work Phone:
Hire/Start Date:	Travel time (one-way), work to child care in hours:

Work Schedule: (example: 8am – 5pm) ***Note: If your schedule varies, please indicate your work schedule for the past four (4) weeks***

Week Beginning/end dates (mm/dd/yr. – mm/dd/yr.)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

28. Job #2 – ☐ Traditional ☐ Self-employed ☐ Seasonal ☐ Per diem

Employee Name:	Job Title:
Name of Employer:	Work Phone:
Hire/Start Date:	Travel time, work to child care in hours:

Work Schedule: (example: 8am – 5pm) ***Note: If your schedule varies, please indicate your work schedule for the past four (4) weeks***

Week Beginning/end dates (mm/dd/yr. – mm/dd/yr.)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

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Signature Required

I certify under penalty of perjury that to the best of my knowledge the provided information is true.

I understand that this information will be provided to the Department of Health and Human Services (DHHS) for use in the administration of this program.

I authorize the agency to verify this information by whatever means necessary.

I agree to notify the DHHS, Child Care Affordability Program (CCAP) within ten (10) days of any
1. Cessation of work or attendance at an educational or job training program and/or
2. Change of child care provider and/or
3. If family income exceeds over eighty-five percent (85%) of State Median Income (SMI). and/or
4. If family income exceeds over one hundred twenty five percent (125%) of SMI

I acknowledge and agree to CCAP Rules found at: www.maine.gov/dhhs/ocfs/support-for-families/child-care/paying-for-child-care

The application review process may take the Department up to 15 days.

_____
Primary Applicant Signature (typed signature is not accepted)

_____
Date

_____
Preparer Signature (if applicable)

_____
Date

Please sign, date, and return all pages and documentation by mail, email, or fax:

Email: CCAP.DHHS@Maine.gov

Fax: (207) 287-6308

Mail: Office of Child and Family Services
Child Care Affordability Program
2 Anthony Avenue 11 State House Station
Augusta, ME 04333-0011

Child Care Affordability Program – Child Care Provider Information Sheet

Please have your Child Care Provider complete this form and **return it to you for packet completion**

Child Care Provider Responsible for Completion
1. Parent Name:
2. Child(ren's) Name(s):
3. Date child is expected to begin your program (care cannot be billed until an award is received and the child physically attends care):

Provider Information	
1. Business Name: Stepping Stones Early Learning Center INC	2. Provider hours of operation (example 7am-5pm): 6am-6pm
3. Before/after school hours of operation (example: 7am-8am/3pm-5pm): 6am-8:50am/3pm-6pm	
4. Name of Contact Person: Amanda Leclerc	5. Phone Number: (207) 946-5437
6. Address: 301 Sawyer Rd Greene ME 04236	
7. Email Address: Amanda@steppingstoneschildcare.me	
8. Provider Type: (select below)	
☑ Licensed	License Number/CCAP Billing Number: 213805
☐ License Exempt Provider	***Background check paperwork may take up to 45 days to process*** ***Additional paperwork will be sent for completion***

- Must be 18 years old and may not reside at the same address as the child(ren); and
- Can only watch a maximum of two (2) children
- Must be a Maine resident for 6 months

Check one:

In *Providers* Home: ☐ Unrelated ☐ Related (must indicate relationship to child) _____

In *Child's* Home: ☐ Unrelated ☐ Related (must indicate relationship to child) _____

School Age Program/Recreational ☐

By signing below you acknowledge that the **Child Care Affordability Program does not pay retroactively** and the parent is responsible for all payments until you receive an award letter. If you are a new provider to the Child Care Affordability Program you will be receiving additional paperwork that needs to be completed.

Providers Name (Print): Amanda Leclerc Preferred Language: English

Provider's Signature: _____ Date: _____

***Typed signature not accepted**

Employer Information Sheet

Please have your supervisor or human resources staff complete this form

Employment information		☐ **Not Applicable**
1. Employer Name:		
2. Name of Employee:		
3. Hourly Wage/Salary:	**4.** Date of Hire:	**5.** Date of Rehire:
6. Does the schedule include a 30 min unpaid break?	**7.** Are you paid weekly, bi-weekly, or monthly?	
8. Does this position receive tips, commission, overtime, or bonuses? If yes, **you must supply paystubs.**		

Employee's Work Schedule: (example: 8am – 5pm)							
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

Note: If the employee's schedule varies, please indicate work schedule for the past four (4) weeks. If the employee has not been employed for a full four (4) weeks, please estimate expected hour for the remaining weeks

Week Beginning/end dates (mm/dd/yr. – mm/dd/yr.)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

I certify under penalty of perjury that to the best of my knowledge the above information is true.

Human Resource/Supervisor Name (Print): _____

Human Resource/Supervisor Signature: _____
*Typed Signature not accepted

E-Mail Address: _____

Phone: _____

Date: _____

INCOME ELIGIBLITY CRITERIA (125% SMI)

Individuals eligible for child care subsidy from the Department of Health and Human Services, Child Care Affordability Program must comply with income eligibility criteria below.

Funds	State Funds (SPSS) Fund for a Healthy Maine (FHM) Child Care Development Funds (CCDF) Temporary Assistance to Needy Families (TANF)
Income Eligibility	All families must meet income guidelines of gross family income at or below 125% of Maine's State Median Income.
Fee Assessment	Fees are assessed to all families.

Effective 10/19/2024

FAMILY SIZE	ANNUAL INCOME	MONTHLY INCOME (ANNUAL/12)	WEEKLY INCOME (ANNUAL/4.3)
1	$73,618.35	$6,134.86	$1,426.71
2	$96,270.15	$8,022.51	$1,865.70
3	$118,921.95	$9,910.16	$2,304.69
4	$141,573.75	$11,797.81	$2,743.68
5	$164,225.55	$13,685.46	$3,182.67
6	$186,877.35	$15,573.11	$3,621.65
7	$191,124.56	$15,927.04	$3,703.97
8	$195,371.78	$16,280.98	$3,786.27
9	$199,618.99	$16,634.92	$3,868.59
10	$203,866.20	$16,988.85	$3,950.90

Add 3% for additional family members. For families with more than one child in care, the youngest child is always considered the first child enrolled. The total amount of assessed fees to a family shall not exceed 10% of the family's gross income for all of their children.

Weekly fee assessments must be rounded down to the nearest dollar. All assessed parent fees shall be paid directly to the caregiver by the parent.

SMI DATA: https://www.acf.hhs.gov/sites/default/files/documents/ocs/COMM_LIHEAP_IM%202024-02_Att4SMITable_0.pdf