



FAQs About Childcare Services

Who is eligible to obtain a DC childcare voucher through CFSA?

- Any client under protective supervision
- Foster parents or Kinship care providers working at least 20 hours per week
- Any teen parent in care that is either working or in school at least 20 hours per week

How do I apply for a voucher for a DC childcare provider?

To apply for a voucher **in the District**:

1. Locate a childcare provider by contacting the Washington Child Development Council. (See How do I locate a childcare provider?)
2. Get a referral packet on CFSA website here: <http://cfsa.dc.gov/DC/CFSA/For+Partners/Social+Workers/Social+Worker+Support+Forms> or by contacting Julian Smith at **(202) 715-7796** or via email: julian.smith@dc.gov.
3. CFSA will send completed referrals to IMA. It takes up to five business days to process vouchers.

What should I do if my client is not eligible to receive a DC childcare voucher?

Social workers can request childcare services outside of DC by using the FACES Service log. Here is how to get started:

1. Locate a childcare provider using the phone listing. (See How do I locate a childcare provider?)
2. Search in FACES for the childcare provider's name and provider ID.
3. If you cannot find your childcare provider in FACES, you must contact the childcare facility to get a valid copy of their childcare license, and W9 form. (Blank W9 forms are available on CFSA website at <http://cfsa.dc.gov/DC/CFSA/For+Partners/Social+Workers/Social+Worker+Support+Forms>.)
4. Once documents are completed, fax or bring them to CFSA. (See How do I submit referrals?)
5. After the documents have been received, they will be entered into FACES, and a provider ID will be assigned. Use this provider ID to link the child to the childcare provider through the Service Log. This will provide authorization of payment.

How do I submit referrals?

Submit your completed referral via:

Fax to:

Attention: Julian Smith
(202) 727-6505

OR

Deliver to:

CFSA
400 6th St. SW
Office # 5082
Washington, DC 20024,

How do I locate a childcare provider?

Listed below are several contact numbers to assist in finding the childcare that best fits your clients' needs:

Childcare Provider Locator

District of Columbia	Maryland	Virginia
<i>DC Child Care Connections</i> (202) 862-1111	<i>Prince George's County</i> (301) 909-7120	<i>City of Alexandria</i> (703) 838-0750
	<i>Montgomery County</i> (301) 279-1773	<i>Arlington County</i> (703) 228-5101
	<i>Charles County</i> (866) 290-0045	

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency



Directions for Completing Daycare Packet

- **Please Note:** *This packet should only be completed if you are trying to secure a daycare voucher for a daycare in the District of Columbia that accepts daycare vouchers.*

- Eligibility:
- Any protective supervision case
 - Working foster parents
 - Teen ward who is either working or in school

Description of Forms:

- **Information Exchange Form (DHS-886):** - State the names of children referred, name & address of daycare agency, and the reason for referral.
- **District of Columbia Universal Health Certificate (2 Pages)** – Each section of the form must be completed and signed by the physician. (The health information - Date of health exam, immunization records must be included or attached, TB & lead test dates and results required for any child over the age of 1.)
- **Child Care Referral (DHS-715):** *For foster care, kinship care, or protective supervision cases only.* - Complete the form where applicable - Must include Date of Birth, and social security numbers for both the head of household and the child. (PLEASE NOTE: Foster and kinship care referrals must include a copy of their most current pay stub. Paystub must reflect that the head of household is working at least twenty (20) hours per week, and will not be acceptable for referral after 30 days of issuance.
- **Subsidized Child Care Service Application /Rights and Responsibilities Form: (4 Pages)** *Teen wards only.* - Ward must complete all four (4) pages where applicable – Must include Date of Birth, social security number for both applicant and child, and signature of applicant. (PLEASE NOTE: Wards must also submit a verification of employment, or enrollment in school. Verification must be current within 30 days, and must reflect at least 20 hours per week of activity. Verification of enrollment must be a document with the school or program's letterhead stating that the applicant is currently enrolled, the hours they attend and days a week they attend. A class schedule is not acceptable.)
- **Department of Human Services Ward Letter:** *Teen wards only.* - Social worker must complete and sign this document when referring a teen ward.

To locate a daycare near the home of the family contact:
Washington Child Development Council at (202) 387-0002

Once the daycare packet is completed, please deliver it to Julian Smith at Cubicle 4211 on the 4th floor at 400 6th Street SW or fax it to his attention at (202) 727-6505.

The daycare voucher should be ready for pickup in five (5) business days from the date of fax. A CFSA Collaborative Liaison representative will contact you to retrieve the voucher when it is ready.



DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information Parent/Guardian: Please complete Part 1 clearly and completely & sign Part 5 below.

