

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**APPLICATION FOR CHILD CARE ASSISTANCE**

**ATTENTION:** This application is used to apply **ONLY** for **Category 2 or 3 Child Care Assistance**. To apply for Public Assistance or other benefits, including Category 1 Child Care Assistance, you must use the *Statewide Common Application (LDSS-2921)*.

CASE NAME		CASE #	REGISTRY #	OFFICE	UNIT	WORKER	APP DATE / /
DISTRICT	CASE TYPE: <b>40</b>	Services Transaction Type: <input type="checkbox"/> New Open <input type="checkbox"/> Reopen <input type="checkbox"/> Recert			Disposition: <input type="checkbox"/> Denial Reason Code		<input type="checkbox"/> Withdrawal

**SECTION 1. APPLICANT'S INFORMATION**

FIRST NAME	M.I.	LAST NAME (Please include any ALIASES or MAIDEN names in parentheses)			PHONE NUMBER
STREET ADDRESS		APT NO.	CITY		STATE ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		APT NO.	CITY		STATE ZIP CODE
FORMER ADDRESS				OTHER PHONE NUMBERS WHERE YOU CAN BE REACHED	
What is your marital status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
What is the primary language spoken in your home? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify)					

**SECTION 2. LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. LIST YOURSELF ON THE FIRST LINE.**

L N	FIRST Name	M. I.	LAST Name (Please include any ALIASES or MAIDEN names in parentheses)	DATE OF BIRTH (MM/DD/YY)	SE X M/ F	RELATION- SHIP TO YOU	SOCIAL SECURITY NUMBER (SSN) <i>Optional</i>	Enter Y (Yes) or N (No) if Hispanic or Latino					FOR EACH CHILD, Enter Y (Yes) or N (No):			
								H	Enter Y (Yes) or N (No) for each Race*				Child is U.S. Citizen ?	Child needs child care?	Child with a disability?	Both parents reside in home?
									I	A	B	P				
1						SELF							N/A	N/A	N/A	N/A
2																
3																
4																
5																
6																
7																
8																

\* Racial Affiliation Codes: I – Native American or Alaskan Native, A – Asian, B – Black or African American, P – Native Hawaiian or Pacific Islander, W - White

You may use the back or additional pages if you need more room or there is other information that you think we might need.

**SECTION 3. OTHER HOUSEHOLD INFORMATION**

<p><b>DO ANY OF THESE APPLY TO YOU?</b></p> <p><b>For each of the following, answer YES or NO:</b></p>	YES	NO	Need child care to <b>work</b> .
	YES	NO	Need child care for <b>another reason</b> . Give reason:
	YES	NO	<b>Homeless</b> (no fixed, regular, and adequate place to stay at night).
	YES	NO	A parent is serving full-time in the <b>U.S. Military</b> .
	YES	NO	A parent is a member of a <b>National Guard or Military Reserve unit</b> .
	YES	NO	Receiving or applying for <b>Public Assistance</b> through a different application.
	YES	NO	Receiving or applying for <b>other child care funding</b> . Agency Name:
	YES	NO	<b>Pregnant</b> . Due date?

**SECTION 4. LIST EVERYONE UNDER 21 WHOSE PARENT IS NOT IN THE HOUSEHOLD.**

NAME OF PERSON UNDER 21	ABSENT PARENT'S NAME AND ADDRESS	Absent Parent's Date of Birth <i>(optional)</i>	Absent Parent's Social Security Number <i>(optional)</i>

**SECTION 5. APPLICANT'S EMPLOYMENT INFORMATION**

APPLICANT'S EMPLOYER'S NAME		WORK PHONE	START DATE OF JOB
EMPLOYER'S ADDRESS		CITY	STATE
			ZIPCODE
# of HOURS PER WEEK:	GROSS INCOME: \$	Paid how often? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other, specify	
Does the job have rotating or variable shifts? YES NO		Does the job require overtime, O/T? YES NO	
Scheduled Days and Hours Worked (e.g., Mon-Fri 8 A.M. – 4 P.M.):			

**SECTION 6. OTHER EMPLOYMENT INFORMATION. Use this section for an applicant's second job or a spouse's/other parent's job.**

Whose job information? <input type="checkbox"/> Applicant's job OR <input type="checkbox"/> Spouse's / other parent's job			
EMPLOYER'S NAME		WORK PHONE	START DATE OF JOB
EMPLOYER'S ADDRESS		CITY	STATE
			ZIPCODE
# of HOURS PER WEEK:	GROSS INCOME: \$	Paid how often? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other, specify	
Does the job have rotating or variable shifts? YES NO		Does the job require overtime? YES NO	
Scheduled Days and Hours Worked (e.g., Mon-Fri 8 A.M. – 4 P.M.):			

