STATE OF HAWAII – DEPARTMENT OF HUMAN SERVICES
Benefit, Employment and Support Services Division

APPLICATION FOR CHILD CARE SERVICES

ELIGIBILITY REQUIREMENTS (MUST MEET ALL)	DOCUMENTATION REQUIRED
1. Child must be under age 13, or 13 through 17, and unable to care for self.	Copies of birth certificates for all children, baptismal or hospital certificates, or court decree.
2. Child must be a US citizen or a Lawful Permanent Resident.	Copies of birth certificates, US passport, Certificate of Naturalization, Certificate of Citizenship or permanent resident card ("Green Card").
3. Child for whom assistance is being requested must reside with the applicant.	Birth document or other court decree. Applicant must be a parent (birth, adoptive, foster, hanai) or a legal guardian.

*The provision of a social security number and copies of the social security card for all household members listed on the application is strictly voluntary. Failure to provide this Information will not affect the application process or the amount of benefits you will receive. The use of social security numbers will be for agency use only as an internal identifier.

REASON FOR CHILD CARE (CHECK ALL THAT APPLY)	DOCUMENTATION REQUIRED (PLEASE ATTACH TO COMPLETED APPLICATION)
☐ Parents in Employment, Education or Training.	School enrollment documents which show credits/ hours enrolled, income verification for the past 2 months, or if self-employed, current copy of G45 tax form and General Excise tax license.
☐ Physical or mental incapacity of child, 13 – 17 years old, **and** child is unable to care for self.	Signed statement from a state-licensed physician or psychologist.
☐ Family receives Child Protective Services (CPS).	Child Welfare Services (CWS) Family Service Plan (court ordered).
☐ Parent/legal guardian may lose job because of child care problems.	Written warning from employer.
☐ Parent/legal guardian has been offered a job and will start on _____.	Written proof of job offer.

PLEASE PRINT
List all family members now living in your home. Please attach a separate sheet if more space is needed.

NAME: Last First M.I.	*Social Security No. (Optional)	Birth Date (mm/dd/yy)	Race	Sex (M/F)	Marital Status	Active Duty, if yes, check one below
Applicant						☐ Active Duty ☐ Reserve/ National Guard
Co-applicant						☐ Active Duty ☐ Reserve/ National Guard

Residence Address		Home/Cell Phone	☐ Check this box if your family is homeless or does not have a fixed, regular, and adequate nighttime residence.
Mailing Address		Work Phone Applicant	
Primary Language Spoken at Home	Interpreter Services Needed? Yes No	Work Phone Co-Applicant	

Name(s) of Child(ren)	*Social Security No. (Optional)	Birth Date (mm/dd/yy)	Race	Sex (M/F)	Special Needs?	Child Care Requested?
Child					Yes No	Yes No
Child					Yes No	Yes No
Child					Yes No	Yes No
Child					Yes No	Yes No
Child					Yes No	Yes No

Applicant(s) Employment/School	Employer or School Address/Phone	Start Time (AM or PM)	End Time (AM or PM)
Applicant			
Co-applicant			

Type of Monthly Income **(ATTACH COPY OF INCOME INDICATED)**	Amount
Employment Earnings (including Self-Employment)	$
Unemployment Insurance Benefits (UIB)	$
Worker's Compensation / Temporary Disability Insurance (TDI)	$
Child Support/ Alimony	$
Adoption Assistance Payments	$
Military Allotment	$
Supplemental Security Income (SSI) / Retirement, Survivors & Disability Insurance (RSDI)	$
Pension	$
Other Income (Specify)	$
TOTAL INCOME	$ 0.00

Assets (Total assets in Applicant and/or Co-applicant's names, including ownership or partial ownership of property located in Hawaii and elsewhere, business or corporations, vehicles, jewelry, etc., but excluding any equity value in the home which is the usual residence of the household and excluding any equity for one vehicle.)	
TOTAL ASSETS VALUE EXCEEDS $1 million (U.S. dollars)	☐ Yes ☐ No

STATEMENT OF APPLICANT

I hereby certify that all the information contained on this form is true and correct to the best of my knowledge. I submit this application with the understanding that I will give any additional information which may be needed and will allow the Department to verify my statements either with me or through other sources as necessary.

I fully understand that the following changes are mandatory to be reported within 10 days of occurrence: gross income exceeds limit for family size, change in residence or mailing address, household members leave or are added to the family, change in marital status, change in child care provider, child care cost, care type or no longer need child care, CPS/CWS case closes, loss of employment, job training or stops attending school. Furthermore, I understand that if I fail to report changes and receive services to which I am not entitled, the amount of overpayment will be collected from me, and I may be prosecuted for fraud.

I understand that I have a right to request a case record review and administrative appeal if I do not agree with the Department's decision on my application for child care services.

I understand that I must report lost or stolen Electronic Benefits Transfer (EBT) cards immediately, or a misdispensement occurrence, by calling the EBT toll-free customer service telephone number. There will be no replacement of any benefits accessed with an EBT card prior to the report of the lost or stolen card or the report of the misdispensement occurrence.

I understand that I must immediately report any changes in the status of my alternate payee. There will be no replacement of any benefits accessed by alternate payees or any other individuals using an EBT card and a valid PIN.

I understand that child care payments are included in DHS "cash assistance household" accounts, and that child care benefits not withdrawn from my EBT account within ninety (90) days will be returned to the State. Child care benefits that are returned to the State may be used to offset any outstanding overpayments owed by the household. (HAR §§17-798.2-20, 17-681-51, 17-681-52, and 17-681-56.)

Applicant Signature: _____ Date: _____

Co-applicant Signature: _____ Date: _____
(Signature required for Co-applicant)

ELIGIBILITY DISPOSITION (For Department Use Only)

☐ APPROVED Family size _____ 85% SMI $_____ Total Income $_____
DATE OF ELIGIBILITY _____

☐ DENIED
- ☐ Family income: $_____, more than DHS Income Limit ☐ Other reasons :_____
- ☐ Family assets: $_____, more than DHS Asset Limit

☐ APPLICATION WITHDRAWN _____ _____ _____
Date WORKER SIGNATURE Date