Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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

Child Care Subsidy Program (CCSP) Application

To process your application, please use black ink, submit a completed signed application along with a copy of all required documentation listed below. Incomplete applications will experience a delay in processing. Child Care Subsidy payments to child care providers will be for child care services provided between the beginning date and end date of the award letter.

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

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

☐ Proof of Residency (driver's license, rental agreement, mortgage statement, utility bills (electric, water, gas)

☐ Official School Schedule for parent(s) (if applicable) with financial aid award letter and school invoice

☐ Income Verification

- Pay stubs (4 most recent weeks); or
- Employment information sheet; or
- (if self-employed) Most recent IRS Tax Return (or) Most recent monthly profit and loss statement

☐ Unearned Income (if applicable)

- Social Security award letter
- Pension/retirement statement
- Alimony
- Child support (court ordered, joint custody, parental rights/responsibilities)
- Financial aid award letter
- Military benefits

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

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Office of Child and Family Services
Child Care Subsidy Program
2 Anthony Avenue
11 State House Station
Augusta, ME 04333-0011
Email: CCSP.DHHS@Maine.gov

Child Care Subsidy program (CCSP) Income Eligibility Criteria Update

Maine Department of Health & Human Services sent this bulletin at 05/16/2022 09:58 AM EDT

Effective 05/14/2022 until further notice

FAMILY SIZE	ANNUAL INCOME	MONTHLY INCOME (ANNUAL/12)	WEEKLY INCOME (ANNUAL/52)
1	$51,435.28	$4,286.27	$989.14
2	$67,261.52	$,5605.12	$1,293.49
3	$83,087.76	$6,923.98	$1,597.84
4	$98,914.00	$8,242.83	$1,902.19
5	$114,740.24	$9,561.68	$2,206.54
6	$130,566.48	$10,880.54	$2,510.89
7	$133,533.90	$11,127.82	$2,567.95
8	$136,501.32	$11,375.11	$2,625.02
9	$139,468.74	$11,622.39	$2,682.09
10	$142,436.16	$11,869.68	$2,739.15

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.

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

SECTION 1: Applicant(s) Information

1. Primary Applicant Name:		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 ☐ No **(if yes, attach proof of legal guardianship)**		
Are you a US citizen? ☐ Yes ☐ No **(if yes, attach proof)**		

2. Physical Address:			
Street Address:			
City:	State:	Zip:	County:
3. Mailing Address: (if different from above)			
Mailing Address/Post Office Box:			
City:	State:	Zip:	County:

SECTION 2: Additional Household Member(s) Including Children

4. Name:		Birthdate:
Are you a US citizen? ☐ Yes ☐ No (if yes, attach proof)		Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	
5. Name:		Birthdate:
Are you a US citizen? ☐ Yes ☐ No (if yes, attach proof)		Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	
6. Name:		Birthdate:
Are you a US citizen? ☐ Yes ☐ No (if yes, attach proof)		Social Security #:
Gender:	Primary Language:	Race:
Hispanic or Latino Origin: ☐ Yes ☐ No	Relationship to Applicant:	
7. Name:		Birthdate:
Are you a US citizen? ☐ Yes ☐ No (if yes, attach proof)		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

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 ☐ No **(if yes, attach documentation)**

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. 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

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

SECTION 4: Children with Special Needs

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

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

SECTION 5: Absent Parent Information ☐ Not Applicable

If you select yes to any of these please attach documentation

18. Do you have shared parental rights/responsibilities? ☐ Yes ☐ No

19. Do you have court ordered shared/joint custody? ☐ Yes ☐ No

20. Are you court ordered or voluntarily receiving child support? ☐ Yes ☐ No

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 Subsidy.

Please list and attach documentation about education/job training programs for all adults in the household who are students. For each student; provide a current official class schedule showing institution name, student name, class days/time, semester dates, and credit hours

21. Student #1 - Name of School:

Degree:	Start Date:	End Date:
Next Semester Start Date:	Anticipated Graduation Date:	
Travel Time Needed Per Day (round trip from child care to school, in hours):		

22. Student #2 - Name of School:

Degree:	Start Date:	End Date:
Next Semester Start Date:	Anticipated Graduation Date:	
Travel Time Needed Per Day (round trip from child care to school, in hours):		

SECTION 6: Employment ☐ Not Applicable

Please submit employment information for all adults in the household. Please submit four (4) weeks of current paystubs for all working adults or an employment information sheet can be submitted. Self-employed individuals must submit a copy of their most current taxes or most recent monthly profit and loss statement. 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, in addition to all supporting documentation referenced above

23. 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

24. 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

INFORMATION

If you would like information on developmental screenings, please go to the following link:
https://www.cdc.gov/ncbddd/childdevelopment/screening.html