*You may use the back or additional pages if you need more room or there is other information that you think we might need.*

**SECTION 7. INCOME INFORMATION**

Indicate if you or anyone who is applying with you receives money from:	YES	NO	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)
Wages/Salary, including overtime, commissions, training programs, tips								
Self-Employment								
Child Support Payments (received)								
Alimony/Spousal Support (received)								
Unemployment Insurance Benefits								
Social Security Benefits (including SSI)								
Disability Benefits (NYS, VA, Private)								
Rental/Boarder/Lodger Income (received)								
Dividends/Interest - Stocks, Bonds, Savings								
Pensions/Annuities								
Public Assistance (PA) Grant								
Other (please specify)								

**SECTION 8. TRAVEL TIME BETWEEN CHILD CARE PROVIDER AND WORK/EDUCATIONAL/OTHER APPROVED ACTIVITY**

<b>DROP-OFF</b>	Travel time from the child care provider to work/activity?	Public Transportation?	YES	NO
<b>PICK-UP</b>	Travel time from work/activity to the child care provider?	Public Transportation?	YES	NO

**SECTION 9. NOTICES. READ THE IMPORTANT CERTIFICATIONS AND CONSENTS BELOW.**

**PENALTIES** – Federal and state laws provide for penalties of fine, imprisonment, or both if you do not tell the truth when you apply for Child Care Assistance or when you are questioned about your eligibility, or if you cause someone else not to tell the truth regarding your application or continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial or continuing eligibility for Child Care Assistance; or if you conceal or fail to disclose facts that would affect the right of someone, for whom you have applied, to obtain or continue to receive Child Care Assistance. If you are the authorized representative applying on behalf of someone else, Child Care Assistance must be used for that person and not yourself. It is unlawful to obtain Child Care Assistance by concealing information or providing false information.

**CITIZENSHIP** – I understand that by signing this application form I certify, under penalty of perjury, that all the children in need of Child Care Assistance are United States citizens or nationals or persons with satisfactory immigration status. I understand that this information about these children may be submitted to the Immigration and Naturalization Service for verification of immigration status, if applicable. I further understand that the use or disclosure of this information about these children is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of provisions of the Child Care Assistance program.

**CHANGE REPORTING** – I understand that by signing this application form I agree to inform the agency **immediately** of any change in my needs, income, living arrangement or address to the best of my knowledge or belief. I agree to inform the agency immediately of any change in child care arrangements, including where child care is provided, who is providing care, provider’s fees, and hours for which child care is needed.

**CONSENT FOR INVESTIGATION** – I understand that by signing this application form I agree to cooperate fully with any investigation to verify or confirm the information I have given or any other investigation in connection with my request for Child Care Assistance. I will provide additional information if it is requested.

**NON-DISCRIMINATION** – This application will be considered without regard to race, color, sex, disability, religious creed, national origin or political belief.

**RESOURCES** – I certify that my family resources do not exceed \$1,000,000 and my family’s income does not exceed 85 percent of the state median income for a family of the same size.

**SECTION 10. CERTIFICATION AND SIGNATURE**

**CERTIFICATION:** I swear and/or affirm under the penalties of perjury that all of the information I have given or will give to the local Department of Social Services relating to Child Care Assistance is correct. I have read and understand the notices above. I understand and agree to the consents.

<b>APPLICANT'S/REPRESENTATIVE'S SIGNATURE</b>	<b>DATE SIGNED</b>	<b>SECOND APPLICANT'S SIGNATURE</b>	<b>DATE SIGNED</b>
X		X	
<b>PRINT NAME:</b>		<b>PRINT NAME:</b>	

<p><b>RETURN YOUR APPLICATION TO: THE LOCAL DEPARTMENT OF SOCIAL SERVICES (DSS) OF THE COUNTY YOU LIVE IN.</b></p>	<p>Suffolk County Department of Social Services                  FCSA Child Care Unit                  POB 18100                  Hauppauge NY 11788-8100</p>
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**SECTION 11. IF YOU WANT TO WITHDRAW YOUR APPLICATION**

I CONSENT TO WITHDRAW MY APPLICATION FOR CHILD CARE ASSISTANCE. I understand I may reapply at any time.	<b>DATE SIGNED</b>
SIGNATURE X _____	

