Appendix 1: Eligibility Check Lists

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix 1

Eligibility Check List

Food Stamps NON-TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral (IMA)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child(Shot records are not acceptable			
Record of Case Action			
Income Calculation Sheet			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Payment Change and Termination Authorization (598)			
Work Schedule (Nontraditional Only) (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

TANF Countable Activity
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral (IMA)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Training NON-TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate /(Shot records are not acceptable)			
Adoption Papers, Legal Custody Order			
Birth Certificate / Child(ren) (Full Size Only)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Income Calculation Sheet			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Proof of Residence / Notarized Letter with 2pc mail / Official			
Rent Receipt / Phone / Utility Bill			
Proof of Residence / Other			
Proof of Activity / Letter from program or School / Receipt of			
Payment Change and Termination Authorization (598			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List - Training

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ Date: _____

Intake: _____ Date: _____

Follow up: _____ Date: _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Job Search TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral (IMA)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
Follow Up Form (YES or NO)			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Job Search NON-TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral (Approved Job Search Program)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Foster Care
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Childcare Referral / CFSA			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Record of Case Action			
Proof of Employment			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Protective Services TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Childcare Referral / CFSA			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Record of Case Action			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Protective Services NON-TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Childcare Referral / CFSA			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Record of Case Action			
Follow Up Form (YES or NO)			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Court TANF

Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Childcare Referral / Court			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Record of Case Action			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Court NON-TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Childcare Referral / Court			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Record of Case Action			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker 's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Child with a Disability TANF Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
Proof of Disability / Letter from Physician / IEP / IFSP / Developmental Evaluation			
ACEDS Printout or Letter from IMA Worker			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Child with a Disability NON-TANF Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Adoption Papers, Legal Custody Order			
Birth Certificate / Child(ren) (Full Size Only)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Proof of Disability / Letter from Physician / IEP / IFSP / Developmental Evaluation			
Proof of Residence / Notarized Letter with 2pc mail / Official Rent Receipt / Phone / Utility Bill			
Proof of Residence / Other			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Teen Parent TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral (IMA)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Initial intake Only)			
Picture ID			
Record of Case Action			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Teen Parent NON-TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child			
Birth Certificate / Child(ren) (Shot records are not acceptable)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Proof of Activity / Letter from program or School			
Proof of Residence / School Print-Out			
Proof of Residence / Other			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Undergraduate Program TANF Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral (IMA)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Proof of Activity / Letter from program or School			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Undergraduate Program NON-TANF Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Proof of Activity / Letter from program or School / Receipt of			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Adoption Papers, Legal Custody Order			
Birth Certificate / Child(ren) (Full Size Only)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Income Calculation Sheet			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Proof of Residence / Notarized Letter with 2pc mail / Official Rent Receipt / Phone / Utility Bill			
Proof of Residence / Other			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List – Undergraduate Program

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ Date: _____

Intake: _____ Date: _____

Follow up: _____ Date: _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STSTE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

TANF Payee
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
Proof of Employment / Training			
ACEDS Printout or Letter from IMA Worker			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Working Parent
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Adoption Papers, Legal Custody Order			
Birth Certificate / Child(ren) (Full Size Only)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Income Calculation Sheet			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Proof of Residence / Notarized Letter with 2pc mail / Official Rent Receipt / Phone / Utility Bill			
Proof of Residence / Other			
Payment Change and Termination Authorization (598)			
Work Schedule (Nontraditional Only) (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday			

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List – Working Parent

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Adult with a Disability TANF Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
Proof of Disability / Letter from Physician specifying need for child care (Adult)			
ACEDS Printout or Letter from IMA Worker			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Adult with a Disability NON-TANF

Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Adoption Papers, Legal Custody Order			
Birth Certificate / Child(ren) (Full Size Only)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Proof of Disability / Letter from Physician specifying need for child care (Adult)			
Income Calculation Sheet			
Proof of Income / 3 Most Recent Pay Stubs / Child Support Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Proof of Residence / Notarized Letter with 2pc mail / Official Rent Receipt / Phone / Utility Bill			
Proof of Residence / Other			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List – Adult with a Disability

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Vocational Rehab TANF
Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral / Letter (Vocational Rehab)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Picture ID			
Record of Case Action			
ACEDS Printout or Letter from IMA Worker			
Follow Up Form (YES or NO)			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ **Date:** _____

Intake: _____ **Date:** _____

Follow up: _____ **Date:** _____

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List

Vocational Rehab NON-TANF Intake

Customer Name: _____

SSN: _____ **Date:** _____
(Date of Eligibility Determination)

	Prescreening	Intake	Follow up
Application / Applicant's Signature / Worker's Signature			
Childcare Referral / Letter (Vocational Rehab)			
Admission Form (Signed by Parent)			
Admission Form (Signed by Provider)			
Health Certificate / Child (Shot records are not acceptable)			
Adoption Papers, Legal Custody Order			
Birth Certificate / Child(ren) (Full Size Only)			
Social Security Card / Child(ren) / Self / Spouse			
Picture ID			
Record of Case Action			
Income Calculation Sheet			
Proof of Income / 3 Most Recent Pay Stubs / Child Support /Vet. Benefits/ Social Security			
Proof of Income / Other _____			
Proof of Private Childcare Deduction			
Proof of Dependent College Education			
Proof of Residence / Notarized Letter with 2pc mail / Official Rent Receipt / Phone / Utility Bill			
Proof of Residence / Other			
Payment Change and Termination Authorization (598)			
Work Schedule (If you requested Non-traditional hours which are before 7:00 a.m. or after 6:00 p.m., overnight, Saturday or Sunday)			

GOVERNMENT OF DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 1

Eligibility Check List – Vocational Rehab

Comments:

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Staff/ Eligibility Worker's Signature

Prescreening: _____ Date: _____

Intake: _____ Date: _____

Follow up: _____ Date: _____

Appendix 2: Record of Case Action Form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 2

RECORD OF CASE ACTION

CASE NAME: _____

DATE	ACTION TAKEN	Initials

Appendix 3: Application for Subsidized Child Care Services Form

OSSE
DC Office of the State Superintendent of Education

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
APPLICATION FOR SUBSIDIZED CHILD CARE SERVICES

Appendix – 3

Names, Addresses, and income information of both parents must be reported.
Please complete all blanks, including information of absent parent, and attached required documents ***(PLEASE PRINT)***

PARENT(S) AND/OR GUARDIAN INFORMATION

1. Name of Applicant: _____ DOB: _____ SSN: _____
(Parent, Guardian or Payee) Last First MI

Race (optional) [ ] American Indian or Alaskan Native [ ] Asian [ ] Black or African American [ ] White [ ] Native Hawaiian or Other Pacific Islander

Address: _____ ___ _____
Street Apartment City State Zip Code Ward

Telephone No: _____ _____
Home with Area Code Work/School with Area Code

2. LANGUAGE PREFERENCE: What is the Primary Language you speak?

Please select one
[ ] English [ ] Mandarin Chinese [ ] Cantonese Chinese [ ] Vietnamese [ ] Amharic [ ] French [ ] Spanish [ ] Other_____

3. **MARITAL STATUS:**_____

4. Name of Spouse/Other parent: _____ DOB: _____ SSN: _____
Last First MI

Race (optional) [ ] American Indian or Alaskan Native [ ] Asian [ ] Black or African American [ ] White [ ] Native Hawaiian or Other Pacific Islander

Address: _____ _____
Street Apartment City State Zip Code Ward

Telephone No: _____ _____
Home with Area Code Work/School with Area Code

CHILD INFORMATION (LIST ALL CHILD(REN) IN THE FAMILY

Complete this section for each child in the family. Use the codes below to complete the Citizenship, Race, Ethnicity and Language columns. Enter each code that applies, using at least one code for each child. Enter "Yes" or No' in the Disabled Colum to indicate if the child has a disability.
Citizenship/Immigration Code: 1= United States Citizenship, 2= Permanent Resident, 3= Granted conditional entry, 5=Parolee 1 year or more, 6= Deportation withheld, 7= Refugee, 8= Battered spouse, child, or parent of child(ren)
Ethnicity Codes: 1 =Yes/Hispanic or Latino, 2= No/Hispanic/ Latino
Race Code: 1= American Indian/ Alaskan Native, 2= Asian, 3= Black/ African American, 4= White, 5= Native Hawaiian/Pacific Islander
Language: 1= English, 2= Mandarin Chinese , 3=Cantonese Chinese , 4=Vietnamese, 5= Amharic , 6= French , 7= Spanish , 8=Other_____

