County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

Child Care Assistance and Referral (CCAR) of the Office for Children assists low to moderate income families with the costs of child care. To be eligible for CCAR, you must be a Fairfax County resident and be:

Working or enrolled in an approved job training program and meet the annual household income guidelines. If you are eligible under this category, you will pay a sliding fee for your child care.

Please complete the enclosed application and return it with proof of address and information about your work and/or training. The checklist below will help you to complete the application correctly and send in the documents that CCAR needs to determine your eligibility for this program.

Working or enrolled in VIEW/Fairfax Works! or a job training program and receiving public assistance through Temporary Assistance for Needy Families (TANF). Call us for more information before completing the application.

Participating in certain programs with the Department of Family Services (DFS) and referred to CCAR for child care. If you are a foster parent or have a Social Worker at DFS, call him/her to ask about eligibility for child care. If you are eligible, your Social Worker will let us know and we can assist you immediately.

While you are waiting to hear from us, you may wish to begin looking for care. A good way to start your search is to look at the Office for Children's website, www.fairfaxcounty.gov/childcare. At this web site you will find information about the Office for Children's programs, services and forms. You will also find lists of child care providers and centers in Fairfax County organized by zip code areas.

Please remember that if you begin child care before CCAR approval of your application and arrangement with your provider, you will be completely responsible for payment for care.

If we can further assist you in making your choice, please call CCAR at 703-449-8484.

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DOCUMENTS NEEDED WITH YOUR CCAR APPLICATION

To process your application, the staff of Child Care Assistance and Referral (CCAR) needs to know where your family lives and information about your family's work and/or school schedules.

To Show Where You Live

Send a copy of one of the items below. It must include your name and address.

Dated with the current month

√ Cable or satellite bill
√ Electric, gas, water or trash bill
√ Telephone bill from an installed (not cell) phone
√ Mortgage statement

or

√ Current Lease
√ Letter from property manager (on company letterhead)

To Show That You Work and/or Go To School

Your name (and, if applicable, your spouse/ partner's name) must be on these documents.

*If you **work**, send your
√ Most recent pay stub (within 30-60 days)

*If you go to **school** or are in a **training** program send your
√ Current schedule from your school or training program

*If you **work and go to school**, you need to **send both** a √ pay stub and a √ current schedule

FAIRFAX COUNTY OFFICE FOR CHILDREN
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NEW _____
RENEWAL _____

CHILD CARE ASSISTANCE SERVICE APPLICATION

Names, Addresses, and income information of both parents and/or contributing household members must be reported.
Please complete all blanks, including information for absent parent, and attach required documents.

(PLEASE PRINT)

PARENT and/or GUARDIAN and/or CONTRIBUTING HOUSEHOLD MEMBER

Residing with child: _____ (Yes or No) **(Mother)** **Name:** ***(Last)*** ***(First)***	*Residing with child: _____ (Yes or No)* **(Father)** **Name:** ***(Last)*** ***(First)***
Social Security Number: *(optional)*	**Social Security Number:** *(optional)*
Address: *Street :*_____ *City:* *Zip code:*	**Address:** *Street :*_____ *City:* *Zip code:*
Home Phone Number: ( )	**Home Phone Number: ( )**
Date of Birth: **Age:**	**Date of Birth:** **Age:**
Marital Status: (*Check "√" one)* __ Married __Single __Divorced __Widowed __ Separated __Single, Living with Partner	**Marital Status:** (*Check "√" one)* __ Married __Single __Divorced __Widowed __ Separated __Single, Living with Partner
Race: (*Check "√" one)* __White __ American Indian/Alaskan Native __Asian __ Black / African American __Native Hawaiian/Other Pacific Island	**Race:** (*Check "√" one)* __White __ American Indian/Alaskan Native __Asian __ Black / African American __Native Hawaiian/Other Pacific Island
Ethnicity: (*Check "√" one)* __Hispanic __Non-Hispanic **Language Preference:**	**Ethnicity:** (*Check "√" one)* __Hispanic __Non-Hispanic **Language Preference:**
Guardian ***(Complete if applicable)*** **Name & Relationship:**	**Contributing Household Member** ***(Complete if applicable:)*** **Name & Relationship:**
Social Security Number: *(optional)*	**Social Security Number:** *(optional)*
Address: *Street :*_____ *City:* *Zip code:*	**Address:** *Street :*_____ *City:* *Zip code:*
Home Phone Number: ( )	**Home Phone Number: ( )**
Date of Birth: **Age:**	**Date of Birth:** **Age:**
Marital Status: (*Check "√" one)* __ Married __Single __ Divorced __Widowed __ Separated __ Single, Living with Partner	**Marital Status:** (*Check "√" one)* __ Married __Single __Divorced __Widowed __ Separated __Single, Living with Partner
Race: (*Check "√" one)* __White __ American Indian/Alaskan Native __Asian __ Black / African American __Native Hawaiian/Other Pacific Island	**Race:** (*Check "√" one)* __White __ American Indian/Alaskan Native __Asian __ Black / African American __Native Hawaiian/Other Pacific Island

CHILDREN IN FAMILY

CHILD'S NAME *(Last Name, First Name)*	DOB M/D/Y	AGE	SSN# *(Optional)*	SEX (M/F)	RACE	Hispanic (Yes / No)	Need Child Care? (Yes / No)	Child in SACC? (Yes / No)	Child in Head Start? (Yes / No)

OTHER HOUSEHOLD MEMBERS

FULL NAME	DOB	RELATIONSHIP		FULL NAME	DOB	RELATIONSHIP

NAME _____ SSN #_____(*optional*) **(Page 2)**

FAIRFAX COUNTY OFFICE FOR CHILDREN COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES

