



STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES

REQUEST FOR REDETERMINATION INFORMATION

Child Care Case #: _____

Date of Notice: _____

Approval Ending Date: _____

Reason for Child Care: _____

Client: _____

Caseload Code: _____

Provider(s):

Your eligibility for CHILD CARE needs to be redetermined at this time. Please complete and return this form to us at the address listed below. If we do not receive this information within 10 business days, your child care will be CANCELED. If you are having problems filling out this form, please contact us.

IF YOU'RE EMPLOYED, ATTACH COPIES OF YOUR 2 MOST RECENT PAYSTUBS.

IF YOU'RE ATTENDING A TANF REQUIRED ACTIVITY, ATTACH A COPY OF YOUR CURRENT RSP.

IF YOU'RE ATTENDING SCHOOL, ATTACH A COPY OF YOUR SCHOOL SCHEDULE AND MOST RECENT REPORT CARD.

IF YOU'RE A TEEN PARENT ATTENDING HIGH SCHOOL/GED, ONLY A COPY OF YOUR SCHOOL SCHEDULE IS NEEDED.

List a phone number where we can reach you during the day:

FOR OFFICE USE: _____ 1) Work/On-the-job Training for TANF and Non-TANF
REASON FOR _____ 2) TANF Education/Training Activity or Teen Parent in High School/GED
CHILD CARE _____ 3) TANF Work & Education/Training Activity or Teen Parent Work & High School/GED
_____ 4) Non-TANF Education & Training

TYPE OF EDUCATION/TRAINING _____ 1) High School or GED _____ 4) 2 Year College Degree
CURRENTLY ATTENDING _____ 2) Other Below Post-Secondary _____ 5) 4 Year College Degree
(Check One) _____ 3) Occupational/Vocational

WORK INFORMATION

Employer/Company Name	Job Title
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Address	City	State	Zip Code
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Phone Number	Ext.	Date you started this job:
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Is this a new job since your last application/redetermination? YES NO

If YES, your previous employer's name:	Date previous job ended:
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I earn (before taxes): COMPLETE ONE
_____ per hour _____ per week _____ per month _____ per year:

I get paid (check one): _____ 1) Weekly _____ 2) Every 2 Weeks _____ 3) Twice a Month _____ 4) Monthly	Number of Hours Worked Weekly:
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Be sure to complete the information on pages 2, 3 & 4 and MAIL OR HAND DELIVER (DO NOT FAX) to:

Illinois Action For Children – Child Care Assistance Program
1340 S. Damen Avenue, 3rd Floor, Chicago, IL 60608
Phone (312) 823-1100 Fax (312) 823-1200

Case Name:

WORK SCHEDULE: Please give a typical work schedule (circle am or pm)

Does your schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Do you receive health insurance from your employer? YES NO

How long does it take to travel from the child care provider to work?

SCHOOL/TRAINING/TANF-REQUIRED ACTIVITY INFORMATION

School Name/Training Program				Phone Number			
Address			City		State		ZipCode

How long does it take to travel from the child care provider to school?

SCHOOL SCHEDULE: Please complete the following schedule (circle am or pm)

Does your schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Is the other parent or stepparent of any of the children living in your home?
 NO (Go to Family Information on page 3) YES (Complete the section below)

OTHER PARENT/STEPPARENT INFORMATION

Is the other parent or stepparent working? YES NO
 Is the other parent or stepparent attending school? YES NO
 If the other parent/stepparent is not working or in school, why can't he/she care for the child(ren)?

Other Parent/Stepparent Last Name		First Name	
Social Security Number		Date of Birth	

WORK INFORMATION

Employer/Company Name			Job Title			
Address		City		State		Zip Code

Phone Number _____ Ext. _____ Date they started this job: _____

Is this a new job since the last application/redetermination? YES NO

If YES, previous employer's name: _____ Date previous job ended: _____

They earn (before taxes): COMPLETE ONE
 _____ per hour _____ per week _____ per month _____ per year

They get paid (check one): 1) Weekly 2) Every 2 Weeks
 3) Twice a Month 4) Monthly

Number of Hours Worked Weekly: _____

Case Name:

WORK SCHEDULE: Please give a typical work schedule (circle am or pm)

Does their schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Do they receive health insurance from their employer? YES NO

How long does it take to travel from the child care provider to work?

SCHOOL/TRAINING/TANF-REQUIRED ACTIVITY INFORMATION

School Name/Training Program _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

How long does it take to travel from the child care provider to school?

SCHOOL SCHEDULE: Please complete the following schedule (circle am or pm)

Does their schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

FAMILY INFORMATION

What is your family size? _____ How many adults are in your family? _____
 How many children are in your family? _____ How many children are receiving child care? _____
 Family means the applicant (you); the biological, step or adoptive parent of any children requiring child care who are living in your household; and your biological or adoptive children living in the same household. Other persons who are related to you by blood or law may also be counted if they rely on you for 50% or more of their support.

INCOME INFORMATION: Enter the MONTHLY income for all family members counted in family size. If the income does not apply, write "N/A".

TYPE OF INCOME	CLIENT	FAMILY MEMBERS	FOR OFFICE USE
Gross Employment Income: including tips. Enter any self-employment income below. Attach copies of 2 most recent pay stubs for each person.			
Self-Employment Income			
Child Support Received			
TANF Cash Assistance			
Other Federal Cash Income: For example, Social Security payments and railroad benefits.			
Other Monthly Income: For example, interest income, royalties, pensions, annuities, alimony, ongoing monthly adoption assistance, unemployment compensation, DCFS payments, veteran's pension, survivor's benefits, and permanent disability payments.			
SUBTOTAL			
MINUS: Child Support Paid by Applicant's Family			
TOTAL			

Case Name:

Housing Cash Assistance Including Vouchers With Specific Cash Value:

(For Federal reporting, does not count when totaling Monthly Family Income)

FOR OFFICE USE: PARENT CO-PAYMENT

LIST THE CHILDREN CARED FOR BY EACH PROVIDER If your children go to school, preschool, or Headstart during the day, list only the hours that they are with the child care provider. (This is not a Provider Change Form.)

#1 Provider Name:

CHILD'S NAME	AGE		MON	TUE	WED	THU	FRI	SAT	SUN
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am

#2 Provider Name:

CHILD'S NAME	AGE		MON	TUE	WED	THU	FRI	SAT	SUN
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am

#3 Provider Name:

CHILD'S NAME	AGE		MON	TUE	WED	THU	FRI	SAT	SUN
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am

I certify that:

- All of the above statements are true;
- The information provided is true, correct and accurate;
- The information provided will be disclosed only for administrative purposes and that I may be required to verify the information I have provided;
 - I understand that I am responsible for paying a share of my child care costs (parent co-payment) to my provider and that failure to do so may result in the loss of child care benefits;
 - I understand that I have the right to appeal and to have a fair hearing of a grievance;
- I understand that giving false information or failure to correct information can result in referral for prosecution for fraud.

Client's Signature: _____ Date: _____