Name Last First	DOB	SSN	Sex	Dis-abled	Citizen-ship/ Immi-Gration Status	Eth-nicity	Race	Language	Child 's Father or Mother (If this person different from # 4) Name / DOB/ SSN

Appendix – 3

PARENT(S) AND /OR GUARDIAN ACTIVITY INFORMATION

Your Activity	Spouse/ Other Parent Activity
1. **Name of school or employer**:_____	1. **Name of school or employer**:_____
Address:_____	Address:_____
Days and hours of your activity:_____	Days and hours of your activity:_____
Start and end dates of activity:_____	Start and end dates of activity:_____
2. **Name of school or employer**:_____	2. **Name of school or employer**:_____
Address:_____	Address:_____
Days and hours of your activity:_____	Days and hours of your activity:_____
Start and end dates of activity:_____	Start and end dates of activity:_____

REASON FOR CHILD CARE

☐ **WORKING** ☐ **TRAINING** ☐ **DISABLED ADULT** ☐ **CHILD WITH A DISABILITY** ☐ **OTHER** _____

HOUSEHOLD INCOME INFORMATION:

Type of income	Gross Amount per pay period	How often: (Check "√"one)
Mother's/Guardian's Income		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
Father's/ Guardian's Income		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
Child Support		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
Alimony		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
SSI Benefits		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
Unemployment Benefits		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
Other:_____		☐ weekly ☐ bi-weekly ☐ bi-monthly ☐ monthly
TANF		☐ Yes $_____ ☐ No
Food Stamp		☐ Yes $_____ ☐ No
Social Security		☐ Yes $_____ ☐ No

Attach proof of all income for: applicant, spouse, parents of minor parent, adult and spouse with physical custody of minor child.

CHILD SUPPORT INFORMATION

1) Are you receiving child support for all children in your household who are eligible for child support? ☐ Yes ☐ No
2) Have you applied for child support for all children in your household eligible to receive child support? ☐ Yes ☐ No

2

DISTRIBUTION – Original In Case Folder
- Copy to Applicant

RIGHTS AND RESPONSIBILITIES OF APPLICANT FOR SUBSIDIZED CHILD CARE SERVICES

Appendix - 3

RIGHTS:

I understand that if I am not satisfied with any decision by the Department regarding eligibility, my receipt or termination of services, I may request a Fair Hearing. If I am receiving services and request a Fair Hearing before the effective date of this action, my benefits will continue uninterrupted until a hearing decision is made. If I do not request a Fair Hearing before the effective date of this action, I may request a hearing within 90 days from the date of the notice of the action, but I will not continue to receive benefits while the hearing is pending. I must make my request by phone or in writing to:

The Office of Administrative Hearings,
441 4th Street, N.W., Suite 540-South,
Washington, D.C. 20001
(202) 727-8280

or I can ask my caseworker to help me make the request. After requesting a Fair Hearing the Department will send me a written notice telling me the time and place of the Administrative Review. The Administrative Review is not the same as a Fair Hearing. This means I may meet with Department staff to try to resolve my issue. If I choose not to attend the Review or if my issue is not resolved at the Review this in no way impacts my Fair Hearing with the Office of Administrative Hearings. If the Review resolves my issue, I alone may decide to withdraw my request for a Fair Hearing.

If I request a fair hearing, I understand that (1) I have the right to be represented by legal counsel or by a lay person who is not an employee of the District; (2) I may bring witnesses on my behalf; (3) reasonable expenses related to the hearing, such as transportation costs for me or my witnesses, will be paid by the Mayor; and (4) legal services are available to me.

I have been informed that I may choose one of the following types of child care: child care in a child development center, child care in a family child care home, child care in my home by an adult or relative I identify, or child care in the home of my relative.

I understand that I will be notified in writing within a minimum of 15 days of the effective date of any adverse action by the Agency such as intention to discontinue, withhold, terminate, suspend, reduce assistance or make assistance subject to additional conditions. I understand that I may apply for a Fair Hearing as described above if I disagree with notice of any adverse action.

RESPONSIBILITIES:

I understand that I must fully and accurately report circumstances affecting my eligibility, relating to family relationships, employment or training status, income, place of residence, and telephone numbers, and must provide original documentation to substantiate the information. I must report any changes in these circumstances within 3 business days. I must cooperate with all agency efforts to verify the eligibility information.

I have been informed of the absence policy and that I must provide documentation of excused absences to the child care provider. If my child is absent 6 days or more in one month without an adequate excuse I am aware that he/she will be terminated from the subsidy program. I have also been informed that I must report within 3 days when my child no longer attends a facility. I have been informed that I am required to have an eligibility review completed on _____(date) and every _____ months thereafter, to determine if I am eligible to continue receiving subsidized child care. I understand that a notice will be sent to the address I have provided informing me of the appointment date and time and if I do not appear for the appointment or reschedule the appointment my child care benefits will be terminated. As noted in paragraph one, I have the right to a fair hearing.

I understand that I am responsible for making all co-payments directly to the child care provider for the entire time my child is enrolled even on days the child is absent. Failure to be up to date with co-payment may result in termination of services.

WARNING TO APPLICANTS:

3

Government officials will rely on the information you provide on this application to determine your eligibility for Subsidized Child Care Services. You are therefore informed that it is a criminal offense under District of Columbia law for you to knowingly make false or misleading statements on this application. Persons convicted of making false or misleading statements shall be fined up to $1,000 or imprisoned for up to 180 days or both. By signing your name on **Block 10** on the front of this application and below you are certifying that you are aware of the penalties for making false or misleading statements on this application. Accordingly, if you are not sure of the accuracy of the information requested, it is your responsibility to bring the information to the attention of the appropriate government employee prior to signing the application. *See D.C. Code § 22-2514*

INFORMATION ON SOCIAL SECURITY NUMBER:
In accordance with ACYF-PI-CC-00-04. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. Issuance Date: October 27, 2000, the social security number is not required for determining eligibility for subsidized child care. Eligibility will not be denied should an applicant not provide a Social Security Number. Social Security Numbers will be used solely for searching for records in a database and for identifying individuals with the same name. All applicant files are kept confidential.

I have read and agree to the following:

- I have read and 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 authorized the Subsidized Child Care Program 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 and residence
-

APPLICANT SIGNATURE: _____ **DATE:** _____
Print Name

_____
Signature

AGENCY USE ONLY

Annual Gross Income: _____

Family Size: _____ Dependent Children: _____

View ACEDS/ TANF verification: _____ (Yes /No)

Total Parent Copayment: $_____ (daily) $_____ (weekly, if applicable)

Child 1 _____ Parent Fee: $_____ Other Fee: $_____

Child 2 _____ Parent Fee: $_____ Other Fee: $_____

INITIAL ELIGIBILITY DETERMINATION ☐ **ELIGIBLE**
☐ **INELIGIBLE**_____
Specify reason if ineligible

I hereby certify that the rights and responsibility have been discussed with the applicant and she/he has signed to verify her/his understanding:

ELIGIBILITY WORKER:_____ **DATE:**_____
Print Name

CCSD _____
Level II _____

_____
Signature

4

Appendix 4: Child Care Admission Form (Traditional & Non-Traditional)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

APPENDIX - 4

TRADITIONAL CHILD CARE ADMISSION FORM

TO BE COMPLETED BY THE ELIGIBILITY WORKER

This is to authorize TRADITIONAL child care admission for:

Child's Name: _____ **SSN:** _____

Parent/Guardian Full Name: _____ **SSN:** _____

Beginning Date: _____ **Child Care Provider:** _____

OSSE Payment: ____/__ **Parent Co-Payment:** ____/____ **OSSE Daily Payment Rate:** _____/_____

CHILD PLACEMENT:

Category: ☐ **DCC** ☐ **FDC** ☐ **RHC** ☐ **IHC**

Age Group: ☐ Infant ☐ Preschool ☐Toddler ☐ School Age

Description: ☐ FT ☐ PT ☐ B/A

Provider Type: ☐ Level I ☐ Level II

Eligibility Worker: _____ **Contact No.** _____

Eligibility Worker's Signature: _____ **Date:** _____

***** **NO PAYMENT WILL BE MADE UNLESS THIS PROCEDURE IS FOLLOWED** *****

The Child Care Admission form must be signed and returned to the Child Care Services Division (CCSD) the day the child begins child care.

