



# COVID-19 PRIORITIZED ESSENTIAL WORKERS CHILD CARE APPLICATION

During the declared COVID-19 Public Health Emergency, the children of Prioritized Essential Workers are eligible to receive child care through the Illinois Department of Human Services (IDHS) Child Care Assistance Program (CCAP). Prioritized Essential Workers include those working in Health Care, Human Services, essential Government services (e.g. Corrections, law enforcement, fire department), and essential Infrastructure (e.g. utility maintenance, construction, airport operations). If you have any questions about your eligibility, please contact your local Child Care Resource and Referral Agency (CCR&R). To find your local CCR&R, please visit: <https://www.inccrra.org/about/sdasearch>.

PLEASE TYPE OR PRINT CLEARLY IN BLUE OR BLACK INK. If a question does not apply, please write "n/a" in the box – **do not leave any field blank**.

<b>SECTION 1 – APPLICANT INFORMATION</b>					
<i>The applicant must meet the definition of a Prioritized Essential Worker in order to be determined eligible.</i>					
First Name		Last Name		Date of Birth (mm/dd/yyyy)	
Home Address		Apt #	City	State	Zip Code
Mailing Address <input type="checkbox"/> Same as above		Apt #	City	State	Zip Code
County of Residence		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary language spoken in the home: <input type="checkbox"/> English <input type="checkbox"/> Other (list): _____ <input type="checkbox"/> Spanish		
Telephone Number		Type <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other	Email Address		
<b>SECTION 2 – OTHER PARENT/GUARDIAN INFORMATION</b>					
<i>This section must be completed if the other parent/guardian is living in the same home as the applicant and child(ren).</i>					
First Name		Last Name		Date of Birth (mm/dd/yyyy)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number		Type <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other	Email Address	
<b>SECTION 3 – WORK INFORMATION</b>					
<i>To qualify, each parent/guardian in the home must be an essential worker unable to work remotely. The applicant must meet the definition of a Prioritized Essential Worker. Please submit documentation as proof of each parent/guardian's employment status along with this application. Acceptable documentation includes a pay stub within the past 30 days or a letter from your employer. If submitting a letter from your employer, please have them list 1) the company name; 2) your job title; 3) standard working hours; and, 4) your salary and frequency of pay (e.g. weekly, biweekly).</i>					
<b>Applicant Work Information</b>					
Employer/Company Name		Industry Type <input type="checkbox"/> Health Care <input type="checkbox"/> Human Services <input type="checkbox"/> Government <input type="checkbox"/> Infrastructure		Job Title	
Address		City		State	Zip Code
Work Telephone Number:					
<b>Other Parent/Guardian Work Information</b>					
Employer/Company Name		Job Title		Work Telephone Number	
Address		City		State	Zip Code
Does this individual have the option to work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain why child care is needed.			



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## SECTION 4 – REQUESTED CHILD CARE SCHEDULE

Identify below the days and hours that child care is needed. Only the times that both parents are working (including travel time to and from work) should be listed in this section.

	MON	TUES	WED	THURS	FRI	SAT	SUN
FROM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
TO	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM

## SECTION 5 – CHILD INFORMATION

Please complete the section below for each child in need of child care from an Emergency Child Care provider.

### Child 1

Child First Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Ethnic Origin (check all that apply)

- White       Hispanic or Latino       American Indian or Alaskan Native       Other  
 Black or African American       Asian       Native Hawaiian or Pacific Islander

### Child 2

Child First Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Ethnic Origin (check all that apply)

- White       Hispanic or Latino       American Indian or Alaskan Native       Other  
 Black or African American       Asian       Native Hawaiian or Pacific Islander

### Child 3

Child First Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Ethnic Origin (check all that apply)

- White       Hispanic or Latino       American Indian or Alaskan Native       Other  
 Black or African American       Asian       Native Hawaiian or Pacific Islander

### Child 4

Child First Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Ethnic Origin (check all that apply)

- White       Hispanic or Latino       American Indian or Alaskan Native       Other  
 Black or African American       Asian       Native Hawaiian or Pacific Islander

### Child 5

Child First Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Ethnic Origin (check all that apply)

- White       Hispanic or Latino       American Indian or Alaskan Native       Other  
 Black or African American       Asian       Native Hawaiian or Pacific Islander

## SECTION 6 – CHILD CARE PROVIDER INFORMATION

15-digit CCMS Provider ID	Provider Type <input type="checkbox"/> Licensed center <input type="checkbox"/> License exempt center <input type="checkbox"/> Licensed home <input type="checkbox"/> License exempt home		
First Name	Last Name	Date of Birth	
Corporate Name	Doing Business As (DBA)	DCFS Emerg. Child Care Lic. #	



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Service Address	Apt #	City	State	Zip Code
Telephone Number	Email Address		Date Care will Begin	
Provider's relationship to child(ren):				

### SECTION 7 – APPLICATION AUTHORIZATION

I have provided all required information. After reading each of the following statements, I certify that:

- I am responsible for the selection of the child care provider(s) for my child(ren).
- I understand that I must be working as a Prioritized Essential Worker, defined as working in Health Care, Human Services, essential Government services (e.g. Corrections, law enforcement, fire department), or essential Infrastructure (e.g. utility maintenance, construction, airport operations) to be determined eligible to receive child care benefits at this time.
- I understand that if there is another parent or guardian in the home, they must be identified as an essential worker by their company and required to work outside of the time in order to be determined eligible to receive child care benefits at this time.
- The information provided will be disclosed only for administrative purposes and that I may be required to verify the information that I have provided.
- I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct, and complete to the best of my knowledge. I understand that giving false information or failing to provide correct information can also result in an overpayment which I will have to pay back and could result in my prosecution for fraud.

**My signature is my consent and authorization for information to be released by or to the Illinois Department of Human Services or its agents that may establish my eligibility, or my continued eligibility for the Child Care Assistance Program.**

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please submit your completed application to your local CCR&R, along with any necessary supporting documentation. Please keep a copy of your submitted application for your records. To find your local CCR&R, please visit: <https://www.inccrra.org/about/sdasearch>.**