South Dakota Department of Social Services

Child Care Assistance Application

What is Child Care Assistance?

Child Care Assistance (CCA) is available to families who meet income guidelines and minimum work and/or school requirements. Federal Child Care and Development Block Grant funds help low-income families pay for child care as they work, attend school or both. You can use this application to apply for Child Care Assistance.

When will I get assistance?

- You will receive CCA benefits within 30 days if you are eligible.
- You will receive a Notice of Decision for CCA explaining eligibility or ineligibility and providing all benefit information.

Apply online?

You can apply online for Child Care Assistance at https://eaportal.sd.gov/

What you may need to apply?

- Verification of your identity if you are a first-time applicant for CCA
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Expense information (for example, business expenses or child support paid)
- Verification of hours of work or school. (for example, paystubs, school schedules)

Why do we ask for this information?

We ask about income, expense, and other information to let you know if you qualify for a CCA benefit.

We'll keep all the information you provide private and secure, as required by law. To view our Notice of Privacy Practices, go to **dss.sd.gov/keyresources/hipaa/**

What happens next?

Please Mail, fax, or take your application to your local DSS office. If you don't have all the information we ask for, we'll follow up with you. To determine if you are eligible, we must have the full application **and your signature on page 10**.

Get help with this application?

- **Online: dss.sd.gov**
- **Phone:** Call your local office **dss.sd.gov/findyourlocaloffice/**
- **In person:** Visit your local office **dss.sd.gov/findyourlocaloffice/**

1. TELL US ABOUT YOU

First Name:	MI:	Last Name:
Birth Date:	Social Security Number (optional):	
Residential Address:		
City:	State:	County:	Zip Code:
Mailing Address: (if different from residential address)		
City:	State:	County:	Zip Code:
Phone Number	Secondary Phone Number: (Optional)	
Directions to your home: (if no street address)	Do you live on an Indian Reservation? ☐ Yes ☐ No	
What is the best time to contact you between 8AM and 5PM?	E-mail address: (optional)	

2. WHO LIVES IN YOUR HOME?

Please provide the following information for the people in your household. This section can also be used to report any changes for the existing household members.

*SSN: Optional

**Marital Status Codes: N- Never Married/Single M- Married S- Separated D- Divorced W- Widow/ Widower

*** Race Codes: W- White A- American Indian/Alaska Native B- Black H- Hawaiian/Pacific Islander O- Asian M-Middle Eastern/North African L -Hispanic/Latino

Full Legal Name	Relationship	*SSN	DOB (mm/dd/yy)	Gender (M/F)	**Marial Status	Last Grade Completed	***Race	Citizenship	Date entered home (mm/dd/yy)	Child in Need of Care (Yes/No)
										☐ Yes ☐ No
										☐ Yes ☐ No
										☐ Yes ☐ No
										☐ Yes ☐ No
										☐ Yes ☐ No
										☐ Yes ☐ No

List below the name(s) of any household members who have an absent parent. ☐ Yes ☐ No If yes, complete the complete the questions below.	
Parent Name:	Child(ren) Name(s):
Parent Name:	Child(ren) Name(s):
Parent Name:	Child(ren) Name(s):
List below the name(s) of any child you live with receiving an adoption or guardianship subsidy.	
Child(ren) Name(s):	Child(ren) Name(s):

3. AUTHORIZED REPRESENTATIVE

Do you wish to have someone help you fill out your application and/ or speak on your behalf as an authorized representative? If yes, please complete the information below. ☐ Yes ☐ No

Name:	Relationship or Organization:	
Mailing Address:		
City:	State:	Zip Code:
Phone Number:	E-mail Address:	

4. ADDITIONAL HOUSEHOLD INFORMATION REQUIRED

Is any member of your household Active-Duty U.S. Military? If yes, complete below.

Full Name	What date did they enter the service?	Branch of Service	Is the person deployed?
			☐ Yes ☐ No
			☐ Yes ☐ No

Is any member of your household a member of the National Guard or Military Reserve? If yes, complete below.

Full Name	What date did they enter service?	National Guard or Military Reserve?	Is this person deployed?
			☐ Yes ☐ No
			☐ Yes ☐ No

Do you receive Supplemental Nutrition Assistance Program (SNAP) Benefits?

☐ Yes ☐ No

Do you receive federal rental assistance or live in subsidized housing?