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other
Parent or Guardian Name:	Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Home Address:	Ward:	
Emergency Contact Person:	Emergency Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	City/State (if other than D.C.):	Zip code:	
School or Child Care Facility:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Other	Primary Care Provider (PCP):		

Part 2: Child's Health History, Examination & Recommendations Health Provider: Form must be fully completed.

DATE OF HEALTH EXAM:	WT <input type="checkbox"/> LBS <input type="checkbox"/> KG	HT <input type="checkbox"/> IN <input type="checkbox"/> CM	BP: ^(2 yrs) <input type="checkbox"/> NML <input type="checkbox"/> ABNL	Body Mass Index (BMI) ^(2 yrs) %
HGB / HCT <i>(Required for Head Start)</i>	Vision Screening Right 20/____ Left 20/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Referred	Hearing Screening Pass _____ Fail _____ <input type="checkbox"/> Referred	
HEALTH CONCERNS:	REFERRED or TREATED	HEALTH CONCERNS:	REFERRED or TREATED	
Asthma <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Language/Speech <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Seizure <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Development/ Behavioral <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	Other _____ <input type="checkbox"/> NONE <input type="checkbox"/> YES	<input type="checkbox"/> Referred <input type="checkbox"/> Under Rx	
ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Referred				

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
 NONE YES, please detail:

B. Significant food/medication/environmental allergies that may require emergency medical care at school, child care, camp, or sports activity.
 NONE YES, please detail:

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
 NONE YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	<input type="checkbox"/> HIGH → <input type="checkbox"/> LOW	Tuberculin Skin Test (TST) DATE:	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE	If TST Positive <input type="checkbox"/> CXR NEGATIVE <input type="checkbox"/> CXR POSITIVE <input type="checkbox"/> TREATED	Health Provider: POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-598-4040
LEAD EXPOSURE RISKS	<input type="checkbox"/> YES → <input type="checkbox"/> NO	LEAD TEST DATE:	RESULT:	Health Provider: All lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

- YES NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.
- YES NO This athlete is cleared for competitive sports.
- YES NO Age-appropriate health screening requirements performed within current year. If no, please explain:

Print Name	MD/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name	Signature	Date
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DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____ / _____ / _____ Date of Birth: _____ / _____ / _____
Last First Middle Mo. /Day/ Yr.

Sex: Male Female School or Child Care Facility: _____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
	1	2	3	4	5	6	7
Diphtheria, Tetanus, Pertussis (DTP, DTaP)							
DT (<7 yrs.) / Td (>7 yrs.)							
Tdap Booster							
Haemophilus influenza Type b (Hib)							
Hepatitis B (HepB)							
Polio (IPV, OPV)							
Measles, Mumps, Rubella (MMR)							
Measles							
Mumps							
Rubella							
Varicella							
Chicken Pox Disease History: Yes <input type="checkbox"/> When: Month _____ Year _____							
Verified by: _____ (Health Care Provider)							
<small>Name & Title</small>							
Pneumococcal Conjugate							
Hepatitis A (HepA) (Born on or after 01/01/2005)							
Meningococcal Vaccine							
Human Papillomavirus (HPV)							
Influenza (Recommended)							
Rotavirus (Recommended)							
Other							

Signature of Medical Provider _____ Print Name or Stamp _____ Date _____

Section 2: MEDICAL EXEMPTION: For Health Care Provider Use Only:

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: Tetanus: Pertussis: Hib: HepB: Polio: Measles: Mumps: Rubella: Varicella: Pneumococcal:
 HepA: Meningococcal: HPV:

Reason: _____

This is a permanent condition or temporary condition until ____/____/____.

Signature of Medical Provider _____ Print Name or Stamp _____ Date _____

Section 3: Alternative Proof of Immunity: To be completed by Health Care Provider or Health Official:

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: Tetanus: Pertussis: Hib: HepB: Polio: Measles: Mumps: Rubella: Varicella: Pneumococcal:
 HepA: Meningococcal: HPV:

Signature of Medical Provider _____ Print Name or Stamp _____ Date _____

Government of the District of Columbia ♦ Department of Human Services
Child Care Referral

Date Received _____

★ ★ ★


PLEASE:

- (1) Use the Child Care Code below in the Appropriate column (col. 4) to indicate the type(s) of Child Care needed for children Referred for service.
 - A. Full Day
 - B. After School
 - C. Before School
 - D. Before and After School
 - E. Non-Traditional
 - F. Child Care not required
- (2) Use the following code To indicate sex of children In column 3.
 - F M

List all Children in Family and Use Appropriate Child Care Code for Services Requested

1	2	3	4
Child's Full Name	DOB	Sex	Child Care Code
Social Security #			
Social Security #			
Social Security #			

