

	Case Name:
	Case ID#:
	Worker:

Note: Please complete and return this form only if there has been a change in your household circumstances.

I understand that I am responsible for reporting all changes that could affect my eligibility for Child Care Assistance or the agency payment amount within 10 days of my knowledge of the change. Failure to timely report these changes could result in action by the agency. I understand that I must report if my child care provider moves in with me or if I move in with my provider or we begin sharing the same mailing address (with the exception of a post office box).

I must report the following changes within 10 days of the change:

- Household address has changed
- Any household composition changes (A child receiving child care benefits moves out of the home or is no longer in the child care provider’s care, etc.)
- My child care provider moves in with me or I move in with my provider or we begin sharing the same mailing address (with the exception of a post office box)
- Number of hours/day that my child(ren) attend child care has changed
- Change of child care providers
- Add or remove household designees
- Changes in gross monthly income which result in my household’s income exceeding the 85% state median income gross income limit for CCAP.
- A change or termination of employment, training, or education for any parent or adult household member

I am reporting the following changes (check all that apply):

- 1. I no longer need child care assistance.**
- 2. My household has moved.**

Date of Move:	Phone Number:	
New Mailing Address:	New Residential Address:	
City:	State:	Zip Code:

- 3. The composition of my household has changed.**

Enter information about each person who has moved in (including newborns) or out of your home.

Name	Birthdate	Social Security Number (Optional)	Moved In/Out	Date of Move	Care Needed
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No

Note: Social security numbers are not required for Child Care Assistance eligibility and eligibility cannot be denied for failure to provide social security numbers. If provided, social security numbers may be used to verify income and need for assistance or for data collection or statistical purposes.

4. My household shares the same mailing or residential address as my child care provider.

Date of Change :
New Mailing Address:
New Residential Address:
Phone Number:

5. The number of hours or days that my child(ren) attend child care has changed.

Child(ren) with a change in attendance at child care are:				
Name of Child (Last, First)	Birthdate	Total Hours Needed Each Week	Days Each Week	Date of Change
			<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	
			<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	
			<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	
			<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	

6. My child needs summer care effective: Begin date: _____ End date: _____

7. I have changed child care providers for my child(ren).

8. I choose to remain at my current provider, effective date: _____

Child(ren) placed with a new or current provider:						
Name of Child (Last, First)	Birthdate	Provider Contact Information	Type of Care: (One per child)	Total Hours Needed Each Week	Days Each Week	Date Changed
		Name: _____ Address: _____ Phone #: _____ TIPS Provider #: _____	<input type="radio"/> In Home <input type="radio"/> Provider's Home <input type="radio"/> Class A Center <input type="radio"/> Other		<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	
		Name: _____ Address: _____ Phone #: _____ TIPS Provider #: _____	<input type="radio"/> In Home <input type="radio"/> Provider's Home <input type="radio"/> Class A Center <input type="radio"/> Other		<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	
		Name: _____ Address: _____ Phone #: _____ TIPS Provider #: _____	<input type="radio"/> In Home <input type="radio"/> Provider's Home <input type="radio"/> Class A Center <input type="radio"/> Other		<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	
		Name: _____ Address: _____ Phone #: _____ TIPS Provider #: _____	<input type="radio"/> In Home <input type="radio"/> Provider's Home <input type="radio"/> Class A Center <input type="radio"/> Other		<input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> Th <input type="radio"/> Fri	

9. Add/Remove Household Designee(s)

Name of Household Designee	Birthdate	Residential Address of Household Designee	Add/Remove (Circle below)	HD Relationship to Head of Household
			<input type="radio"/> Add <input type="radio"/> Remove	
			<input type="radio"/> Add <input type="radio"/> Remove	
			<input type="radio"/> Add <input type="radio"/> Remove	
			<input type="radio"/> Add <input type="radio"/> Remove	

10. A member of my household is no longer working or attending an educational or training program.
(Termination letter must be attached)

Person who has stopped working or going to classes:
The last date worked or attended training classes:

11. A member of my household has changed jobs, started a new job, or had a change in earned income.
(Employment validation or new wage form(s) must be attached)

Persons with a change in job or earnings:					
Person Employed	Name and Address of Employer	Number of Hours per week	Gross Monthly Earned	How often Paid	Date Change

12. My total household income has exceeded the chart below for my household size.

2 PERSONS	3 PERSONS	4 PERSONS	5 PERSONS	6 PERSONS	7 PERSONS	8 PERSONS	9 PERSONS
\$2,403	\$2,884	\$3,433	\$3,983	\$4,532	\$4,635	\$4,738	\$4,841

13. A member of my household has begun receiving, is no longer receiving, or had a change in amount of one of these types of unearned income: Child Support, Alimony, Unemployment Benefits, SSI, Social Security, Veteran's Benefits, Retirement Benefits, Disability Benefits, or Adoption Subsidy. (Supporting documentation must be attached)

Person who receives (or received income)	Type of Income	No longer receiving	Begun/Continues Receiving	Amount Received	Effective Date of Receiving

14. Other (Explain): _____

I understand that adjustments may be made in my Child Care Assistance payments because of the above change(s) in my situation. I understand that I will be notified in writing by LDOE if the change(s) affect my eligibility or the payment amount made by the Child Care Assistance Program.

Signature:	Date:
Address:	Home Phone Number/Work Phone Number: