



# 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:**  DCF  CareerSource  Communities Connected For Kids  Children's Home Society  Neighbor to Family

## SECTION A: CLIENT/FAMILY INFORMATION

**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:**  Assistance  Non-Assistance  
Career Source Only  
 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  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 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 150% - 200%  TANF "Child Only"  
 Income Eligible 100% <=150%  Other \_\_\_\_\_  TANF(Relative Caregiver)

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

### SUBMIT REFERRAL TO:

