



# 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:
	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.	Evening Phone No.	

If there is NO spouse: enter the Marital Status:  Single  Divorced  Widowed  Separated

Parent/ (if different from above):	Last Name First Name MI (Print)	Social Security No.	Date of Birth	Gender	Race
Address		City	State	Zip	
		Day Time Phone No.	Evening Phone No.		

**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)

**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	FAHIS Investigation Intake #	FOR COALITION USE ONLY		
						Center/Home Placed	Date Enrolled	Assessed Fee

Gross Monthly Family Income: \_\_\_\_\_ (Attach Income Documentation, if available)

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.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorizing Worker: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisory Approval: \_\_\_\_\_ Tel.: \_\_\_\_\_ Date: \_\_\_\_\_

Coalition: \_\_\_\_\_ Date: \_\_\_\_\_

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