The Child Care Admission Form becomes INVALID if the child is not enrolled in the facility named above within thirty (30) calendar days of the date authorized to begin child care.

No changes should be made to the above section completed by CCSD Eligibility Worker by the parent, provider or anyone else; otherwise this authorization for child care will become INVALID.

Customer Signature: _____ **Date:** _____

TO BE COMPLETED BY CHILD CARE PROVIDER

Date Child Admitted: _____

NAME OF PERSON AUTHORIZED TO SIGN:

Name: _____ Phone Number: _____
Print

Signature: _____ Date: _____

PLEASE E-MAIL OR BRING THE COMPLETED FORM (SIGNED AND DATED) VIA TRANSMITTAL OR HAND CARRY SLIP TO:

Income Maintenance Administration
Child Care Services Division (CCSD)
4001 South Capitol Street, SW-First Floor
Washington, D.C. 20032
Phone: (202) 727-0284 Fax: (202) 727-9709

Original to Provider
Copy in case file

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

APPENDIX - 4

NON- TRADITIONAL CHILD CARE ADMISSION FORM

TO BE COMPLETED BY THE ELIGIBILITY WORKER

This is to authorize NON-TRADITIONAL child care admission for:

Child's Name: _____ **SSN:** _____

Parent/Guardian : _____ **SSN:** _____
Full Name

Beginning Date: _____ **Child Care Provider:** _____

Child Placement: **Category:** ☐ DCC ☐ FDC ☐ RHC ☐ IHC

OSSE Payment: _____/_____ **Parent Co-Payment:** _____/_____ **OSSE Daily Payment Rate:** _____/_____

Type of Service: _____ **Full Time [ ] Part Time [ ]**
[ ] Infant [ ] Toddler [ ] Pre-school [ ] School Age

Type of Service: _____ **Full Time [ ] Part Time [ ]**
[ ] Infant [ ] Toddler [ ] Pre-school [ ] School Age

COMMENTS: _____

_____

Eligibility Worker: _____ **Contact No.** _____

Eligibility Worker's Signature: _____ **Date:** _____

***** NO PAYMENT WILL BE MADE UNLESS THIS PROCEDURE IS FOLLOWED *****

The Child Care Admission form must be signed and returned to the Child Care Services Division (CCSD) the day the child begins child care

The Child Care Admission Form becomes INVALID if the child is not enrolled in the facility named above within thirty (30) calendar days of the date authorized to begin child care.

No changes should be made to the above section completed by CCSD Eligibility Worker by the parent, provider or anyone else; otherwise this authorization for child care will become INVALID.

Customer Signature: _____ **Date:** _____

TO BE COMPLETED BY CHILD CARE PROVIDER

Date Child Admitted: _____

NAME OF PERSON AUTHORIZED TO SIGN:

Name: _____ Phone Number: _____
Print

Signature: _____ Date: _____

PLEASE E-MAIL OR BRING THE COMPLETED FORM (SIGNED AND DATED) VIA TRANSMITTAL OR HAND CARRY SLIP TO:

Income Maintenance Administration
Child Care Services Division (CCSD)
4001 South Capitol Street, SW-First Floor
Washington, D.C. 20032
Phone: (202) 727-0284 Fax: (202) 727-9709

Original to provider
Copy in case file

Appendix 5: Health Certificate and Instructions for completion

Appendix - 5

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information — **Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐M ☐F	*Race/Ethnicity:* ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____
Parent or Guardian Name:	*Telephone:* ☐Home ☐Cell ☐Work	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐Home ☐Cell ☐Work	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None ☐Other_____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations — **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐LBS ☐KG	HT ☐IN ☐CM	BP: [>3 yrs] ☐NML ☐ABNL	Body Mass Index [>2 yrs] (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening Right 20/____ Left 20/____ ☐Glasses ☐Referred		Hearing Screening Pass_____ Fail_____ ☐Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Appendix - 5

Student's Name: _____/_____/_____ Date of Birth: ____/____/____
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility: _____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by: _____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason: _____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form *replaces* all forms dated before February 24, 2009. This District of Columbia Universal Health Certificate (DCUHC) will be used for entry into Child Care Facilities, Head Start and DC public, private and parochial schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DCUHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) guidelines for child and adolescent preventive health care; from birth to 21 years of age. **This form is a confidential document,** consistent with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) for health providers, and *the Family Educational Rights and Privacy Act of 1974* (FERPA) for educational institutions.

General Instructions: Please use a black ball point pen when completing this form.

Part 1: Child's Personal Information:
Parent or Guardian: Please complete all of your child's personal information including the child's last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which the address is located, and the name and phone number of an emergency contact in case you cannot be reached. Provide the name of the school or child care facility. Check the box that describes your child's type of health insurance coverage. If the child's type of insurance coverage is not listed, check "other" and write the type of coverage in the space provided. Write the name of your child's primary care provider (doctor). If your child does not have a primary care provider, write "none" in the space provided. **This form will not be complete without the parent or guardian's signature in Part 5.**

Part 2: Child's Health History, Examination & Recommendations: (To be completed by the health care provider). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines. The date entered here must indicate the date of the examination.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG); **HT:** Child's height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
- **Body Mass Index (BMI):** If the child is 2 years of age or older, the BMI has to be calculated and recorded inclusive of percentile.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is ***required*** **for Head Start children**. Also, anemia screening is recommended for menstruating adolescents based on AAP guidelines. Please record blood level and indicate which test was performed by circling HGB, HCT or both.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO/NONE "HEALTH CONCERNS", then check the **'NO" or None"** box in each health screening area.
- **SPECIAL NOTE:** "Annual Dentist Visit" – for children three years of age and older, the health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If "No", the child should be referred to a dentist.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child's ability to perform in a school-related activity or program or mark "NONE".
- **B:** Please note any significant allergies that may require ***emergency medical care*** at a school-related activity or program or mark "NONE".
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark
- "NONE".
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Physician's Medication Authorization Order and attached it to the health certificate.

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

• **TUBERCULOSIS (TB) RISK ASSESSMENT:** Perform risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2006 AAP RED BOOK, 27th Ed., page 682.* Current DC regulations require one TST (Tuberculin Skin Test) for all children entering child care or school; whichever comes first. TST is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note the test and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and whether the child was treated. **All positive TSTs must be reported to the DC T.B. Control Program on 202-698-4040.**
• **LEAD EXPOSURE RISKS:** DC law requires that all children are tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6. Please document both the "Date" and "Result" of most recent lead test. Please indicate if "Pending." "Pending" results will be **valid for two months from date of testing** and will not exclude a child from school-related activity or program. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead Poisoning Prevention Program. For detailed instructions, call 202-654-6036/6037. Providers may fax results to: 202-481-3770.**

Part 4: Required Provider (physician or nurse practitioner) Certification and Signature:
The provider will respond by marking "Yes" or "No" to the following statements:
The child was appropriately examined with a review of the health history;
The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation 2nd Ed. (1997; and The child has received age-appropriate screenings (in accordance with AAP and EPSDT guidelines) within the current year. If "No" is marked, explain the reason in the space provided. All information will be kept confidential.

Part 5: Required Parent/Guardian Signatures. (Release of Health Information).
The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the health provider to share the health information on this form with the child's school, child care facility, camp or appropriate DC Government agency.

Forms are available online at www.doh.dc.gov

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 6: IMMUNIZATION INFORMATION

General Instructions: Please use black ball point pen when completing form

Child/Student Personal Information: Print clearly child/students last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

Section 1: Immunization Information – Enter clearly date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature and date. As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised May 2, 2008), the following immunizations are required.

Instructions: Find the age of the child/student in the column labeled "Child's Current Age". Read across the row for each required vaccine. The number in the box is the number of doses required for that vaccine based on the CURRENT age or grade level of the child. The age range in the column does not mean that the child has until the highest age in that range to meet compliance. Any child whose age falls within that range must have received the required number of doses based on his/her CURRENT age in order to be in compliance.

