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: ☐ Early Learning Coalition of St. Lucie County ☐ Early Learning Coalition Indian River · Martin · Okeechobee

FROM: ☐ DCF ☐ Career Source ☐ Communities Connected for Kids ☐ Children's Home Society ☐ Family Preservation Services ☐ Neighbor to Family

SECTION A: CLIENT/FAMILY INFORMATION If address for parent/guardian is a P.O. Box, enter street address in "Comments" below.

County of Residence	Last Name First Name MI (Print)	Date of Birth	Gender	Race
	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

MARITAL STATUS (select one) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

I. Program Status: Career Source Only

☐ Assistance ☐ Non-Assistance

☐ TCA ☐ TCC ☐ Applicant ☐ Recipient ☐ Unemployed Parent ☐ Refugee

☐ TCC Authorized: TCC Begin Date:_____ TCC End Date: _____

II. Primary Purpose of Care: ☒ PROTECTION

Rilya Wilson Act: ☐ Yes ☐ No

At Risk: ☐ PI ☐ PS ☐ FC ☐ Diversion

Medicaid Eligible: ☐ Yes ☐ No

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

Custody: ☐ DCF Placement & Care/Custody ☐ Not Under DCF Placement & Care/Custody

III. Secondary Purpose Of Care: ☐ Emergency ☐ Theraputic 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 childcare provider and state or local agencies for developing an intervention plan. **Developmental Screenings:** ☐ **Yes** ☐ **No** **Child Assessments:** ☐ **Yes** ☐ **No**

Parent/Legal Guardian Signature: _____ Date: _____

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

(Print legal names of child(ren) authorized for care)

Name	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.

Casworker Name:_____ Tel.: _____ Email: _____

Authorizing Worker Signature: _____ Date: _____

Supervisory Approval: _____ Tel.: _____ Date: _____

Coalition: _____ Date: _____

Coalition Use Only: ☐ Income Eligible <100% ☐ Income Eligible 100% <=150% ☐ Income Eligible 150% - 200% ☐ Other _____ ☐ TANF "Child Only" ☐ TANF(Relative Caregiver)

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

SUBMIT REFERRAL TO:

☐ Early Learning Coalition of St. Lucie County
FAX: 772-409-1968

☐ Early Learning Coalition Indian River · Martin · Okeechobee
EMAIL: refer@elcirmo.org

Copy To: Coalition, Applicant/Client, and Referring Agency