State of Montana
Department of Public Health and Human Services
Human and Community Services Division
Early Childhood Services Bureau
http://www.bestbeginnings.mt.gov

Best Beginnings Child Care Scholarship
Application for TANF / Working Caretaker Relative

This application is for: ☐TANF ☐Working Caretaker Relative

HEAD OF HOUSEHOLD

This is the applicant who is requesting child care assistance and assumes responsibility for following the program rules and requirements, including penalties and repayment of any overpaid benefits.

What is your preferred **spoken** language?	What is your preferred **written** language?	Do you need an interpreter? ☐ Yes ☐ No
LAST NAME	FIRST NAME	MIDDLE NAME

OTHER NAMES YOU MIGHT BE KNOWN AS OR HAVE USED IN THE PAST	E-MAIL ADDRESS

ADDRESS (physical)

CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION

MAILING ADDRESS (if different)

CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION

PHONE: ☐ Cell ☐ Home ☐ Work ☐ Other

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MILITARY STATUS ☐ Not in the Military ☐ Active Duty US Military ☐ National Guard / Military Reserve

Does an agency assist you in housing costs? ☐Yes ☐No

Do you ☐ own ☐ rent ☐ live with relatives ☐ live with someone else ☐ Other:

Do you live in an… ☐ Apartment ☐ House ☐ Mobile Home ☐ Other: _____

If other please specify, for example, hotel, motel, camp ground, shelter

Has a special need been identified for any child in the household? ☐ Yes ☐ No
If yes, please talk more with your caseworker regarding additional services.

Is any child in the household on an IEP or 504 in school, enrolled or referred to Part C (Montana Milestones) or Part B (IDEA)?
☐Yes ☐ No

CHILD CARE PROVIDER INFORMATION

List the provider where your children attend child care. Is this provider a relative? If yes, please indicate the relationship below. If you need a list of child care providers, please contact your regional CCR&R agency.

Provider Name	Provider Address	Phone Number	Relative?

Child's Child Care Schedule – Working Caretaker Relative ONLY

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm

HERE ARE YOUR RIGHTS AND RESPONSIBILITIES

	a. I have the right to choose my child care provider. The scholarship will only pay a child care provider that is licensed, registered, or certified.
	b. I will pay a monthly co-payment to the child care provider. If I have an unpaid co-payment, I will be ineligible when I re-apply for the scholarship until receipts of unpaid copayments are received.
	c. I understand that child care providers may set their own rates. Providers may charge in addition to the child care program co-payment obligation. I am responsible for any amount over and above the state reimbursement rates and any registration and activity fees not paid by the Best Beginnings Child Care Scholarship.
	d. I have the right to appeal any loss of scholarship. I will submit a request for a fair hearing within 90 days of receiving the notice regarding the loss of scholarship.
	e. I have a right to receive a monthly EOB (Explanation of Benefits), which shows the care that has been paid for by the state.
	f.I understand that my Best Beginnings Scholarship will be terminated if my family becomes ineligible or if program funds become unavailable.
	g. I understand this child care scholarship is available only during employability/service plan approved activities, which may be less than the maximum limits indicated on the child care certification plan. If child care is used for non-TANF approved activities, I could be responsible for an overpayment.
	h. I understand my child must be living with me for child care to be paid for under the Best Beginnings Child Care Scholarship.
	i. I will be notified of changes that reduce my child care scholarship. A letter will be mailed 10 days before any loss of benefits.
	j. **Reporting Change in Provider:** I will report a change in child care provider to my regional Child Care Resource and Referral agency within one business day. *Failure to report may mean that the provider will not receive a payment under the scholarship.* The payment start date for the new provider will be the date the change is reported.
	k. **Reporting a Change in Activity Requirements:** I must report a job loss to my regional Child Care Resource and Referral agency within 10 calendar days. *Failure to report within the required 10 calendar may mean that you don't receive a full grace period.*
	l. **Reporting a Change in Address:** I will report a change in address to my regional Child Care Resource and Referral agency within 10 calendar days. *Failure to report may mean that you don't receive timely notice on changes to eligibility.*
	m. **Repayment**: Anyone who causes an improper payment to a provider by withholding information about any of the above changes will be required to repay the amount of the improper payment. Repayment must be current with the Business and Fiscal Services Division.
Instructions: Please initial all above requirements.	

1. *Authorization to Release Information / Request for Verification*

Certain information is needed to determine eligibility. This includes residency, relationship of applicant to children, school attendance, household composition, income, and other circumstances relevant to the need for child care. The Department or this Child Care Resource & Referral agency may request information about any of the issues involved in the Best Beginnings Eligibility Application Packet. You have the responsibility to provide any additional information necessary to determine eligibility. If you are not able to gather the requested information by yourself, your Department representative may be able to help you. Because this is your confidential information, you must give permission for your CCR&R representative to help you.

***Please Note:** This release does not authorize CCR&R staff to obtain any HIPAA-protected information on the behalf of the child(ren), parent(s), or provider(s).

2. *Applicant & Spouse/Other Adult – Please initial option 1 or 2 and sign below*

OPTION 1: Applicant	**OPTION 2: Applicant**
___ I give the Department and the Child Care Resource and Referral agency permission to gather information that is necessary to determine eligibility for my family and me. This authorization expires one year from the date this application is signed. I understand that I can revoke this consent in writing at any time.	___ I **DO NOT** wish to sign an authorization to release information. I understand that because of confidentiality issues, the Department and the Child Care Resource and Referral agency will not be able to help in gathering information necessary to determine eligibility. I choose to provide the necessary documentation myself.
OPTION 1: Spouse/Other Adult	**OPTION 2: Spouse/Other Adult**
___ I give the Department and the Child Care Resource and Referral agency permission to gather information that is necessary to determine eligibility for my family and me. This authorization expires one year from the date this application is signed. I understand that I can revoke this consent in writing at any time.	___ I **DO NOT** wish to sign an authorization to release information. I understand that because of confidentiality issues, the Department and the Child Care Resource and Referral agency will not be able to help in gathering information necessary to determine eligibility. I choose to provide the necessary documentation myself.

I hereby affirm that the statements included in this application are accurate, complete, and true to the best of my knowledge. I understand that I must periodically re-apply for assistance and that my eligibility will be re-determined at that time.

_____ _____

Applicant (or Authorized Representative) Signature Date *Spouse/Other Adult (or Authorized Representative) Signature Date*

CCR&R OFFICE USE ONLY	**CS** _____ **CE**_____	**HoH Name**		**Date Received**
Begin Date	**End Date**	**Reason**	**Determination Date**	**Determined By**