Vaccine types and dosage numbers required for children enrolled in Child Care Programs[1, 2]

Child's Current Age	DTaP/DTP/DT	Polio	Hib[7]	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate[12]	Meningococcal	Human Papillomavirus (HPV)
Less than 2 months	0	0	0	0	0	1	0	0	0	0
2 – 3 months	1	1	1	0	0	1	0	1	0	0
4 – 5 months	2	2	2	0	0	2	0	2	0	0
6 – 11 months	3	3	2 / 3	0	0	3	0	3	0	0
12 – 14 months	3	3	3 / 4	1	1	3	1	4	0	0
15 – 23 months	4	3	3 / 4	1	1	3	1	4	0	0
24 – 47 months	4	3	3 / 4	1	1	3	2	4	0	0
48 – 59 months	5[3]	4[6]	3 / 4	2	2	3	2	4	0	0

Vaccine types and dosage numbers required for children enrolled in Public, Charter, Parochial and Private Schools[1, 2]

Grade Level		DTaP/DTP/DT/ Td/Tdap	Polio[6]	Hib	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate	Meningococcal[13]	Human Papillomavirus[14] (HPV)
Grade	(Ungraded)										
Grades K – 5	(5 – 10 yrs)	5[3, 4]	4	0	2	2	3	2	0	0	0
Grades 6 - 12	(11 – 18+ yrs)	6[4, 5]	4	0	2	2	3	2	0	1	3

[1]Spacing: Doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day, must be separated by a minimum of 28 days.

[2]Exemptions: Medical exemptions from immunizations may be granted for valid reasons with proper documentation from health care provider (Section 2). Blood titers may be obtained in lieu of immunizations (Section 3). A copy of the lab report must be submitted to school/child care facility. Documentation for religious exemptions must be submitted by parent/guardian to the school/child care facility.

[3]DTP/DTaP: Five (5) doses of DTP/DTaP are required at 4 years of age for school entry unless 4th dose was given on or after the 4th birthday. Interval between dose 4 and dose 5 of DTP/DTaP must be 6 months.

[4]Td/Tdap: Three (3) doses of Td required if primary series started after 7th birthday. If ≥11 years old, one of three doses must be tetanus, diphtheria, and pertussis (Tdap) vaccine dose. Tdap booster required five years after last dose of tetanus, diphtheria-containing vaccine. Td booster required every 10 years.

[5]Tdap: Student must meet the minimum prior requirement for the 4th or 5th doses of DTP/DTaP vaccine and have one (1) dose of Tdap.

[6]Polio: Four doses are required at age 4 for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are required to complete the primary series. Polio is not routinely given for students ≥ 18 years of age.

[7]HIB: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age, however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.

[8]MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and Varicella must be given on the same day or separated by 28 days.

[9]Varicella: Second dose required at 4 years of age. First dose must be given on or after the first birthday. If first dose given between 12 months and 12 years of age, second dose is given 3 months after first dose; if first dose is given at ≥ 13 years, 2nd dose may be given one month after first dose. The Varicella vaccine is not required for a student who has a history of chickenpox verified by a primary care provider and includes the month and year of disease.

[10]Hepatitis B: If monovalent hepatitis B vaccine is given in conjunction with a combination vaccine, i.e. DTaP-IPV-Hepatitis B, four doses of hepatitis B is acceptable; however, dose 3 or 4 must be given at age 24 weeks or later and at least 8 weeks after the previous dose. If monovalent hepatitis B vaccine is administered, dose 3 must be given at least 16 weeks after dose one and at least 8 weeks after dose 2. For students 11-15 years old, a clearly documented 2-dose adult hepatitis B vaccine (Recombivax) is acceptable.

[11]Hepatitis A: Required for students born on or after January 1, 2005.

[12]Pneumococcal: The number of pneumococcal doses required depends on the student's current age and the age when the first dose was administered. Administer 1 dose to healthy children aged 24 through 59 months who are not completely vaccinated for their age. The vaccine is not required for students 5 years of age and older.

[13]Meningococcal: Required at age 11 years of age and older.

[14]HPV: Required for students entering the sixth grade for the first time. Information concerning human papillomavirus (HPV) and the HPV vaccine must be provided to parent/guardian or student. A parent/guardian may sign a form approved by the Department of Health to "Opt-Out".

Section 2: Medical Exemption – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name or stamp and date this section.

Section 3: Alternative Proof of Immunity – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name or stamp and date this section.

Appendix 6: Child Care Referral form for IMA/DCPS

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

CHILD CARE REFERRAL

REFERRING AGENCY: IMA __ DCPS ___ Other (Specify) _____ _____

IMA TANF VENDOR _____
Name Address

Customer's Name:_____ Date of Birth:_____ SSN:_____

_____ Washington D.C. _____ Home Phone: _____
Address Zip Code

Customer Activity Employed [ ] _____ Training [ ] _____
Name of Work Site Name of training site

Job Search [ ] _____ Start Date: _____

_____ _____
Employer/Training Site Address Telephone No. Employer/Training Site

Days per week in training _____ Work_____ Hours Daily _____ to _____

_____ _____
(Print) Referring Worker's Name Telephone No. Signature of Referring Worker Date

List all Child (ren) in Family:

CHILD'S FULL NAME	SSN	DOB	SEX	NEEDS CHILD CARE?

FOR AGENCY USE ONLY

Date Received: Logged by: _____ Date:_____

ACTION TAKEN
[ ] Child (ren) placed in child care.
[ ] Customer failed to respond to appointments for child care
[ ] Unable to arrange child care
[ ] Child care terminated

_____ _____
Name of Eligibility Worker (Print) Signature of Eligibility Worker Date

File in case record

Appendix 7: Child Care Referral form for CFSA, Court, etc.

Government of the District of Columbia ♦ Office of the State Superintendent of Education
Child Care Referral

Date Received _____

PLEASE:
(1) Use the Child Care Code below in the Appropriate column (col. 4) to indicate the type(s) of Child Care needed for children Referred for service.

A. Full Day
B. After School
C. Before School
D. Before and After School
E. Non-Traditional
F. Child Care not required

(2) Use the following code To indicate sex of children In column 3.
F M

List all Children in Family and Use Appropriate Child Care Code for Services Requested

1 Child's Full Name	2 DOB	3 Sex	4 Child Care Code
_____	____	____	_____
Social Security #_____			
_____	____	____	_____
Social Security #_____			
_____	____	____	_____
Social Security #_____			

5. Case Number: _____

6. Family Income: [ ] TANF [ ] Other $_____ per month

7. Referral Source (Circle Appropriate Letter)

a. Prot Serv Div b. Foster Care c. Court
d. RSA e. DDA f. FSA

8. Reason for Referral:

[ ] Training or School (name facility: _____
Hours (daily) _____ to _____

[ ] Employment – Hours per week: _____
Hours (daily) _____ to _____

9. Head of Household:

Name_____

_____ DOB:_____
Social Security Number

Address:_____
(Number & Street)

_____
(City, state & zip code) (Home Phone)

Employment: Address _____

_____
(Name & Address of Employer)

_____
City , State & Zip Code Work Phone

10. Spouse's Name (If Applicable)

_____
(Name)
Home
DOB:_____ Phone:_____

Address:_____
(Number & Street)

_____
(City & State) (Zip Code)

Employment: Work Phone #_____

_____
(Name & Address of Employer)

_____
(City & State) (Zip code)

11. Mother's name (If different from 9 or 10)

Name:_____

Home
DOB:_____ Phone:_____

Address:_____
(Number & Street)

_____
(City & State) (Zip Code)

Employment: Work Phone:_____

_____
(Name & Address of Employer)

_____
(City & State) (Zip Code)

Referring Worker's Name_____ Signature & Date_____ Telephone Number:_____

Supervisor's Signature _____ Worker's e-mail address _____

see other side

Office of Early Childhood Education

Appendix - 7

Please attach the following information with the Child Care Referral:

1. Current DOH health certificate for each child. Immunization book is not acceptable.
2. Current pay statement for Foster Parent.
3. Provision of signed and dated written document(s) providing status of eligibility.
4. Additional information may be needed based on the eligibility category
5. Please send the Child Care Referral to 51 N Street, NE, Suite 410 Washington, DC 20002

   Telephone # 202-727-0284 Fax 202-727-9709

NOTE:
Please note that payment will only be authorized for child care providers in the District of Columbia that has been approved by the Office of the State Superintendent of Education, Office of Early Childhood Education to receive subsidized child care payments.

The DHS/ Child Care Services Division should be notified of any changes regarding the referred case, for example if transferred to another social worker or closed. Our ability to contact the correct worker is essential for our participation in the child's supervision as well as maintenance of our eligibility records.

