MDHS
MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

Mississippi Child Care Payment Program
Redetermination Application for Families

APPLICANT INFORMATION				
Name:			SSN*:	
DOB:	Gender:	Race:	Ethnicity**: ☐Hispanic ☐ Non-Hispanic	
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐ Widowed ☐ Never Married	Do you receive Supplemental Security Income (SSI)? ☐Yes ☐No	Do you receive housing assistance from any government entity? ☐Yes ☐No	What is the primary language spoken in the home?	
Are you a deployed member of the U.S. Military? ☐No ☐Yes				
Physical Address:				
City:	State:	Zip:		
Home Phone:	Cell Phone:	Work Phone:		
Email Address:				
Is mailing address the same as physical address? ☐Yes If no, complete section below:				
Mailing Address:	City:	State:	Zip:	

INCOME INFORMATION		
Are you working at least 25 hours per week? ☐Yes ☐No	Are you enrolled full-time in an educational program? ☐Yes ☐No	Are you working less than 25 hours per week AND enrolled at least part-time in an educational program? ☐Yes ☐No
(Self) Name of Employer:	Gross Pay Received:	Pay Schedule: ☐Weekly ☐Bi-Weekly ☐Twice Monthly ☐Monthly
(Self) Employer #2:	Gross Pay Received:	Pay Schedule: ☐Weekly ☐Bi-Weekly ☐Twice Monthly ☐Monthly
(Self) Social Security Income Amount:	Other Income: _____ Amount: _____	Other Income: _____ Amount: _____
(Spouse) Name of Employer:	Gross Pay Received:	Pay Schedule: ☐Weekly ☐Bi-Weekly ☐Twice Monthly ☐Monthly
(Spouse) Employer #2:	Gross Pay Received:	Pay Schedule: ☐Weekly ☐Bi-Weekly ☐Twice Monthly ☐Monthly
(Spouse) Social Security Income Amount:	Other Income: _____ Amount: _____	Other Income: _____ Amount: _____
☐ I attest that I do not have any asset or combination of assets that exceed $1,000,000.		

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CHILD INFORMATION				
Child 1 First Name:	Middle Name:		Last Name:	Suffix:
DOB:	Gender:	Race:	Ethnicity**: ☐Hispanic ☐ Non-Hispanic	
SSN*:	Does your child have special needs? ☐Yes ☐No Is this child receiving Supplemental Security Income (SSI)? ☐Yes ☐No		Do you have a child support case open with the Division of Child Support Enforcement? ☐Yes ☐No	
Child's father lives in the home? ☐Yes ☐No			Child's mother lives in the home? ☐Yes ☐No	
Is your child in: ☐Kindergarten ☐Head Start ☐Elementary School ☐Middle School ☐Not Enrolled				
Days Care is Needed (Check all that apply) ☐Monday-Friday ☐Saturday ☐Sunday ☐Nights *Night and weekend care is only allowed when proof of evening work/school schedule is provided.*			Hours Care is Needed: Monday-Friday _____am/pm to _____ am/pm Saturday _____am/pm to _____ am/pm Sunday _____am/pm to _____ am/pm	
Chosen Provider Name:	Provider Address:		Provider Phone:	
Child 2 First Name:	Middle Name:		Last Name:	Suffix:
DOB:	Gender:	Race:	Ethnicity**: ☐Hispanic ☐ Non-Hispanic	
SSN*:	Does your child have special needs? ☐Yes ☐No Is this child receiving Supplemental Security Income (SSI)? ☐Yes ☐No		Do you have a child support case open with the Division of Child Support Enforcement? ☐Yes ☐No	
Child's father lives in the home? ☐Yes ☐No			Child's mother lives in the home? ☐Yes ☐No	
Is your child in: ☐Kindergarten ☐Head Start ☐Elementary School ☐Middle School ☐Not Enrolled				
Days Care is Needed (Check all that apply) ☐Monday-Friday ☐Saturday ☐Sunday ☐Nights *Night and weekend care is only allowed when proof of evening work/school schedule is provided.*			Hours Care is Needed: Monday-Friday _____am/pm to _____ am/pm Saturday _____am/pm to _____ am/pm Sunday _____am/pm to _____ am/pm	
Chosen Provider Name:	Provider Address:		Provider Phone:	
Child 3*** First Name:	Middle Name:		Last Name:	Suffix:
DOB:	Gender:	Race:	Ethnicity**: ☐Hispanic ☐ Non-Hispanic	
SSN*:	Does your child have special needs? ☐Yes ☐No Is this child receiving Supplemental Security Income (SSI)? ☐Yes ☐No		Do you have a child support case open with the Division of Child Support Enforcement? ☐Yes ☐No	
Child's father lives in the home? ☐Yes ☐No			Child's mother lives in the home? ☐Yes ☐No	
Is your child in: ☐Kindergarten ☐Head Start ☐Elementary School ☐Middle School ☐Not Enrolled				

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Days Care is Needed (Check all that apply)	Hours Care is Needed:
☐Monday-Friday ☐Saturday ☐Sunday ☐Nights *Night and weekend care is only allowed when proof of evening work/school schedule is provided.*	Monday-Friday _____am/pm to _____ am/pm Saturday _____am/pm to _____ am/pm Sunday _____am/pm to _____ am/pm

Chosen Provider Name:	Provider Address:	Provider Phone:

* The absence of this information cannot be a basis to deny eligibility.
** MDHS is required by the federal government to collect this information. It will not be used to determine program eligibility.
*** Use additional application forms as needed to provide information on more than 3 children.

HOUSEHOLD MEMBERS

Name:	Gender:	Relationship to Parent/Guardian:
Name:	Gender:	Relationship to Parent/Guardian:
Name:	Gender:	Relationship to Parent/Guardian:

☐ I certify that the information I have provided is true and correct. I certify that I have not omitted or misrepresented any information required for eligibility for the Mississippi Child Care Payment Program.

☐ I understand and agree that by accepting these services, it is my responsibility to adhere to all policies set by DECCD for the Mississippi Child Care Payment Program. I understand that a copy of the policies for this program is located on the DECCD website.

Please send signed and completed application, Parent Rights & Responsibilities document, Parent Statement of Agreement, and other required documentation by electronic upload, mail, email, or fax.

Link to electronic upload: https://app.smartsheet.com/b/form/92ca98a8c3364fa298d7c05e2356cff5

Mail: DECCD
P.O. Box 352
Jackson, Mississippi 39205

Email: ccpayment@mdhs.ms.gov

Fax: 601-359-4422

_____ _____
Applicant Signature Date