Signature Required-Please sign, date and return

I certify under penalty of perjury that to the best of my knowledge the above information is true. I understand that this information will be provided to the Department of Health and 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 ten (10) days of any cessation of work or attendance at an educational or job training program and/or change of child care provider. **The application review process may take the Department up to 30 days.**

Primary Applicant Signature: _____ Date: _____

Preparer Signature: _____ Date: _____

Employer Information Sheet

Please have your supervisor or human resources staff complete this form	
Employer Responsible for Completion ☐ Not Applicable	
1. Employer Name:	
2. Name of Employee:	
3. Hourly Wage/Salary:	**4.** Date of Hire:
5. Does the schedule include an unpaid lunch break?	**6.** Are you paid weekly, bi-weekly or monthly?

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.

Supervisor/Human Resources Staff Name (Print): _____

Supervisor/Human Resources Staff Signature: _____ Date: _____

Email Address: _____ Phone: _____

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Child and Family Services

Child Care Subsidy Program – Child Care Provider Information Sheet

Please have your Child Care Provider complete this form

Child Care Provider Responsible for Completion

1. Parent Name:
2. Child(ren's) Name(s):
3. When is the child expected to attend your program?

Provider Information

1. Business Name: Stepping Stones Early Learning Center INC
2. Name of Contact Person: Amanda Leclerc
3. Phone Number: (207) 946-5437
4. Address: 301 Sawyer Rd. Greene, ME 04236
5. Email Address: Amanda@steppingstoneschildcare.me
6. Do you currently participate in the Maine's Quality Ratings and Improvement System? ☑ Yes ☐ No
7. Provider Type: (select below)

☑ Licensed License 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) _____

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

School Age Program/Recreational ☐

By signing below you acknowledge that the Child Care Subsidy 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 Subsidy Program you will be receiving additional paperwork that needs to be completed.

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

Provider's Signature: _____ Date: _____

***Signature Required-Please sign, date and return to the following address:**

Department of Health and Human Services
Office of Child and Family Services
Child Care Subsidy Program
2 Anthony Avenue
11 State House Station
Augusta, ME 04333-0011

Tel: (207) 624-7999 Fax: (207) 287-6308 Toll Free: 1-877-680-5866 TTY users call Maine relay 711
Email: CCSP.DHHS@Maine.gov

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Authorization to Release Information

We are committed to the privacy of your health information. Please read this form carefully.

❒Office of Maine Care Services	❒ Substance Abuse and Mental Health Services
❒Office for Family Independence including Medical Review Team	☑ Office of Child and Family Services
❒ Maine Centers for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	☑ Other: Child Care Subsidy Program
❒ Riverview Psychiatric Center	

Individual's Name:	Individual's Date of Birth: Individual's Social Security Number:

Individual's Address:

Street Town/City State Zip Code

Records to be released, including written, electronic and verbal communication:

❒All Healthcare, including treatment, services, supplies and medicines

☑ Claims Information ☑Billing, payment, income, banking, tax, asset, and/or other information regarding eligibility for DHHS program benefits such as MaineCare

❒Other: _____

❒ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/14 - 1/15/14")

I authorize the DHHS office(s) checked above to: ☑Release my information to: ☑ Obtain my information from:

Name: Stepping Stones Early Learning Center INC

Address: 301 Sawyer Rd. (Street) Greene, (Town/City) ME (State) 04236 (Zip Code)

Fax No., where applicable: (207) 514-8177 Phone No. to verify Receipt of Fax (207) 946-5437

If requesting that electronic information be transmitted by email, please clearly print the email address below:

Amanda@steppingstoneschildcare.me

❒ I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information possibly could be read by a third party. I accept those risks and still request that DHHS send my information by email. Initials _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

❒ For a legal matter ☑ To see if I qualify for insurance coverage or benefits ☑For coordination of my care
❒ A Personal Request ❒ Other (note here):

By initialing below, I agree to disclose the following types of records:

_____ **Mental health treatment provider or program**

_____ **Substance/alcohol/drug Abuse treatment provider or program**

_____ **HIV infection status or test results:** Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.

I (individual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner. I may revoke my permission to share my records at any time by contacting the Privacy Official of the office releasing those records. If DHHS released my records, I may call 207-287-3707 and ask for the office where I receive services to revoke my permission.
- I understand that taking back my permission does not apply to the information that was already shared after I signed this form.
- If I take back my permission, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- This form permits the people or offices listed on Page 1 to speak to each other for the purpose(s) on this form.
- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.
- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.
- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.
- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX**. ❒ I understand that the review will be supervised.
- DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.
- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date: _____ Signature_____

Personal Representative's authority to sign: _____