Appendix - 7

Appendix 8: Appendix 8: Calculation of Parents' Income

OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 8

CALCULATION OF PARENT'S INCOME

WEEKLY PAY

NAME OF CUSTOMER _____ **SS#** _____

All pay statements used for verification of employment must be the **ORIGINAL** document and must be current within the past 30 days. If several documents are presented, at least one must be dated no more than thirty (30) days prior to the date of the eligibility determination.

The three most recent consecutive pay statements should be submitted. In cases where the customer has a variable work schedule, an average salary is computed from the several statements. However, if the customer has a regular schedule of hours, such as 40 hours per week, the salary computation should be based on the regular earnings for that tour of duty, even though every pay statement may not reflect a full schedule.

All income is converted to a yearly figure.

	Gross Amount	Pay Date
1.	$_____	_____
2.	_____	_____
3.	_____	_____

Total $ _____ divided by 3 $_____ x 52 = A. $_____

OTHER COUNTABLE INCOME _____ B) $_____
Source

TOTAL ANNUAL GROSS INCOME (add A + B) **C) $**_____

Minus **DEDUCTION(S)** (If none enter – 0)
(Check source) D) $_____

- ☐ Private Child Care $ _____
- ☐ Child Support $ _____
- ☐ Child w/ Disability $ _____

Adjusted Annual Gross Income (subtract D from C) **E) $**_____

FAMILY SIZE _____

Find parent co-payment on the fee scale. Fees should be assigned in order from the oldest receiving subsidized child care to the youngest.

Child 1 _____	Parent fee _____	Other Fee_____
Child 2 _____	Parent fee _____	Other Fee_____

_____ _____
Eligibility Worker Signature Date

.....

OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix – 8

CALCULATION OF PARENT'S INCOME

BI-WEEKLY PAY

NAME OF CUSTOMER _____ **SS#** _____

All pay statements used for verification of employment must be the **ORIGINAL** document and must be current within the past 30 days. If several documents are presented, at least one must be dated no more than thirty (30) days prior to the date of the eligibility determination.

The three most recent consecutive pay statements should be submitted. In cases where the customer has a variable work schedule, an average salary is computed from the several statements. However, if the customer has a regular schedule of hours, such as 40 hours per week, the salary computation should be based on the regular earnings for that tour of duty, even though every pay statement may not reflect a full schedule.

All income is converted to a yearly figure.

	Gross Amount	Pay Date
1.	$_____	_____
2.	_____	_____
3.	_____	_____

Total $ _____ divided by 3 $_____ x 26 = A. $_____

OTHER COUNTABLE INCOME _____ B) $_____
Source

TOTAL ANNUAL GROSS INCOME (add A + B) **C) $**_____

Minus **DEDUCTION(S)** (If none enter 0) D) $_____
(Check Source)

☐ Private Child Care $ _____
☐ Child Support $ _____
☐ Child w/ Disability $ _____

Adjusted Annual Gross Income (subtract D from C) **E) $**_____

FAMILY SIZE _____

Find parent co-payment on the fee Scale. Fees should be assigned in order from the oldest receiving subsidized child care to the youngest.

Child 1 _____	Parent fee _____	Other Fee_____
Child 2 _____	Parent fee _____	Other Fee_____

_____ _____
Eligibility Worker Signature Date

.....

OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 8

CALCULATION OF PARENT'S INCOME

MONTHLY PAY

NAME OF CUSTOMER _____ **SS#** _____

All pay statements used for verification of employment must be the **ORIGINAL** document and must be current within the past 30 days. If several documents are presented, at least one must be dated no more than thirty (30) days prior to the date of the eligibility determination.

The three most recent consecutive pay statements should be submitted. In cases where the customer has a variable work schedule, an average salary is computed from the several statements. However, if the customer has a regular schedule of hours, such as 40 hours per week, the salary computation should be based on the regular earnings for that tour of duty, even though every pay statement may not reflect a full schedule.

All income is converted to a yearly figure.

	Gross Amount	Pay Date
1.	$_____	_____
2.	_____	_____
3.	_____	_____

Total $ _____ divided by 3 $ _____ x 12 = A. $_____

OTHER COUNTABLE INCOME _____ B) $_____
Source

TOTAL ANNUAL GROSS INCOME (add A + B) **C) $**_____

Minus **DEDUCTION(S)** (If none enter 0) D) $_____
(Check Source)

☐ Private Child Care $ _____

☐ Child Support $ _____

☐ Child w/ Disability $ _____

Adjusted Annual Gross Income (subtract D from C) **E) $**_____

FAMILY SIZE _____

Find parent co-payment on the fee scale. Fees should be assigned in order from the oldest receiving subsidized child care to the youngest.

Child 1 _____	Parent fee _____	Other Fee _____
Child 2 _____	Parent fee _____	Other Fee _____

_____ _____
Eligibility Worker Signature Date

.....

OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

Appendix - 8

CALCULATION OF PARENT'S INCOME

BI-MONTHLY PAY

NAME OF CUSTOMER _____ **SS#** _____

All pay statements used for verification of employment must be the **ORIGINAL** document and must be current within the past 30 days. If several documents are presented, at least one must be dated no more than thirty (30) days prior to the date of the eligibility determination.

The three most recent consecutive pay statements should be submitted. In cases where the customer has a variable work schedule, an average salary is computed from the several statements. However, if the customer has a regular schedule of hours, such as 40 hours per week, the salary computation should be based on the regular earnings for that tour of duty, even though every pay statement may not reflect a full schedule.

All income is converted to a yearly figure.

	Gross Amount	Pay Date
1.	$_____	_____
2.	_____	_____
3.	_____	_____

Total $ _____ divided by 3 $_____ x 24 = A. $_____

OTHER COUNTABLE INCOME _____ (Source) B) $_____

TOTAL ANNUAL GROSS INCOME (add A + B) **C) $**_____

Minus **DEDUCTION(S)** (If none enter 0) D) $_____
(Check Source)

☐ Private Child Care $ _____

☐ Child Support $ _____

☐ Child w/ Disability $ _____

Adjusted Annual Gross Income (subtract D from C) **E) $** _____

FAMILY SIZE _____

Find parent co-payment on the fee Scale. Fees should be assigned in order from the oldest receiving subsidized child care to the youngest.

Child 1 _____	Parent fee _____	Other Fee_____
Child 2 _____	Parent fee _____	Other Fee_____

_____ _____
Eligibility Worker Signature Date

.....

Appendix 9

THE OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The State Superintendent of Education, pursuant to authority set forth in Mayor's Order 2009-3 January 15, 2009, and Sections 5a and 6 of the Day Care Policy Amendment Act of 1998, effective April 13, 1999 (D.C. Law 12-216; D.C. Official Code §§ 4-404.01 and 4-405); hereby gives notice of the adoption of an emergency rules on September 28, 2009 to be added to Title 29, Chapter 3, Section 380 of the District of Columbia Municipal Regulations (DCMR) entitled "Schedule of Parent Fees for the District of Columbia Government Subsidized Child Care Services in Child Development Facilities, Child Development Homes, and by Relatives and In-Home Caregivers," effective as of October 1, 2009. This schedule is also published on the OSSE website at www.osse.dc.gov. The Superintendent also hereby gives notice of intent to take final rulemaking action to adopt these rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. This emergency rule expires one hundred twenty (120) days after the effective date of this notice or upon adoption of a final regulation, whichever is first.

The purpose of this emergency and proposed regulation is to update the District of Columbia's child care subsidy program sliding fee schedule for parent co-payments. The sliding fee schedule is based on the "2009 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia." There is an immediate need to preserve the public welfare by updating these fees and increasing the rate of payment to eligible recipients

In 2008, child care operating functions of the Early Care Education Administration were transferred from the Department of Human Services to the Office of the State Superintendent of Education (OSSE). In this regard, OSSE now serves as the lead agency for the District of Columbia Child Care and Development Fund providing District of Columbia families with a broad range of child care options. The OSSE is in the process of reviewing all regulations that now fall within its Early Child Education (ECE) program, including regulations for child care development facilities operating standards found in other subsections of chapter 3 of Title 29 of the DCMR.

Title 29 DCMR, Chapter 3, entitled "Child Care Development Facilities" is revised to include a new subsection 380 as follows:

380 SCHEDULE OF PARENT FEES FOR THE DISTRICT OF COLUMBIA GOVERNMENT SUBSIDIZED CHILD CARE SERVICES IN CHILD DEVELOPMENT FACILITIES, CHILD DEVELOPMENT HOMES, AND BY RELATIVES AND IN-HOME CAREGIVERS

380.1 Parents with a residence in the District of Columbia may be eligible to receive part time and full time child care services funded by payments from the District of Columbia. Eligible parents shall provide a co-payment consistent with the provisions of this chapter**.**

380.2 The sliding fee scale for parent co-payments is based upon the Federal Poverty Guidelines (FPG) taking in to consideration the family size and income.

380.3 Parent(s) with an income equal to or less than fifty percent (50%) of the FPG shall not pay any co-payment.

380.4 Parent(s) with an income equal to or below two hundred fifty percent (250%) of the FPG or eight five percent of the state median income, whichever is lower, are eligible for participation in the District of Columbia child care subsidy program.

380.5 Parents already receiving subsidized child day care services with an income at an amount equal to or below three hundred (300%) of the FPG or eighty five percent of the state median income, whichever is lower, may be eligible for continuation of child care co-payments under the following circumstances:

a) Continuing employment during the child care hours;

b) Continuing residency in the District of Columbia;

c) Submission of all the required documentation for redetermination;

d) Maintenance of routine attendance; and

e) Qualifying family size.

380.6 Parents with children with medical disabilities or special health care needs may deduct from their income all medical expenses for that same year, related to a child with disabilities or special health care needs in determining eligibility for subsidized child day care services in this chapter, provided that the medical expenses are:

a) Performed by a licensed health care practitioner; and

b) Substantiated with payment statements; payment receipts, and/or insurance statements identifying the health care service.

380.7 The parent co-payment requirements in this chapter shall apply solely to the first two children in the family.

380.8 The copayment for the second child shall be seventy-five percent (75%) of the amount of the co-payment for the first child.

380.9 Parents are responsible for paying co-payments directly to a child development facility.

380.10 The co-payment fee schedule for purposes of this chapter shall be published annually.

Appendix 9

380.11 The following schedule of co-payments shall apply to services provided by a child development facility, or duly authorized relative or in-home caregiver providing child care services subsidized by the District of Columbia.

SLIDING FEE SCALE 2009						DAILY CO-PAY CHILDREN IN CARE			
	ANNUAL INCOME BY FAMILY SIZE					FULL TIME		PART TIME	
%FPG	1	2	3	4	5	First	Second	First	Second
0-50%	$5,415	$7,285	$9,155	$11,025	$12,895	$0	$0	$0	$0
51-60%	$6,498	$8,742	$10,986	$13,230	$15,474	$0.57	$0.43	$0.29	$0.22
61-70%	$7,581	$10,199	$12,817	$15,435	$18,053	$0.75	$0.57	$0.38	$0.29
71-80%	$8,664	$11,656	$14,648	$17,640	$20,632	$1.01	$0.75	$0.51	$0.38
81-90%	$9,747	$13,113	$16,479	$19,845	$23,211	$1.27	$0.95	$0.64	$0.48
91-100%	$10,830	$14,570	$18,310	$22,050	$25,790	$1.62	$1.22	$0.81	$0.61
101-110%	$11,913	$16,027	$20,141	$24,255	$28,369	$2.02	$1.51	$1.01	$0.76
111-120%	$12,996	$17,484	$21,972	$26,460	$30,948	$2.45	$1.84	$1.23	$0.92
121-130%	$14,079	$18,941	$23,803	$28,665	$33,527	$2.93	$2.20	$1.47	$1.10
131-140%	$15,162	$20,398	$25,634	$30,870	$36,106	$3.46	$2.60	$1.73	$1.30
141-150%	$16,245	$21,855	$27,465	$33,075	$38,685	$4.07	$3.05	$2.04	$1.53
151-160%	$17,328	$23,312	$29,296	$35,280	$41,264	$4.73	$3.55	$2.37	$1.78
161-170%	$18,411	$24,769	$31,127	$37,485	$43,843	$5.43	$4.08	$2.72	$2.04
171-180%	$19,494	$26,226	$32,958	$39,690	$46,422	$6.19	$4.65	$3.10	$2.33
181-190%	$20,577	$27,683	$34,789	$41,895	$49,001	$7.00	$5.25	$3.50	$2.63
191-200%	$21,660	$29,140	$36,620	$44,100	$51,580	$7.91	$5.93	$3.96	$2.97
201-210%	$22,743	$30,597	$38,451	$46,305	$54,159	$8.88	$6.66	$4.44	$3.33
211-220%	$23,826	$32,054	$40,282	$48,510	$56,738	$9.90	$7.43	$4.95	$3.72
221-230%	$24,909	$33,511	$42,113	$50,715	$59,317	$10.91	$8.19	$5.46	$4.10
231-240%	$25,992	$34,968	$43,944	$52,920	$61,896	$11.97	$8.98	$5.99	$4.49
241-250%	$27,075	$36,425	$45,775	$55,125	$64,475	$13.08	$9.81	$6.54	$4.91
251-260%	**$28,158**	**$37,882**	**$47,606**	**$57,330**	**$67,054**	**$14.24**	**$10.68**	**$7.12**	**$5.34**
261-270%	**$29,241**	**$39,339**	**$49,437**	**$59,535**	**$69,633**	**$15.44**	**$11.58**	**$7.72**	**$5.79**
271-280%	**$30,324**	**$40,796**	**$51,101**	**$60,835**	**$70,569**	**$16.78**	**$12.58**	**$8.39**	**$6.29**
281-290%	**$31,407**	**$41,368**				**$18.08**	**$13.56**	**$9.04**	**$6.78**
291-300%	**$31,634**					**$19.44**	**$14.58**	**$9.72**	**$7.29**

Appendix 9

SLIDING FEE SCALE 2009

	ANNUAL INCOME BY FAMILY SIZE					DAILY CO-PAY CHILDREN IN CARE			
						FULL TIME		PART TIME	
%FPG	6	7	8	9	10	First	Second	First	Second
0-50%	$14,765	$16,635	$18,505	$20,375	$22,245	$0	$0	$0	$0
51-60%	$17,718	$19,962	$22,206	$24,450	$26,694	$0.57	$0.43	$0.29	$0.22
61-70%	$20,671	$23,289	$25,907	$28,525	$31,143	$0.75	$0.57	$0.38	$0.29
71-80%	$23,624	$26,616	$29,608	$32,600	$35,592	$1.01	$0.75	$0.51	$0.38
81-90%	$26,577	$29,943	$33,309	$36,675	$40,041	$1.27	$0.95	$0.64	$0.48
91-100%	$29,530	$33,270	$37,010	$40,750	$44,490	$1.62	$1.22	$0.81	$0.61
101-110%	$32,483	$36,597	$40,711	$44,825	$48,939	$2.02	$1.51	$1.01	$0.76
111-120%	$35,436	$39,924	$44,412	$48,900	$53,388	$2.45	$1.84	$1.23	$0.92
121-130%	$38,389	$43,251	$48,113	$52,975	$57,837	$2.93	$2.20	$1.47	$1.10
131-140%	$41,342	$46,578	$51,814	$57,050	$62,286	$3.46	$2.60	$1.73	$1.30
141-150%	$44,295	$49,905	$55,515	$61,125	$66,735	$4.07	$3.05	$2.04	$1.53
151-160%	$47,248	$53,232	$59,216	$65,200	$71,184	$4.73	$3.55	$2.37	$1.78
161-170%	$50,201	$56,559	$62,917	$69,275	$75,633	$5.43	$4.08	$2.72	$2.04
171-180%	$53,154	$59,886	$66,618	$73,350	$80,082	$6.19	$4.65	$3.10	$2.33
181-190%	$56,107	$63,213	$70,319	$77,425	$84,531	$7.00	$5.25	$3.50	$2.63
191-200%	$59,060	$66,540	$74,020	$81,500	$87,602	$7.91	$5.93	$3.96	$2.97
201-210%	$62,013	$69,867	$77,721	$85,575		$8.88	$6.66	$4.44	$3.33
211-220%	$64,966	$73,194	$81,422	$85,777		$9.90	$7.43	$4.95	$3.72
221-230%	$67,919	$76,521	$83,952			$10.91	$8.19	$5.46	$4.10
231-240%	$70,872	$79,848				$11.97	$8.98	$5.99	$4.49
241-250%	$73,825	$82,127				$13.08	$9.81	$6.54	$4.91
251-260%	**$76,778**					**$14.24**	**$10.68**	**$7.12**	**$5.34**
261-270%	**$79,731**					**$15.44**	**$11.58**	**$7.72**	**$5.79**
271-280%	**$80,302**					**$16.78**	**$12.58**	**$8.39**	**$6.29**
281-290%						**$18.08**	**$13.56**	**$9.04**	**$6.78**
291-300%						**$19.44**	**$14.58**	**$9.72**	**$7.29**

380.12 The sliding fee schedule may be revised periodically based on the annual FPG and shall be posted for a 30 day comment period prior to the effective date of revisions to the schedule.