☐ Yes ☐ No

If your current address is a temporary living arrangement, you may meet the definition of “homeless” according to the McKinney Vento Act. See section 11 for help answering the following question.

Do you consider yourself homeless?

☐ Yes ☐ No

Do your family assets exceed one million dollars ($1,000,000)?
☐ Yes ☐ No
What is the primary language spoken at home?
☐ English ☐ Spanish ☐ Native Central, South American, and Mexican languages (e.g., Mixteco, Quichean) ☐ Caribbean Languages (e.g., Haitian-Creole, Patois) ☐ Middle Eastern and South Asian languages (e.g., Arabic, Hebrew, Hindi, Urdu, Bengali) ☐ East Asian Languages (e.g., Chinese, Vietnamese, Tagalog) ☐ Native North American/Alaska Native Languages Pacific Island Languages (e.g., Palauan, Fijian) ☐ European and Slavic Languages (e.g., German, French, Italian, Croatian, Yiddish, Portuguese, Russian) ☐ African Languages (e.g., Swahili, Wolof) ☐ Other (e.g., American Sign Language) ☐ Decline to respond
Do You Need Interpreter Services ☐ Yes ☐ No
If yes, preferred language:

5. INFORMATION ABOUT CHILD CARE NEED

Do you need child care assistance in order to work or attend school or a training program?
☐ Yes ☐ No
Is anyone in your household unable to work, attend school, or care for their child(ren) due to an incapacity?
☐ Yes ☐ No If yes, please indicate who:
Are you applying for Child Care Assistance **only** for children that are in foster care, Harbor Family services, or have a long term safety plan? **If yes, you may skip sections 6, 7, 8, and 9.**
☐ Yes ☐ No
Complete the following for each child in your household in need of care for each provider they attend. If additional space is needed, please attach additional pages. **Each child may only have a maximum of two child care providers at a time.**
Child 1: Child Name

Provider Name	Provider Address	Provider ID	Provider Phone

When did this provider begin caring for this child?		Date:	
Is this provider caring only for your children?		☐ Yes ☐ No	
Is this provider a relative?	☐ Yes ☐ No	If yes, please list the relationship to the child:	
Where is the care for this child being provided?		☐ Child's Home ☐ Provider's Home ☐ Location other than the home of the child or provider	
Does this child have a special need that requires accommodation while in care at this provider?		☐ Yes ☐ No	

Non-School Age Children (Children not yet in kindergarten)	
How many hours per week does this child attend this provider?	
School Age Children (Children in kindergarten or age 6+)	
Does this child need care all year (during the summer and during the school year)?	☐ Yes ☐ No
When does this child need care with this provider?	☐ School year only ☐ Summer Only ☐ School year and Summer

How many hours per week does this child attend or is planned to attend this provider during the school year?	When does this child need care during the school days?	Does this child typically attend care with this provider on weekends or overnights during the school year?	Does this child typically attend care with this provider before 5am or after 8pm on weekdays during the school year?	How many hours per week does this child attend or is planned to attend this provider during the summer?
	☐ Before School ☐ After School ☐ Before and After School	☐ Yes ☐ No	☐ Yes ☐ No	

Child 2: Child Name			
Provider Name	Provider Address	Provider ID	Provider Phone

When did this provider begin caring for this child?		Date:	
Is this provider caring only for your children?		☐ Yes ☐ No	
Is this provider a relative?	☐ Yes ☐ No	If yes, please list the relationship to the child:	
Where is the care for this child being provided?		☐ Child's Home ☐ Provider's Home ☐ Location other than the home of the child or provider	
Does this child have a special need that requires accommodation while in care at this provider?		☐ Yes ☐ No	

Non-School Age Children (Children not yet in kindergarten)	
How many hours per week does this child attend this provider?	
School Age Children (Children in kindergarten or age 6+)	
Does this child need care all year (during the summer and during the school year)?	☐ Yes ☐ No
When does this child need care with this provider?	☐ School year only ☐ Summer Only ☐ School year and Summer

How many hours per week does this child attend or is planned to attend this provider during the school year?	When does this child need care during the school days?	Does this child typically attend care with this provider on weekends or overnights during the school year?	Does this child typically attend care with this provider before 5am or after 8pm on weekdays during the school year?	How many hours per week does this child attend or is planned to attend this provider during the summer?
	☐ Before School ☐ After School	☐ Yes ☐ No	☐ Yes ☐ No	

