At-Risk Child Care Application and Authorization

Authorization: ☐ INITIAL AUTHORIZATION ☐ REDETERMINATION ☐ UPDATE

If update, change in: ☐ Hours ☐ Children ☐ Address ☐ Custody ☐ Eligibility Extension ☐ Termination of Care ☐ Worker/Unit

TO:	FROM: (Print Worker Name)	EMAIL ADDRESS:
ELC Santa Rosa	Unit, Number & Address	
	City, Zip Code	

SECTION A: CLIENT/FAMILY INFORMATION

If address for parent/guardian is a P.O. Box, enter street address in "Comments" below.

Social Security No.	Last Name First Name MI (Print)	Date of Birth	Gender	Race
Social Security No.	Spouse or Other Parent (if applicable) (Print): Last Name First Name MI	Date of Birth	Gender	Race

Address	City	State	Zip	Day Time Phone No.	Email Address

SECTION B: ELIGIBILITY

I. **Status:** ☒ **Assistance** ☐ **Non-Assistance** **Rilya Wilson Act:** ☐ **Yes** ☐ **No**

☒ **At Risk:** ☐ PI ☐ PS ☐ FC ☐ Diversion

☒ **Placement Location:** ☐ In Home ☐ Out of Home: Relative/Non-Relative ☐ Foster Care

Custody: ☐ DCF Placement & Care/Custody **Medicaid Eligible:** ☐ **Yes** ☐ **No**

☐ Not Under DCF Placement & Care/Custody

II. **FOR COALITION USE ONLY**

☐ Income Eligible <100% ☐ Income Eligible 150% - 200% ☐ TANF "Child Only"

☐ Income Eligible 100% <=150% ☐ OTHER ☐ TANF (Relative Caregiver)

III. **Primary Purpose of Care:** ☒ **PROTECTION**

Secondary Purpose of Care: ☐ Emergency ☐ Therapeutic Plan ☐ TANF At Risk (RCG)

☐ Employment ☐ Work Activity ☐ Education Activity (TED)

IV. **Parental/Agency Consent:** The completion of a developmental screening or child assessment is authorized for the child(ren) in care. Consent is given for results to be shared with the child care provider and state or local agencies for developing an intervention plan.

Developmental screening: ☐ Yes ☐ No

Child Assessment: ☐ Yes ☐ No

Parent/Legal Guardian Signature: _____

SECTION C: AUTHORIZATION – Child care services are authorized for this client for approved activity(ies). The minimum hours of care per child includes hours per week for reasonable transportation time. *Children authorized to receive care:*

Name	SSN	Birth Date	Race/ Gender	Minimum Hours of care/week	FSFN Case ID/ Intake #	FOR COALITION USE ONLY: Center/Home Placed	Date Enrolled	Assessed Fee

Care Authorization from _____ through _____ (Not to exceed a 6 month period)

Comments:_____

SECTION D: AUTHORIZING SIGNATURE(S): I hereby certify that the information provided above is correct.

Authorizing Worker:_____ Date:_____

Supervisory Approval:_____ Tel.:_____ Date:_____

Coalition:_____ Date:_____

THIS FORM IS *VOID* AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE