INFORMATION COLLECTION SHEET
FOR CHILD CARE ASSISTANCE

List below the names of ALL children for whom you are requesting child care assistance, their ages, days and times in care, and total hours per week that they are in care.

Child's name	**Age**	Day(s) in care	**Times** (inc. drive time)	**Total hours per day** (inc. drive time)	**Total hours per week** (inc. drive time)

For all employed household members applying:

Name of your employer:_____

Your weekly work schedule: (please complete with your actual schedule or a sample week)

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Start Time							
End Time							

What is your scheduled work week (i.e. Wed-Tues):_____
Do you anticipate any change or fluctuation in your work schedule? _____ **Yes** _____ **No**
If yes, please explain in detail:_____
_____

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Weekly work schedule for:_____

Name of Employer:_____
(please complete with your actual schedule or a sample week)

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Start Time							
End Time							

What is your scheduled work week (i.e. Wed-Tues):_____
Do you anticipate any change or fluctuation in your work schedule? _____ Yes _____ No
If yes, please explain in detail:_____
_____

Child Care Provider(s) Information:

Provider No 1:

Name: _____ Phone: _____
Address: _____
_____
Is this provider registered with the New York State Office of Children and Family Services?
Yes _____ No _____
If no, then your provider must complete an enrollment form once a year.

Provider No 2:

Name: _____ Phone: _____
Address: _____
_____
Is this provider registered with the New York State Office of Children and Family Services?
Yes _____ No _____
If no, then your provider must complete an enrollment form once a year.

I certify that the statements made above are accurate and true to the best of my knowledge. I acknowledge that any changes in work schedule and/or hours, household composition or income information shall be provided to the Department of Social Services within 10 business days of said change. I understand that providing false information may result in the suspension or termination of payment by the Department of Social Services.

_____ _____
Parent/Guardian Signature Date

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