	☐ Before and After School			

Child 3: Child Name			
Provider Name	Provider Address	Provider ID	Provider Phone

When did this provider begin caring for this child?		Date:	
Is this provider caring only for your children?		☐ Yes ☐ No	
Is this provider a relative?	☐ Yes ☐ No	If yes, please list the relationship to the child:	
Where is the care for this child being provided?		☐ Child's Home ☐ Provider's Home ☐ Location other than the home of the child or provider	
Does this child have a special need that requires accommodation while in care at this provider?		☐ Yes ☐ No	

Non-School Age Children (Children not yet in kindergarten)	
How many hours per week does this child attend this provider?	

School Age Children (Children in kindergarten or age 6+)	
Does this child need care all year (during the summer and during the school year)?	☐ Yes ☐ No
When does this child need care with this provider?	☐ School year only ☐ Summer Only ☐ School year and Summer

How many hours per week does this child attend or is planned to attend this provider during the school year?	When does this child need care during the school days?	Does this child typically attend care with this provider on weekends or overnights during the school year?	Does this child typically attend care with this provider before 5am or after 8pm on weekdays during the school year?	How many hours per week does this child attend or is planned to attend tis provider during the summer?
	☐ Before School ☐ After School ☐ Before and After School	☐ Yes ☐ No	☐ Yes ☐ No	

Child 4: Child Name			
Provider Name	Provider Address	Provider ID	Provider Phone

When did this provider begin caring for this child?		Date:	
Is this provider caring only for your children?		☐ Yes ☐ No	
Is this provider a relative?	☐ Yes ☐ No	If yes, please list the relationship to the child:	

Where is the care for this child being provided?	☐ Child's Home ☐ Provider's Home ☐ Location other than the home of the child or provider
Does this child have a special need that requires accommodation while in care at this provider?	☐ Yes ☐ No
Non-School Age Children (Children not yet in kindergarten)	
How many hours per week does this child attend this provider?	
School Age Children (Children in kindergarten or age 6+)	
Does this child need care all year (during the summer and during the school year)?	☐ Yes ☐ No
When does this child need care with this provider?	☐ School year only ☐ Summer Only ☐ School year and Summer

How many hours per week does this child attend or is planned to attend this provider during the school year?	When does this child need care during the school days?	Does this child typically attend care with this provider on weekends or overnights during the school year?	Does this child typically attend care with this provider before 5am or after 8pm on weekdays during the school year?	How many hours per week does this child attend or is planned to attend tis provider during the summer?
	☐ Before School ☐ After School ☐ Before and After School	☐ Yes ☐ No	☐ Yes ☐ No	

6. INCOME FROM JOBS

Please list below all the income that you and your household members receive from any jobs you have. **You must provide proof of all income with your application.**

Household Member Name	Employer Name	Employer Address	Amount of Pay	Pay Frequency (e.g. hourly, weekly, bi-weekly, monthly, etc.)	Average number of hours worked per week	Start date

If anyone in your household is self-employed complete the information below. **You must provide proof of income received and all expenses.**

Household Member Name	Business Name	Business Address	Gross Income for Year	Business Expense(s) for Year	Net Income for Year

7. INCOME FROM SOURCES OTHER THAN JOBS

Please list all other sources of income you and your household members receive. Some examples of unearned income are payments from Child Support, Alimony, Temporary Assistance for Needy Families (TANF), Unemployment, Worker's Compensation, Social Security, Income from Rental Property, etc.
You must provide proof of all income with your paper application form.

Household Member Name	Source of Income	Amount	Frequency (e.g. weekly, bi-weekly, monthly, etc.)

8. DEDUCTIONS

Do you or anyone in your household make court ordered child support payments? **You must provide proof of all Child support payments to receive this deduction.**

Household Member Name	Is this payment made through the SD Division of Child Support? Yes/No	Amount	Frequency (e.g. weekly, bi-weekly, monthly, etc.)
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

9. TANF PARTICIPATION

South Dakota Temporary Assistance for Needy Families (TANF) is a temporary public assistance work program administered by the Department of Social Services and the Department of Labor and Regulation. The Tribal Temporary Assistance for Needy Families (TANF) program is administered through individual tribes.