380.13 For purposes of section 380 of this chapter the following terms shall have the meaning ascribed herein:

Child - means an individual from birth through the age of 12 years (or up to the child's 19th birthday if the child has special needs) and is a resident of the District of Columbia.

Family -means a unit consisting of one or more adults and children related by blood, marriage, adoption or legal guardianship who reside in the same household and are eligible for child care.

Income - means the combined total adjusted gross income of the parent(s) with primary responsibility for the child, declared in the joint and/or individual annual federal income tax filing for the most recent calendar year; or in the event such filing is not required with the federal government, other appropriate documentation to establish a parent(s) total annual income. Examples of income sources include, but are not limited to revenues from: wages, salaries, tips, partnership income, interest, dividends, capital gains, fringe benefits, IRA distributions, pensions, annuities, royalties, trusts, rental income, S corporations, farm income, alimony, child support, Social Security Income, unemployment compensation, and disability compensation.

Residence - means the location in the District of Columbia where the parent(s) with primary responsibility for the child resides and claims as the permanent place of residence for purposes of one or more of the following: federal and state taxes; receiving public financial support; voter registration; driver registration; valid residential lease; or other criteria that reveals an intent to establish the District of Columbia as the person's domicile.

State - means District of Columbia for purposes of this chapter.

Persons wishing to comment on this rule should submit their comments in writing to Kerri L. Briggs, PhD., State Superintendent of Education, 441 4th Street, NW, Room 350N, Washington, D.C. 20001, Attention; Jessica Morffi re: Title 29, chapter 3. subsection 380; or to osse.publiccomment@dc.gov. All comments must be received no later than 30 days after publication of this notice in the *D.C. Register*. Copies of this rulemaking may also be obtained from the OSSE website at www.osse.dc.gov or upon request at the above referenced location.

Appendix 10: Parent's Fee Change form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

OSSE DC Office of the State Superintendent of Education

PARENT'S FEE CHANGE

Appendix - 10

Date:_____

Dear _____:
Child Care Home Provider/Center Director

To confirm our contact on _____ with _____
Name of Parent

Concerning _____
Name of Child (ren)

Our records indicate the following changes:

[ ] Change in Parents Daily Rate

From $_____ to $_____/ $_____ for child #1_____
B/A Full Day

From $_____to $_____/ $_____for child #2 _____
B/A Full Day

From $_____to $_____/ $_____for child #3 _____
B/A Full Day

[ ] Change of Child Care Worker from_____ to _____

Effective date of action _____

[ ] Termination Effective Date of Action _____

Parent Signature _____ **Date**_____

● ● ● ● ● ● ● ● ● ● ● ● ● ● ●

Please be advised that this will be your only notification.

Thank you for the services you render to provide child care and early education to our children.

Sincerely,

Eligibility Worker
Telephone:

Orig - Provider
1 copy - Parent
1 copy - Case file

Appendix 11: Eligibility Review Appointment form letter

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION
51 N[h] Street, N.E., Suite 400
Washington, D.C. 20002
(202) 727-0284 Office (202) 727-9709 Fax

Appendix - 11

ELIGIBILITY REVIEW APPOINTMENT

Date:

Dear: Parent/Guardian

This is to advise you of your eligibility review in order to determine your continued eligibility to receive child care services, as required by the Office of the State Superintendent of Education. Your scheduled appointment is

Date:

Time:

Place: 51 N[h] Street, N.W., Suite 400, Washington, D.C. 20002

.....

Please bring the following information with you to this review:

____ **Three** most recent consecutive pay statements (original documents only)

____ Verification of any other source of income (TANF, SSI, Child Support, Spouse's income, etc.)

____ Statement from school or training site verifying your enrollment and attendance, officially prepared by the proper source (stating schedule, duration and type of program)P

____ Birth Certificate(s) for your child(ren) (must show parent's name)

____ Social Security Card(s) for your child(ren)

____ Social Security Card for yourself/spouse

____ Information to verify that you reside at your current address (i.e., phone bill, utility bill - gas/electric, Official rent receipt, etc.) or if you live with someone, you'll need a notarized letter and two current pieces of mail with your name and address (original documents only).

____ Other Health Certificate Form(s).

All documents must be current within the past 30 days.
If any of the checked items do not apply to your situation, please call your worker.

THIS WILL BE YOUR ONLY APPOINTMENT NOTICE. Should you be unable to keep this appointment, please call the office immediately to arrange another appointment. If we do not hear from you, your services will be terminated on _____

Sincerely,

Eligibility Worker _____ Telephone # _____

Original - Parent/Guardian Copy - File

Appendix 12: Notice of Termination of Child Care Services form letter

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
OFFICE OF EARLY CHILDHOOD EDUCATION

OSSE DC Office of the State Superintendent of Education

NOTICE OF TERMINATION OF CHILD CARE SERVICES

Appendix - 12

Date: _____

To: _____
Parent/Guardian

_____
Provider

From: _____ Signature _____
Eligibility Worker

Eligibility worker telephone number _____

This is to notify you that child care services for: _____
Child's Name

_____
Child's Name

_____
Child's Name

will be terminated effective _____. The reason for termination[1] is

_____

If you disagree with the above action you may request a fair hearing. If you request a fair hearing before the effective date of this action listed above, your child care benefits will continue uninterrupted until hearing decision is made. If you do not request a fair hearing before the effective date of this action, you may within 90 days from the date of the notice of the action request a hearing, but you will not continue to receive benefits while the hearing is pending. A hearing decision will be rendered within 60 days of your request. Your request must be made in writing to the Office of Administrative Hearings, 441 4th Street, N.W., Suite 540-South, Washington D.C. 20001.

If you request a fair hearing, you (1) have the right to be represented by legal counsel or by a lay person who is not an employee of the District; (2) may bring witnesses on your behalf; (3) reasonable expenses related to the hearing, such as transportation costs for you or your witnesses, will be paid by the Mayor; and (4) legal services are available to you.

[1] Except in the case of request by parent or guardian, termination of services may be issued for failure to comply with the following laws and regulations governing child care services including The Day Care Policy Act of 1979, effective September 19, 1979 (D.C. law 3-16; D.C. code, sec. 3-301, et. Seq.), as amended; The Child Care Services Assistance Fund Act of 1988, effective January 6, 1989 (D.C. Law 7-220); current Child Care Development Fund State Plan; Child Care Subsidy Eligibility Manual.

Distribution – Original in case file
copy to provider
copy to customer

Appendix 13: Payment Summary Error Report form

OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION • OFFICE OF EARLY CHILDHOOD EDUCATION
COMPLIANCE AND INTEGRITY DIVISION• CHILD CARE ELIGIBILITY MONITORING UNIT

LEVEL [ ] PAYMENT SUMMARY ERROR REPORT

NAME OF PROVIDER: _____ (PLEASE PRINT NAME)

PERSON COMPLETING FORM: _____ (PLEASE PRINT)

TELEPHONE NUMBER: _____ (area code)

Reporting Month: _____

Date:

CHILD'S NAME	CHILD'S SSN	ELIGIBILITY WORKER'S NAME	DATE CHILD ENTERED	Status of Attendance		COMMENTS (Use Codes Below)
				Child Attending Y/N	Terminated (List Date)	

Upon completion please bring this report to the Eligibility Monitoring Unit located at 717 14th Street NW, Suite 700, Washington, DC 20005 • Office (202) 727-1839

CODES: Enter the appropriate code for each child in the comments section. Follow the instructions listed for each code.
01 - Never Paid (Always attach the child care admission form).
02 - Partial Payment (In the comments section, enter the time period for which you were not paid - include month, date, and year).
03 - Termination (Be sure that the full date of termination - the month, date and year - is listed in the appropriate section of the "Status of Attendance ").

