



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

Initial \_\_\_\_\_  
 Redetermination \_\_\_\_\_

**Child Care Subsidy Program Application**

Applicant Name: \_\_\_\_\_ Town of Residence: \_\_\_\_\_  
 Primary Language/Dialect: \_\_\_\_\_

If you are eligible for subsidy but funding is not available, your name will be placed on a waiting list until funding becomes available. **You are responsible for all child care costs prior to an award being issued. This program does not pay for child care retroactively.**

**Answer the following question regarding program eligibility:**

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

**If you answered no to the question above, you are not eligible for this program.**

**Complete for all adults (or teen parents) in the household:** (please print)

Name	Relationship to Applicant

**Complete for all children in the household:** (please print)

Name	Mother's Name	Father's Name	Is child care needed? (Y/N)	Special Needs (Y/N)*

\*If yes, please attach medical/school documentation showing diagnosed special needs.

**Complete for all children of an absent parent living in the household:** (please print)

Child Name	Do you receive child support?*	Do you have shared custody arrangements? <u>If yes, attach court-ordered or signed and notarized visitation schedule.</u>	Is this child in guardianship? <u>If yes, attach proof of legal guardianship.</u>	Is the absent parent court-ordered to pay for a portion of child care expenses? <u>If yes, indicate amount and attach copy of court order.</u>

**\*Documentation of child support is required for all children of an absent parent unless good cause\* not to pursue child support can be shown. Submit one of the following for each child:**

- Court order
- Signed statement and copies of one month’s worth of checks
- Notarized agreement signed by both parents showing full name and physical address of both parents, child support amount and how often paid
- Proof of attempt to collect child support through DHHS Support Enforcement or the legal system

*\*If no child support arrangements are in place at the time of application, you must show proof you have pursued or begun collecting child support within six months of award or your assistance will be terminated.*

**Answer for all children attending school/Head Start:** (please print)

This program will not cover child care during hours when attending school/Head Start or if home schooled, we will only pay subsidy for school aged children for hours that are before and after the public school day for their district or union. If a child is/will be attending school within the next 6 months, indicate start date.

Child Name	Hours attending school/Head Start (ex. Mon.-Fri. 8am-12pm)	Start Date

Do you require additional child care during summer and regular school vacations?

**Indicate the times when adults are working/attending school but care is not needed (children going with family members, children in school, etc):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Supply the following employment information for all working adults in the household:**

One of the following is required for each job to document your work schedule:

- 4 weeks of current, consecutive pay stubs showing hours worked
- Employment information sheet completed and signed by your supervisor/Human Resources (enclosed)
- If self-employed, submit your current federal income taxes (Form 1040 and all schedules)

**Job 1:** Employment Type:     Traditional     Self-Employment

Employee Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

Hire/Start Date: \_\_\_\_\_

Travel Time Needed per Day (both ways): \_\_\_\_\_

Work Schedule (if your schedule varies, attach work schedules for the past 4 weeks on a separate page)

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Begin							
End							

**Job 2:** Employment Type:     Traditional     Self-Employment

Employee Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

Hire/Start Date: \_\_\_\_\_

Travel Time Needed per Day (both ways): \_\_\_\_\_

Work Schedule (if your schedule varies, attach work schedules for the past 4 weeks on a separate page)

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Begin							
End							

Additional information (seasonal, per diem, 3<sup>rd</sup> job, unpaid breaks, split shift, etc): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List information about education/job training programs for all adults in the household who are students:**

**Student 1:**

Name: \_\_\_\_\_

Institution Name: \_\_\_\_\_  On-line classes

Address: \_\_\_\_\_

Current Semester Start Date: \_\_\_\_\_ Current Semester End Date: \_\_\_\_\_

Next Semester Start Date: \_\_\_\_\_ Anticipated Graduation Date: \_\_\_\_\_

**Student 2:**

Name: \_\_\_\_\_

Institution Name: \_\_\_\_\_  On-line classes

Address: \_\_\_\_\_

Current Semester Start Date: \_\_\_\_\_ Current Semester End Date: \_\_\_\_\_

Next Semester Start Date: \_\_\_\_\_ Anticipated Graduation Date: \_\_\_\_\_

For each student attach a current official class schedule showing name, class times, and semester dates. Class schedules must be provided 30 days prior to semester beginning and previous semester grades will be required within 3 weeks of semester ending. On-line classes have special eligibility and may or may not be approved.

**The maximum amount of child care for which you may receive subsidy will be determined based on the work/education schedule information provided to the Child Care Subsidy Program. You will be responsible for the cost of any additional child care you may decide to use.**

**I certify under penalty of perjury that to the best of my knowledge the above information is true. I understand that this information may be provided to the central office of the Department of Health & Human Services for use in administration of this program. I authorize the agency to verify this information by whatever means necessary. I agree to notify the agency within 10 days of any change in income, family size, work or school schedule or employment status.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preparer Signature

\_\_\_\_\_  
Date

Return to:  
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## Employment Information Sheet

Please ask your supervisor or human resources staff to complete this form. Please make additional copies if needed.

Employee Name \_\_\_\_\_

Date of Hire \_\_\_\_\_

Hourly Wage/Salary \_\_\_\_\_

**Work Schedule**

(example: 8:00 am-5:00 pm)

Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total Hours

If this employee works a rotating or varying schedule, please supply his or her work schedule for the past four (4) consecutive weeks below. If the employee has not been employed for four (4) full weeks, please provide work schedules since date of hire and an estimate of expected hours for the remaining weeks.

Week beginning/end dates	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total Hours

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

\_\_\_\_\_  
Supervisor/Human Resources worker name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact telephone number

\_\_\_\_\_  
E-mail (optional)

**Child Care Provider Information**  
*(To be completed by Provider)*

Parent Name: \_\_\_\_\_ Child Name: \_\_\_\_\_

Business Name: Stepping Stones Early Learning Center INC

Name of Contact Person: Amanda Leclerc

Provider Address: 301 Sawyer Rd. Greene, ME 04236

(Child care providers may not reside at the same address as the children)

Provider Telephone: (207) 946-5437 Fax: (207) 946-5437

E-mail (optional): steppingstones@fairpoint.net

EIN/SSN: 5 6 - 2 4 7 2 5 5 9

License number (if applicable): 213805

Type of Provider:

Licensed Center\*

Certified Family Childcare Home\*

Legal Unregulated School Age Program

Unlicensed Provider in Provider's Home

Is the provider related to the child(ren)? If yes, indicate relationship \_\_\_\_\_

Unlicensed Provider in Child's Home

Is the provider related to the child(ren)? If yes, indicate relationship \_\_\_\_\_

\*Licensed or certified providers must participate in the *Quality for ME*, Maine's Quality Rating and Improvement System (QRIS) in order to receive child care subsidy payments.

Provider currently participates in the *Quality for ME* at a Step 3

Fill in current step

Yes       No       N/A (unlicensed provider)

If no, provider will be required to complete additional paperwork. For all questions or to register for QRIS, contact the Office of Child and Family Services (OCFS) at (207) 624-7909 or visit <http://www.maine.gov/dhhs/ocfs/ec/occhs/qualityforme.htm>.

**This program does not pay retroactively for child care already provided.**

Any provider who does participate in the child care subsidy program must agree to accept the approved rates set forth by the legislature.

*Return completed form to:*  
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