Household Member Name	When did this person begin participating in TANF Activities (Date)?	How many hours per week does this person participate in TANF Activities?	How many days per week does this person participate in TANF Activities?	Is this Tribal TANF? Yes/ No
				☐ Yes ☐ No
				☐ Yes ☐ No

10. EDUCATION

Is anyone in your household currently enrolled in school? Please complete for each below.

☐ Yes ☐ No

Full Name	School Name	School Type	Total Credit Hours Enrolled	Hours Per Week Physically in Class	Hours Per week in Online Classes	Hours Per Week You Participate in Required Class Activities (clinicals, practicum, internships)	Expected Graduation Date

11. IMPORTANT INFORMATION

MCKINNEY-VENTO ACT

The McKinney-Vento Act defines homeless as lacking a fixed, regular, and adequate nighttime residence; and includes individuals who:

- Share the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals or awaiting foster care placement;
- Have a primary nighttime residence that is a public or private place not designed for or ordinarily used as regular sleeping accommodations for human beings;
- Live in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings;
- Are migratory and live in any of the circumstances as described above.

RIGHTS AND RESPONSIBILITIES

You have the right to:

- Receive a written decision, in most cases, within thirty (30) days.
- Request an appeal within thirty (30) days if you disagree with any decision made regarding your Child Care Assistance benefits.
- Have the information about you and your household kept confidential according to Federal and State laws.

You have the responsibility to:

- Inform the South Dakota Department of Social Services when your household's income exceeds the maximum amount for your household size.
- Inform the South Dakota Department of Social Services when you or one of your household members have a permanent change in employment or school status; a change in child care provider(s) or child care arrangements within ten (10) days.
- Pay any child care expenses not covered by Child Care Assistance and the assigned copayment if applicable.

VERIFICATIONS

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials may verify information given on this form to determine if it is correct. A Department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your case may be denied or terminated, and you may be subject to criminal prosecution for knowingly providing false information.

NOTICE OF NONDISCRIMINATION

Nondiscrimination: The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605.773.3305

Confidence: The information provided will be held in confidence and used solely for purposes of administration of the program.

Cooperating Requirements: By applying for Child Care Assistance, you have agreed to cooperate with the Department of Social Services in identifying and providing information to help pursue any third party who may be responsible for paying for care and services for each person for whom benefits were requested. You may also be required to cooperate with the Division of Child Support.

Fraud: There are state and federal penalties for fraud and false reporting in connection with your application for Child Care Assistance. You may be required to repay any benefits that are paid to you as a result of incorrect or false information or failing to report changes. Willfully giving false statements, (misrepresentations, impersonations or other fraudulent means), can result in conviction for one or more felony criminal offenses which are punishable by fines and/or confinement in the South Dakota State Penitentiary.

12. REGISTER TO VOTE - OPTIONAL

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 are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

If you do not check either box, you will be considered to have decided NOT to register to vote at this time.
(Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.)

If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

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 the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

13. AUTHORIZATION TO FURNISH AND RELEASE INFORMATION

I hereby authorize any person, agency or institution to supply information requested by the Department of Social Services concerning me or my family, and to allow inspection and reproduction of records in his or their possession pertaining to me or my family by any duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

This authorization is given only in connection with its use by the Department in the administration of its programs and for no other purpose. It shall continue in effect until such time as I state in writing that it is no longer valid.

I herewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

ACKNOWLEDGEMENT

I understand that the information on this form is subject to verification by Federal, State, and local officials to determine that such information on this application is correct and complete including citizenship and alien status of the members applying for benefits. If any information is found to be incorrect, benefits may be reduced or terminated, and I will be responsible for paying the benefits back. I declare and affirm under penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct. I understand I may be subject to criminal prosecution for knowingly providing incorrect information. I have read and understand the legal information and understand my responsibilities and agree to fulfill them. I understand the penalties for giving false information or breaking the rules of the assistance program(s).

SIGNATURES

The recipient should sign this form unless incapacitated or represented by a Legal (Court Appointed) Guardian. An authorized representative may sign the application on behalf of the incapacitated or deceased applicant. The applicant's mark should be witnessed by a person familiar with the applicant.

_____

Signature of Applicant or Recipient Date

Witness to Applicant's mark	Date	Signature of Authorized Representative, Legal Guardian or Power of Attorney	Date