|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **State of Hawaii- Department of Human Services** | **Worker’s Name:** |  | | |
| **Benefit, Employment & Support Services Division** | **Unit # / Tel:** | / | | |
|  |  | | | |
| **Originating Unit:** | CCS/CCR&R |  | FTW CC |

**LEGALLY EXEMPT HOME-BASED HOUSEHOLD FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **A.** | **FAMILY INFORMATION (To be completed by DHS Staff):** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
|  | **CLIENT NAME:** |  | | | | | | |  | **CLIENT ID:** |  | | |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **B.** | **LEGALLY EXEMPT HOME-BASED CHILD CARE HOUSEHOLD INFORMATION**  **(To be completed by provider)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **1.** | **PROVIDER INFORMATION (Must be same provider from DHS 918, page 1, section C.1.):**  I understand that as a legally exempt home-based child care provider for families who receive child care subsidy payments I am required to undergo background checks. | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | |
|  | **Name of Provider** | | | | **Birthdate** | | **Social Security**  **Number** | | | | | | **(For DHS Use Only)** |
|  |  | | | |  | |  | | | | | |  |
|  | | | | | | | | | | | | | |
| **2.** | **HOUSEHOLD INFORMATION:** I understand that as a legally exempt home-based child care provider for families who receive child care subsidy payments all adult household members living in my home where I provide care or in the child’s home (excluding child’s parents) are required to undergo background checks.  List all adult household member’s name, birthdate and social security number. | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
|  | **Name of Adult Household Member** | | | | **Birthdate** | | **Social Security**  **Number** | | | | | | **(For DHS Use Only)** |
|  |  | | | |  | |  | | | | | |  |
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|  | | | | | | | | | | | | | |
| **3.** | Provider’s/Child’s (if care is being provided in the child’s home) home address: | | | | | | | | | | | | |
| Home Address: | |  | | | | | | | | |  | |
| City: | |  | State: HI | | Zip code: | |  | | | |  | |
|  | | | | | | | | | | | | | |
| **Provider’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Please bring the completed DHS 948 Authorization for Background Check and To Release Findings form to your fingerprinting appointment. Each person shall be responsible for his/her own form.** | | | | | | | | | | | | | |