<b>FOR AGENCY USE ONLY:</b>									
<b>CASE NAME</b>	<b>CASE #</b>	<b>REGISTRY #</b>	<b>VERSION #</b>	<b>RE-USE INDICATOR</b>	<b>DISTRICT:</b>	<b>DATE</b>			
				<input type="checkbox"/>	<b>CASE TYPE: 40</b>				
<b>SERVICES TRANS TYPE:</b> <input type="checkbox"/> New Open <input type="checkbox"/> Reopen <input type="checkbox"/> Recert			<b>Disposition:</b>	<input type="checkbox"/> Denial	<b>Reason Code</b>			<input type="checkbox"/> Withdrawal	
<b>ELIGIBILITY DETERMINED BY</b>			<b>DATE</b>	<b>ELIGIBILITY APPROVED BY</b>			<b>DATE</b>		
<b>CHILD CARE AUTHORIZATION FROM DATE</b>		<b>CHILD CARE AUTHORIZATION TO DATE</b>			<b>COMMENTS:</b>				
<b>L1 CIN:</b>	<b>L4 CIN:</b>	<b>L7 CIN:</b>							
<b>L2 CIN:</b>	<b>L5 CIN:</b>	<b>L8 CIN:</b>							
<b>L3 CIN:</b>	<b>L6 CIN:</b>	<b>L9 CIN:</b>							

# NYS Agency-Based Voter Registration Form



"If you are not registered to vote where you live now, would you like to apply to register here today?"

- YES** (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)
- NO** because I choose not to register OR
- I am already registered at my current address OR
- I asked for and received a mail registration form.
- If you do not check any box, you will be considered to have decided not to register to vote at this time.**

(Signature) \_\_\_\_\_

(Date) \_\_\_\_\_

(Please Print Name) \_\_\_\_\_

## Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজীতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

## VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (07/2012)

Yes, I need an application for an Absentee Ballot worker

Yes, I would like to be an Election Day

Please print or type in blue or black ink

<b>1</b>	Are you a U. S. citizen?		<b>2</b>	Will you be 18 years old on or before election day?		<b>For Board use only!</b>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If you answered NO, do not complete this form.		If you answered NO, do not complete this form unless you will be 18 by the end of the year.				
<b>3</b>	Last Name	First Name	Middle Initial	Suffix		
<b>4</b>	Address where you live (do not give P.O. address)		Apt. No.	City/Town/Village	Zip Code	County
<b>5</b>	Address where you get your mail (if different from above)		P.O. Box, star route, etc.	Post Office	Zip Code	
<b>6</b>	Date of Birth	<b>7</b>	Sex (circle)	<b>8</b>	Home Tel. Number (optional)	<b>9</b>
		M	F			
<b>10</b>	The last year you voted	Your Address was (give house number, street and city)			ID Number—Check the applicable box and provide your number: <input type="checkbox"/> New York DMV Number _____ <input type="checkbox"/> Last four digits of your Social Security Number _____ <input type="checkbox"/> I do not have a New York Driver's license number _____	
	In county/state	Under the Name (if different from your name now)				
<b>11</b>	<b>Choose a party -- Check one box only</b> <input type="checkbox"/> Democratic Party <input type="checkbox"/> Republican Party <input type="checkbox"/> Conservative Party <input type="checkbox"/> Working Families Party <input type="checkbox"/> Independence Party <input type="checkbox"/> Green Party <input type="checkbox"/> Other (write in) _____ <input type="checkbox"/> I do not wish to enroll in a party			<b>12</b>	<b>AFFIDAVIT:</b> I swear or affirm that • I am a citizen of the United States. • I will have lived in the county, city or village for at least 30 days before the election. • I will meet all requirements to register to vote in New York State. • This is my signature or mark on the line below. • The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years. _____ (Signature or Mark in Ink)	
						(Date)

## (Optional) Register to donate your organs and tissues

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_  
 Address \_\_\_\_\_  
 Apt Number \_\_\_\_\_ Zip Code \_\_\_\_\_  
 City \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Sex  M  F  
 Eye Color \_\_\_\_\_ Height \_\_\_ Ft. \_\_\_ In.

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.



Sign \_\_\_\_\_

Date \_\_\_\_\_

## Qualifications for Registration

### You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

### To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and not claim the right to vote elsewhere.

## Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

**NYS Board of Elections**

**40 North Pearl St, Suite 5**

**Albany, NY 12207-2729**

**Telephone: 1-800-469-6872;**

**TDD/TTY users contact the New York State Relay at 711;**

or visit our web site - [www.elections.ny.gov](http://www.elections.ny.gov)

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

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## Verifying your identity

We will try to check your identity before Election Day, through the **DMV number (driver's license number or non-driver ID number)**, or the **last four digits of your social security number**, which you will fill in Box 9.

**If you do not have a DMV or Social Security number**, you may use a valid photo ID, a current utility bill, bank statement, pay-check, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

**If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.**

## To complete this form:

**It is a crime to procure a false registration or to furnish false information to the Board of Elections.**

**Box 9:** You must make one selection. For questions refer to *Verifying your identity* above.

**Box 10:** If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

**Box 11:** Check one box only. To vote in a primary election, you must be enrolled in one of these listed parties — Except the Independence Party, which permits non-enrolled voters to participate in certain primary elections.

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