(PLEASE PRINT) CHILD CARE ASSISTANCE SERVICE APPLICATION

EMPLOYMENT INFORMATION

Employer's Name or Business Name: (*Mother's Employment/Contributing Household Member)*	**Employer's Name or Business Name:** (*Father's Employment/Contributing Household Member)*
Work Address: *Street :*_____ *City:* *Zip code:*	**Work Address:** *Street :*_____ *City:* *Zip code:*
Work Phone #: ( ) **Ext:**	**Work Phone #: ( )** **Ext:**
Hours Scheduled to Work: MON TUES WED THURS FRI SAT SUN	**Hours Scheduled to Work:** MON TUES WED THURS FRI SAT SUN
Additional Employer's Name or Business Name: (*Mother's Employment/Contributing Household Member)*	**Additional Employer's Name or Business Name:** (*Father's Employment/Contributing Household Member)*
Work Address: *Street :*_____ *City:* *Zip code:*	**Work Address:** *Street :*_____ *City:* *Zip code:*
Work Phone #: ( ) **Ext:**	**Work Phone #: ( )** **Ext:**
Hours Scheduled to Work: MON TUES WED THURS FRI SAT SUN	**Hours Scheduled to Work:** MON TUES WED THURS FRI SAT SUN

SCHOOL/TRAINING INFORMATION

School or Training Facility's Name: *(Mother's Training)*	**School or Training Facility's Name**: *(Father's Training)*
Schedule Hours: MON TUES WED THURS FRI SAT SUN	**Schedule Hours:** MON TUES WED THURS FRI SAT SUN

HOUSEHOLD INCOME INFORMATION

TYPE OF INCOME	GROSS AMT PER PAY PERIOD	HOW OFTEN: (*Check "√" one)*
Mother's/Guardian's Income		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
Father's/Guardian's Income		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
Income from Other Household Members		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
Alimony/Child Support**		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
TANF/VIEW Assistance		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
Veteran's Benefits		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
SSA/SSI Benefits		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**
Unemployment Benefits		☐ **weekly** ☐ **bi-weekly** ☐ **twice monthly** ☐ **monthly**

*****If child support is due to you and not being paid, you should register and cooperate with the Division of Child Support Enforcement (1-877-822-4612) and must report support payments received.***

I have read and agree to the following:

I have read the inserted sheet, understand my rights and responsibilities, and have attached / will provide the required documents. I certify that this is a true and accurate statement of the financial status and composition of my household.

I authorize Child Care Assistance & Referral to obtain any verification necessary to both determine and review financial eligibility and child care needs. This authorization includes the release of information regarding my employment, salary, work schedule, and/or training/school schedule. This authorization is valid for one year from date of signature below.

SIGNATURE_____**DATE**_____

APPEAL INSTRUCTIONS FOR STATE FUNDED ASSISTANCE

If you are not satisfied with the information you receive and the action being taken, you may appeal the decision within 30 days of the date of this letter. We suggest you begin the appeal process by calling your Eligibility Specialist or Child Care Specialist at the Office for Children at 449-8484 and asking for a conference. You may appeal to the Child Care Assistance and Referral, Office for Children, 12011 Government Center Parkway, 8th Floor, Fairfax, VA 22035 or write directly to:

Manager, Appeals & Fair Hearings
Virginia Department of Social Services
Division of Management & Customer Service
7 North Eighth Street
Richmond, VA 23219

You also may appeal a decision if you are already receiving services. This, too, must be done within 30 days of the date of this letter and may be made to the Child Care Assistance and Referral , Office for Children, Department of Family Services, 12011 Government Center Parkway, 8th Floor, Fairfax, VA 22035 or to the Service Hearing Authority.

If you ask for a conference in the agency or for a hearing within ten days of your notice of action, your service or service payment will continue until a decision is made.

If you feel you were discriminated against at any time, you may file a complaint with the Department of Family Services, the Commissioner of the Department of Social Services, or the Region III Office of Civil Rights. This must be done within 180 days of the alleged discriminatory act. A pamphlet called "Virginia Non-Discrimination Program," which gives addresses and procedures for filing a complaint, is available to you from either the local or state offices listed above.

MAXIMUM YEARLY INCOME FOR PARTICIPATION IN CCAR

Effective 10/01/2006

Number of Family Members	2	3	4	5	6	7	8
Fairfax County	**$36, 300**	**$45,636**	**$55,008**	**$64,356**	**$73,692**	**$83,064**	**$92,400**
Other Jurisdictions **Fairfax City*** **Falls Church City*** **Fort Belvoir**	**$24,420**	**$30,720**	**$37,008**	**$43,296**	**$49,584**	**$55,872**	**$62,160**

***Additional local funding may be available from these jurisdictions.**

Website: www.fairfaxcounty.gov/childcare

Fairfax County is committed to providing equal access for all its citizens to County programs, services and activities. Special accommodations will be provided on request. Call (703) 449-8484 or TDD (703) 324-3923.

CCAR STAFF USE ONLY

Monthly Gross Income: _____ **Funding:** **State** _____ **Local** _____

Family Size: _____ **VIEW/ TANF:** _____ ***(yes / no)***

Number Children in Care: _____ **Total Family Fee:** _____ ***(weekly)*** _____ ***(monthly, if applicable)***

☐ **SACC Fee:** _____ *(monthly)*

Reviewed by _____**Date**_____ **TEAM #**_____

Date Service Record Requested_____ *(if applicable)*