

PLEASE PRINT IN ALL CAPITAL LETTERS

APPLICATION FOR CHILD CARE SUBSIDY

NEW
 RECERTIFICATION
 TRANSITIONAL CHILD CARE

NYC ACS
NYC Administration for
Children's Services

OFFICE USE ONLY

Case #:

Application Date: / /

Section 1 APPLICANT

LAST Name (Please include any aliases or maiden names in parentheses): _____ FIRST Name: _____ M.I.: _____

ADDRESS Residence: _____ APT. #: _____ CITY/BOROUGH: _____ STATE: _____ ZIP CODE: _____

ADDRESS Mailing (if different than above): _____ APT. #: _____ CITY/BOROUGH: _____ STATE: _____ ZIP CODE: _____

TELEPHONE (Work): _____ TELEPHONE (Home): _____ TELEPHONE (Cell or Other): _____

Do you receive PA? YES NO Do you receive Medicaid? YES NO What is your primary language? _____

PA #: _____ MA #: _____

Section 2 FAMILY MEMBERS

Please fill out the information below for your entire household. List yourself first, followed by everyone who lives with you.

1.	2.	3.	4.	5.	6.					
LAST Name (PLEASE INCLUDE ANY ALIASES OR MAIDEN NAMES IN PARENTHESES)	FIRST Name	M.I.	RELATIONSHIP	DOES THIS PERSON NEED CHILD CARE? YES/NO	BOTH OF CHILD'S PARENTS RESIDE IN THE HOME? YES/NO	DATE OF BIRTH MM/DD/YY	SEX M/F	HISPANIC OR LATINO YES/NO	RACE (SEE LEGEND BELOW)	SOCIAL SECURITY NUMBER (OPTIONAL)
			SELF							

RACE: 1. Native American or Alaskan Native 2. Asian 3. African American/Black 4. Native Hawaiian/Pacific Islander 5. Caucasian/White

For additional family members, please attach a separate sheet.

Include information for any spouse/other parent of the children applying for care who lives in the home.

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Family Size: _____

Section 3 EMPLOYMENT

APPLICANT'S EMPLOYER Name: _____ Hours per week: _____ Tel #: _____

ADDRESS: _____ CITY/BOROUGH: _____ STATE: _____ ZIP CODE: _____

APPLICANT'S Scheduled Days and Hours of Employment (i.e.: Mon - Fri, 9 a.m. - 5 p.m.): _____ Does Job have a Rotation Shift? YES NO

SPOUSE/OTHER PARENT EMPLOYER Name: _____ Does Job Require O/T? YES NO

ADDRESS: _____ Hours per week: _____ Tel #: _____

CITY/BOROUGH: _____ STATE: _____ ZIP CODE: _____

SPOUSE/OTHER PARENT Scheduled Days and Hours of Employment (i.e.: Mon - Fri, 9 a.m. - 5 p.m.): _____ Does Job have a Rotation Shift? YES NO

Does Job Require O/T? YES NO

Section 4 CHILD/FAMILY NEEDS

Are you requesting child care primarily so that you can work? YES NO

If not, please read the instruction section titled "Child/Family Needs" and write your reason for care here: _____

Is the child for whom you are requesting care living with someone other than his/her mother or father? YES NO

Does your child have any conditions that require special help or attention? YES NO

Does your child have health insurance? YES NO