NOTE: Error reports will be returned if they are not fully completed. See Instructions on Back

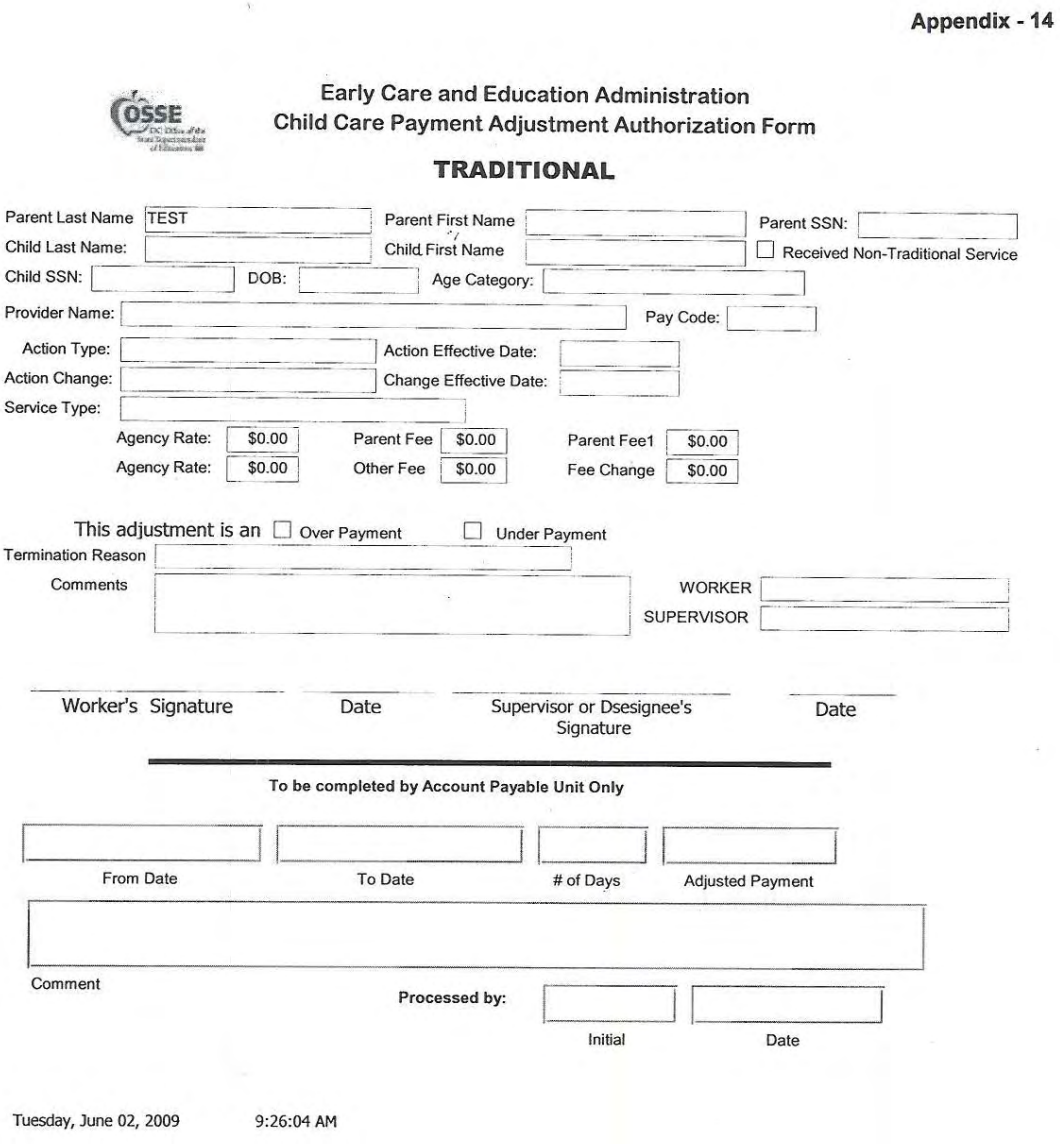
Appendix – 13

Level [ ]:	Indicate whether the provider is Level 1 or Level 11
Name of Provider:	List name of Child Care Center/Family Child Care Provider/Relative Home Care Provider/In-Home Care Provider
Person Completing Form:	Indicate the name of the person completing the error report.
Telephone Number:	Indicate telephone number of provider and any other telephone number where the person completing the error report can be more easily reached
Reporting Month:	Indicate current month of payroll
Date:	Indicate date that the error report is being completed
Child's Name:	Please ensure that the child's name is spelled correctly as written on the child care admission form (and including the necessary hyphens and accents). If the child's name is incorrectly spelled on the child care admission form, write a notation in the comment section.
Child's SSN:	Please ensure that the child's social security number is written correctly. Social security numbers are key to identifying the correct child. If the child's social security number is unknown (000-00-0000), then also enter the parent's name and social security number in the comment section.
Eligibility Worker's Name:	Indicate the name of the eligibility worker listed on the child care admission form or the most recent eligibility worker assigned if known. Write "Provider" if the eligibility was done at the child care center.
Date Child Entered:	Enter the child's date of admittance. If the child had multiple periods of enrollment with breaks in attendance, then enter the most recent entry date (date of admittance listed on the most recent child care admission form received).
Status of Attendance:	Indicate whether the child is currently attending by writing yes (Y) or no (N). If the child no longer attends, indicate the termination date (month, day, and year)
Comments:	Enter the code that applies to each child. You may also use this section to provide any additional information that may provide clarity to the situation.
Codes:	Codes are provided so that you can briefly communicate to us the payment status of each child listed on the error report. Enter (in the comment section) the code that applies to each child.

REMINDERS:

Error Reports:	Error reports are due the last day of each month.
Payments:	Payment received is always for the previous month. That is, if a child enters the day care center in January, 09, you will not receive any payment for that child until February, 09.
Terminations:	All terminations must be reported to the assigned eligibility worker. Terminations must also be listed on the attendance report. If you have already reported the termination and you continue to be paid for the child, **then** you may report that child on the error report.

Appendix 14: Child Care Payment Adjustment Authorization form (Traditional and Non-Traditional)



Appendix - 14

Early Care and Education Administration
Child Care Payment Adjustment Authorization Form

TRADITIONAL

Parent Last Name: TEST
Parent First Name:
Parent SSN:
Child Last Name:
Child First Name:
☐ Received Non-Traditional Service
Child SSN:
DOB:
Age Category:
Provider Name:
Pay Code:
Action Type:
Action Effective Date:
Action Change:
Change Effective Date:
Service Type:
Agency Rate: $0.00
Parent Fee $0.00
Parent Fee1 $0.00
Agency Rate: $0.00
Other Fee $0.00
Fee Change $0.00

This adjustment is an ☐ Over Payment ☐ Under Payment
Termination Reason
Comments
WORKER
SUPERVISOR

Worker's Signature | Date | Supervisor or Dsesignee's Signature | Date

To be completed by Account Payable Unit Only

From Date | To Date | # of Days | Adjusted Payment

Comment

Processed by: Initial | Date

Tuesday, June 02, 2009 9:26:04 AM

Office of Early Childhood Education
Child Care Payment Adjustment Authorization Form
NON-TRADITIONAL

Parent Last Name: TEST Parent First Name: Parent SSN:

Child Last Name: Child First Name: ☐ Received Traditional Service

Child SSN: DOB: Age Category:

Provider Name:

Action Type 1: Effective Date Service 1:

Change Action: Effective Date Schedule:

Agency Rate: $0.00 Parent Fee 1: $0.00 2: $0.00 Other Rate: $0.00 Fee Change 1: $0.00 2: $0.00

Action Type 2: Effective Date Service 2:

Change Action: Effective Date Schedule:

Agency Rate: $0.00 Parent Fee 1: $0.00 2: $0.00 Other Rate: $0.00 Fee Change 1: $0.00 2: $0.00

Action Type 3: Effective Date Service 3:

Change Action: Effective Date Schedule:

Agency Rate: $0.00 Parent Fee 1: $0.00 2: $0.00 Other Rate: $0.00 Fee Change 1: $0.00 2: $0.00

Action Type 4: Effective Date Service 4:

Change Action: Effective Date Schedule:

Agency Rate: $0.00 Parent Fee 1: $0.00 2: $0.00 Other Rate: $0.00 Fee Change 1: $0.00 2: $0.00

This adjustment is an ☐ Over Payment ☐ Under Payment

Reason of Over/Underpayment:

COMMENTS:

WORKER:

SUPERVISOR:

Worker's Signature Date Supervisor or Designee's Signature Date

Thursday, October 01, 2009 8:21:26 AM