- 5. Case Number: _____
- 6. Family Income: [] TANF [] Other \$ _____ per month
- 7. Referral Source (Circle Appropriate Letter)
 - a. Prot Serv Div
 - b. Foster Care
 - c. Court
 - d. RSA
 - e. Coalition for the Homeless
 - f. DCPR
 - g. DDS
 - i. FSA
 - j. Families Forward
- 8. Reason for Referral:
 - [] Training or School (name facility): _____ Hours (daily) _____ to _____
 - [] Employment - Hours per week: _____ Hours (daily) _____ to _____

9. Head of Household:

Name _____ DOB: _____

Social Security Number _____

Address: _____ (Number & Street)

(City, state & zip code) _____ (Home Phone) _____

Employment: Address _____ (Name & Address of Employer)

City, State & Zip Code _____ Work Phone _____

10. Spouse's Name (If Applicable)

(Name) Home Phone: _____

DOB: _____

Address: _____ (Number & Street)

(City & State) _____ (Zip Code) _____

Employment: Work Phone # _____ (Name & Address of Employer)

(City & State) _____ (Zip code) _____

11. Mother's name (If different from 9 or 10)

Name: _____ Home Phone: _____

DOB: _____

Address: _____ (Number & Street)

(City & State) _____ (Zip Code) _____

Employment: Work Phone: _____ (Name & Address of Employer)

(City & State) _____ (Zip Code) _____

Referring Worker's Name _____

Supervisor's Signature _____

Signature & Date _____

Worker's e-mail address _____

Telephone Number: _____

see other side

PARENT(S) AND/OR GUARDIAN ACTIVITY INFORMATION

Your Activity	Spouse/ Other Parent Activity
1. Name of school or employer: _____ Address: _____ Days and hours of your activity: _____ Start and end dates of activity: _____	1. Name of school or employer: _____ Address: _____ Days and hours of your activity: _____ Start and end dates of activity: _____
2. Name of school or employer: _____ Address: _____ Days and hours of your activity: _____ Start and end dates of activity: _____	2. Name of school or employer: _____ Address: _____ Days and hours of your activity: _____ Start and end dates of activity: _____

REASON FOR CHILD CARE

WORKING TRAINING DISABLED ADULT CHILD WITH A DISABILITY OTHER _____

HOUSEHOLD INCOME INFORMATION:

Type of income	Gross Amount per pay period	How often: (Check "✓"one)
Mother's/Guardian's Income		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
Father's/ Guardian's Income		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
Child Support		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
Alimony		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
SSI Benefits		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
Unemployment Benefits		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
Other: _____		<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
TANF		<input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No
Food Stamp		<input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No
Social Security		<input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No

Attach proof of all income for: applicant, spouse, parents of minor parent, adult and spouse with physical custody of minor child.

CHILD SUPPORT INFORMATION

1) Are you receiving child support for all children in your household who are eligible for child support? Yes No
 2) Have you applied for child support for all children in your household eligible to receive child support? Yes No



**RIGHTS AND RESPONSIBILITIES OF APPLICANT
FOR SUBSIDIZED CHILD CARE SERVICES**

RIGHTS:

I understand that if I am not satisfied with any decision by the Department regarding eligibility, my receipt or termination of services, I may request a Fair Hearing. If I am receiving services and request a Fair Hearing before the effective date of this action, my benefits will continue uninterrupted until a hearing decision is made. If I do not request a Fair Hearing before the effective date of this action, I may request a hearing within 90 days from the date of the notice of the action, but I will not continue to receive benefits while the hearing is pending. I must make my request by phone or in writing to:

The Office of Administrative Hearings,
441 4th Street, N.W., Suite 540-South,
Washington, D.C. 20001
(202) 727-8280

or I can ask my caseworker to help me make the request. After requesting a Fair Hearing the Department will send me a written notice telling me the time and place of the Administrative Review. The Administrative Review is not the same as a Fair Hearing. This means I may meet with Department staff to try to resolve my issue. If I choose not to attend the Review or if my issue is not resolved at the Review this in no way impacts my Fair Hearing with the Office of Administrative Hearings. If the Review resolves my issue, I alone may decide to withdraw my request for a Fair Hearing.

If I request a fair hearing, I understand that (1) I have the right to be represented by legal counsel or by a lay person who is not an employee of the District; (2) I may bring witnesses on my behalf; (3) reasonable expenses related to the hearing, such as transportation costs for me or my witnesses, will be paid by the Mayor; and (4) legal services are available to me.

I have been informed that I may choose one of the following types of child care: child care in a child development center, child care in a family child care home, child care in my home by an adult or relative I identify, or child care in the home of my relative. I am aware that to choose child care in my home with an adult other than a relative I must first attempt to locate child care at a minimum of 5 child care centers and/or family child care homes.

