



# CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance  
Child Care Program Office

Office Use Only

## FAMILY REPORT OF CHANGE

Printed Family's Parent First and Last Name: \_\_\_\_\_

ICCIS ID Number, if known: \_\_\_\_\_

To continue Child Care Assistance Program participation without penalty, you must report the following changes in your circumstance and provide the required verification listed within the timeframes prescribed.

**CHANGE IN ELIGIBLE ACTIVITY:** Report within 10 business days of the end of the 3<sup>rd</sup> month following a loss of employment, or ending attendance at a job training or educational program. Your child care benefit will continue for the following 3 months and you will be considered to be participating in job search activities. You must obtain employment or begin attendance at a job training or educational program, report it to this office, and provide verification before the end of this 3 month period, in order to continue program participation. You are not required to report if you are ending employment and beginning with a new employer.

### EMPLOYMENT

Parent First and Last Name: \_\_\_\_\_

**Employment Ended**

Employer Business Name: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

Submit verification including the name of the employer, the last day employed, the date of your last pay check and the gross wages on your last pay check.

**Employment Beginning/Began. Verification of activity, wages, and earnings must be provided.**

Employer Business Name: \_\_\_\_\_ Employment Start Date: \_\_\_\_\_

Employer Name and Contact Number: \_\_\_\_\_

Schedule of work days and times:

Mon: \_\_\_\_\_ Tues: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_

Fri: \_\_\_\_\_ Sat: \_\_\_\_\_ Sun: \_\_\_\_\_

Hourly Rate of Pay: \$ \_\_\_\_\_

Pay Frequency is:  Weekly  Monthly  Every Two Weeks (same day of the week)  
 Twice a Month (such as the 5<sup>th</sup> and the 20<sup>th</sup>)

Note: Every two weeks and twice a month are different. Please be certain of the pay frequency before checking the box.

**JOB TRAINING/EDUCATIONAL PROGRAM ATTENDANCE**

Parent First and Last Name: \_\_\_\_\_

Attendance Ended

Program Name: \_\_\_\_\_ Last Day Attended: \_\_\_\_\_

Attendance Beginning/Began. Verification of program enrollment, class schedule, cost of tuition and fees, and any financial aid received or to be received must be provided.

Program Name: \_\_\_\_\_ Program Start Date: \_\_\_\_\_

**CHANGE IN INCOME:** Report within 10 business days if your family’s countable monthly income exceeds 85% of the State Median Income. See the *Family Income and Contribution Schedule*.

**Increase in family countable income exceeding 85% of the State Median Income.** Attach verification.

Family Member Name: \_\_\_\_\_

Name/type of income source changing: \_\_\_\_\_

Date Received: \_\_\_\_\_ Amount Received: \_\_\_\_\_ New Amount to Continue:  Yes  No

**Decrease in income, not due to employment change above.** Reporting is not required; however, may positively affect your benefit if the decreased amount is expected to continue. Attach Verification.

Family Member Name: \_\_\_\_\_

Name/type of income source changing: \_\_\_\_\_

Date Received: \_\_\_\_\_ Amount Received: \_\_\_\_\_ New Amount to Continue:  Yes  No

**CHANGE IN CHILD CARE NEED:** Report within 10 business days when an increase of child care coverage is needed due to a change in your eligible activity.

Change in days/hours

Child Care Provider Name: \_\_\_\_\_

Child(ren) Name(s): \_\_\_\_\_

Days/Times Care Needed:

Mon: \_\_\_\_\_ Tues: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_

Fri: \_\_\_\_\_ Sat: \_\_\_\_\_ Sun: \_\_\_\_\_

**CHANGE OF CHILD CARE PROVIDER:** At least 10 business days prior to ending care with your child care provider you must give your child care provider written notice. Within 10 business days of the change occurring you must also report the change and provide a copy of the written notice given to your child care provider to the child care assistance office.

Current Child Care Provider Name: \_\_\_\_\_

Date 10 day written notice was given to child care provider: \_\_\_\_\_ Last date of care: \_\_\_\_\_

New Child Care Provider Name: \_\_\_\_\_

Date care to begin or began: \_\_\_\_\_

Child(ren) Name(s): \_\_\_\_\_

Days/Times Care Needed:

Mon: \_\_\_\_\_ Tues: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_

Fri: \_\_\_\_\_ Sat: \_\_\_\_\_ Sun: \_\_\_\_\_

Is full time care needed for school age children for in-service or school closures:  Yes  No

If yes, indicate the names of the children and dates full time care is needed: \_\_\_\_\_

\_\_\_\_\_

Secondary Provider Needed

Child Care Provider Name: \_\_\_\_\_

Date care to begin or began: \_\_\_\_\_

Child(ren) Name(s): \_\_\_\_\_

Days/Times Care Needed:

Mon: \_\_\_\_\_ Tues: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_

Fri: \_\_\_\_\_ Sat: \_\_\_\_\_ Sun: \_\_\_\_\_

Is full time care needed for school age children for in-service or school closures:  Yes  No

If yes, indicate the names of the children and dates full time care is needed: \_\_\_\_\_

\_\_\_\_\_

**CHANGE IN FAMILY ADDRESS/CONTACT INFORMATION:** Report within 10 business days of the change occurring to ensure we have the most current information.

Mailing Address Change

New Mailing Address: \_\_\_\_\_

Physical Address Change

New Physical Address: \_\_\_\_\_

Contact Phone Number Change

Home phone number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Other Contact Number: \_\_\_\_\_

\_\_\_\_\_  
Family's Parent Signature

\_\_\_\_\_  
Date