



### **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. The parent is responsible for any care used prior to the issuance of an award.

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

- Proof of Citizenship for **children** (birth certificate (state issued copy), passport, immigration or naturalization documents) \*Social Security cards are **not** acceptable proof of citizenship.
- Proof of Residency (driver's license, rental agreement, mortgage statement, car registration, hunting/fishing license, utility bills (electric, water, gas) \* internet bill is not accepted as proof of residency.
- 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, child SSI award letter, child only TANF grant
  - Pension/retirement statement/alimony
  - Child support (court ordered, joint custody, parental rights/responsibilities)
  - Financial aid award letter and invoice from the school
  - 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](mailto:CCSP.DHHS@Maine.gov)**



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

| <b>SECTION 1: Applicant(s) Information</b>   |   |                                 |         |
|--|---|---------------------------------|---------|
| <b>1. Primary Applicant Name:</b>  |   | Birthdate:                      |         |
| Email Address:   |   | Last four of Social Security #: |         |
| Home Phone:  |   | Cell Phone:                     |         |
| Gender:  | Primary Language:                           |                                 | Race:   |
| Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Translator needed? <input type="checkbox"/> |                                 |         |
| Are you a court appointed legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(if yes, attach proof of legal guardianship)</b> |   |                                 |         |
| <b>2. Physical Address:</b>  |   |                                 |         |
| Street Address:  |   |                                 |         |
| City:  | State:                                      | Zip:                            | County: |
| <b>3. Mailing Address: (if different from above)</b>   |   |                                 |         |
| Mailing Address/Post Office Box:   |   |                                 |         |
| City:  | State:                                      | Zip:                            | County: |

| <b>SECTION 2: Additional Household Member(s) Including Children</b>  |                            |                    |       |
|--|----------------------------|--------------------|-------|
| <b>4. Name:</b>  |                            | Birthdate:         |       |
| Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof) |                            | Social Security #: |       |
| Gender:  | Primary Language:          |                    | Race: |
| Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Relationship to Applicant: |                    |       |
| <b>5. Name:</b>  |                            | Birthdate:         |       |
| Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof) |                            | Social Security #: |       |
| Gender:  | Primary Language:          |                    | Race: |
| Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Relationship to Applicant: |                    |       |
| <b>6. Name:</b>  |                            | Birthdate:         |       |
| Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof) |                            | Social Security #: |       |
| Gender:  | Primary Language:          |                    | Race: |
| Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Relationship to Applicant: |                    |       |
| <b>7. Name:</b>  |                            | Birthdate:         |       |
| Are you a US citizen or a qualified alien? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach proof) |                            | Social Security #: |       |
| Gender:  | Primary Language:          |                    | Race: |
| Hispanic or Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Relationship to Applicant: |                    |       |

**SECTION 3: Questions**

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

2. 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)**

3. Has a child been placed under the legal guardianship of an individual who has reached retirement age as defined by Social Security?  Yes  No

4. Do you have assets that are equal to or exceed \$1,000,000?  Yes  No

5. Are you currently experiencing homelessness?  Yes  No

6. Do you receive housing assistance?  Yes  No

7. Have you received TANF in the past twelve (12) months?  Yes  No

8. 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

9. Do you have a tribal affiliation?  Yes  No

**SECTION 4: Children with Special Needs**

10. 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. In addition, you will receive a release of information request to return for provider reimbursement.

**SECTION 5: Absent Parent Information (Must be completed if a single parent household)  N/A if a 2-parent household**

11. Do you have shared parental rights/responsibilities for child care payment?  Yes  No \*provide a copy of the court order or notarized agreement

12. Do you have court ordered shared/joint custody?  Yes  No \*provide a copy of the court order or notarized visitation schedule

13. Are you court ordered or voluntarily receiving child support?  Yes  No \*court order is income regardless of payment received

14. Do you receive adoption assistance?  Yes \*please provide documentation  No

**Section 6: Parent School Information**

Educational program refers to a program which is required for completion of a secondary diploma, High School Equivalency Test (HISSET), 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, financial aid letter, and school bill\***

15. 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): |                              |           |

16. 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 7: 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\***

**1. 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 |
|--|--------|--------|---------|-----------|----------|--------|----------|-------------|
|  |        |        |         |           |          |        |          |             |
|  |        |        |         |           |          |        |          |             |
|  |        |        |         |           |          |        |          |             |
|  |        |        |         |           |          |        |          |             |

**2. 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 (DHHS) for use in administration of this program. I authorize the agency to verify this information by whatever means necessary. I agree to notify the DHHS, Child Care Subsidy Program (CCSP) 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 and/or if family income exceeds over eighty-five percent (85%) of State Median Income (SMI).

**The application review process may take the Department up to 30 days.**

Primary Applicant Signature: \_\_\_\_\_ (typed signature is not accepted) 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. Date of Rehire:

6. Does the schedule include a 30 min unpaid break?

7. Are you paid weekly, bi-weekly or monthly?

8. If you receive tips, how much do you receive in tips per week? (Please provide documentation)

**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<br>(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:   | 2. Provider hours of operation: |
| 3. Name of Contact Person:  | 4. Phone Number:                |
| 5. Address:   |                                 |
| 6. Email Address:   |                                 |
| 7. Do you currently participate in the Maine’s Quality Ratings and Improvement System? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |
| 8. Provider Type: (select below)  |                                 |

Licensed License Number/CCSP Billing Number:

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 to child) \_\_\_\_\_  
In Child’s Home:  Unrelated  Related (must indicate relationship to child) \_\_\_\_\_  
School Age Program/Recreational

9. What is your QRIS Step Level:

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): \_\_\_\_\_ Preferred Language: \_\_\_\_\_

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](mailto:CCSP.DHHS@Maine.gov)