I understand that I will be notified in writing within a minimum of 15 days of the effective date of any adverse action by the Agency such as intention to discontinue, withhold, terminate, suspend, reduce assistance or make assistance subject to additional conditions. I understand that I may apply for a Fair Hearing as described above if I disagree with notice of any adverse action.

RESPONSIBILITIES:

I understand that I must fully and accurately report circumstances affecting my eligibility, relating to family relationships, employment or training status, income, place of residence, and telephone numbers, and must provide original documentation to substantiate the information. I must report any changes in these circumstances within 3 business days. I must cooperate with all agency efforts to verify the eligibility information.

I have been informed of the absence policy and that I must provide documentation of excused absences to the child care provider. If my child is absent 6 days or more in one month without an adequate excuse I am aware that he/she will be terminated from the subsidy program. I have also been informed that I must report within 3 days when my child no longer attends a facility. I have been informed that I am required to have an eligibility review completed on _____ (date) and every _____ months thereafter, to determine if I am eligible to continue receiving subsidized child care. I understand that a notice will be sent to the address I have provided informing me of the appointment date and time and if I do not appear for the appointment or reschedule the appointment my child care benefits will be terminated. As noted in paragraph one, I have the right to a fair hearing.

I understand that I am responsible for making all co-payments directly to the child care provider for the entire time the child is enrolled even on days the child is absent. Failure to be up to date with co-payment may result in termination of services prevent me from requesting a placement change.

WARNING TO APPLICANTS:

Government officials will rely on the information you provide on this application to determine your eligibility for Subsidized Child Care Services. You are therefore informed that it is a criminal offense under District of Columbia law for you to knowingly make false or misleading statements on this application. Persons convicted of making false or misleading statements shall be fined up to \$1,000 or imprisoned for up to 180 days or both. By signing your name on Block 10 on the front of this application and below you are certifying that you are aware of the penalties for making false or misleading statements on this application. Accordingly, if you are not sure of the accuracy of the information requested, it is your responsibility to bring the information to the attention of the appropriate government employee prior to signing the application. See D.C. Code § 22-2514

INFORMATION ON SOCIAL SECURITY NUMBER:

In accordance with ACYF-PI-CC-00-04. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. Issuance Date: October 27, 2000, the social security number is not required for determining eligibility for subsidized child care. Eligibility will not be denied should an applicant not provide a Social Security Number. Social Security Numbers will be used solely for searching for records in a database and for identifying individuals with the same name. All applicant files are kept confidential.

I have read and agree to the following:

- I have read and understand my rights and responsibilities, and have attached/will provide the required documents. I certify that this is a true and accurate statement of the financial status and composition of my household.
- I authorized the Subsidized Child Care Program to obtain any verification necessary to both determine and review financial eligibility and child care needs. This authorization includes the release of information regarding my employment, salary, work schedule, and /or training/ school schedule and residence

APPLICANT SIGNATURE: _____ DATE: _____
Print Name

Signature

AGENCY USE ONLY

Annual Gross Income: _____

Family Size: _____ Dependent Children: _____

View ACEDS/ TANF verification: _____ (Yes /No)

Total Parent Copayment: \$ _____ (daily) \$ _____ (weekly, if applicable)

Child 1 _____ Parent Fee: \$ _____ Other Fee: \$ _____

Child 2 _____ Parent Fee: \$ _____ Other Fee: \$ _____

INITIAL ELIGIBILITY DETERMINATION ELIGIBLE
 INELIGIBLE _____
Specify reason if ineligible

I hereby certify that the rights and responsibility have been discussed with the applicant and she/he has signed to verify her/his understanding:

ELIGIBILITY WORKER: _____ DATE: _____
Print Name

Signature

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Income Maintenance Administration
Child Care Services Division



To Whom It May Concern:

This letter is to verify that the person listed below is a Ward of the District of Columbia

Name:
DOB:
SSN:
Address:

I am referring the child(ren) listed for child care assistance. The selected child care provider is

_____.

- | | | |
|------------------|------|------|
| 1. Child's Name: | DOB: | SSN: |
| 2. Child's Name: | DOB: | SSN: |

The Parent is currently attending school in training for _____ hours per week. at
_____. Her current source of income is
_____.

The Parent is currently employed _____ hours per-week:

_____ 3 most recent pay stubs are attached.

_____ Letter to verify employment is attached (*new hires only*) with start date, annual gross income, work hours per week, and the 1st pay day.

If additional information is needed, I can be reached at the contact information below.

Sincerely,

Name & Title:
E-mail address:
Telephone Number
Date: