

FOR MDHS USE ONLY	
TANF Effective Date _____	Registration Date _____
Case Number _____	Received Date _____
Clerk _____	<input type="checkbox"/> TWP <input type="checkbox"/> TCC _____

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CHILD CARE SERVICES APPLICATION

We will consider this application without regard to race, color, age, sex, handicap, religion, national origin, or political beliefs.

Parent/Responsible Adult Information

Name: _____ Phone: Cell: (____) _____

Address: _____ Home: (____) _____

_____ Work: (____) _____

_____ (Must be a valid number where you can be reached.)

Email Address: _____ SSN: _____

(Must have an active email account to receive child care correspondence from DECCD.)

List all of your CHILDREN Living in the home that need child care services:

NAME	SEX		BIRTH DATE	SOCIAL SECURITY NUMBER	RELATIONSHIP	Special Needs*	
	M	F				Y	N

*Special Needs must be documented with a doctor's statement or the receipt of SSI benefits.

If requesting Transitional Child Care (TCC), provide the following:

Do you currently receive child care assistance for the children listed above? Yes No

If yes: Provider's Name: _____ ID No. _____

Address _____ City _____ County: _____

If employed, provide the following:

Employer Name: _____ Contact Person: _____

Address: _____ Phone No: _____

I work Days Nights Shift schedule I work on weekends Yes No

I work _____ days each week. List Daily Work Hours: Circle AM or PM		SUN _____ AM/PM to _____ AM/PM
MON _____ AM/PM to _____ AM/PM	TUE _____ AM/PM to _____ AM/PM	WED _____ AM/PM to _____ AM/PM
THU _____ AM/PM to _____ AM/PM	FRI _____ AM/PM to _____ AM/PM	SAT _____ AM/PM to _____ AM/PM

Applicant's Signature: _____ Date: _____