



CHILD CARE DEVELOPMENT FUND (CCDF)

County Child Care Subsidy Pre-Application (waitlist application)

YOUR COUNTY _____

Date Completed _____

Last Name _____

Street Address _____

Phone Number: Area Code (____) _____

First Name _____

City _____ Zip _____

Are you a licensed foster parent? Yes No

Are you (check one) Working or Attending School? If you are working, are you paid Weekly Bi-Weekly Other

Is your spouse, OR children(s)/father/mother living with you? Yes No If yes, are they Working, Attending School or

PLEASE NOTE: YOU MUST ATTACH A COPY OF A RECENT PAY-STUB FOR YOURSELF AND YOUR SPOUSE OR CHILDREN(S) FATHER/MOTHER, IF OTHER PARENT LIVES WITH YOU. IF SELF EMPLOYED ATTACH TAX FORM SCHEDULE C (not more than 6 months old) or STATEMENT OF PROFIT AND LOSS

Complete the table below for ALL household members including yourself.

LIST ALL MEMBERS OF THE HOUSEHOLD Last Name, First Name	Date of Birth	Social Security Number (Optional)	Does child need child care services?	Does child have special needs? (See Note)	Relationship to Applicant
			N/A	N/A	SELF
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Special Needs Note: Child must be enrolled in one of the following: Children with Special Health Care Services, First Steps, Public School Special Education (IEP), or Head Start (professionally diagnosed with disabilities); or receiving Supplemental Social Security. (Documentation must be submitted)

Other Sources of Income (other than attached paystub)

Child Support \$ _____ month

Social Security \$ _____ month

*TANF \$ _____ month

Unemployment \$ _____ month

Other \$ _____ month

Please return this form to:
 CASY, 1101 S. 13th Street, 2nd Floor, Terre Haute, IN 47802
 Fax: 812-232-1731
 Phone: 812-232-3952 – Toll Free: 800-886-3952

*Must provide proof of TANF benefit

I hereby certify all the information provided is true and correct to the best of my knowledge. I understand submission of this application does not guarantee services will be provided. Further, I understand I will be asked to verify information supplied on this pre-application when/ if I complete an application for services.

Signed, _____ Date _____

Your pre-application must be renewed every 90 days. This process is initiated by the Intake Agency by mail. Please notify the agency of any changes to your application, including address.

