

State of Michigan

PURPOSE: This is the Michigan Child Development and Care (CDC) Application used to apply for child care assistance. You may be eligible to get help for your child care expenses if you need to work, complete your education or training, or complete treatment activities. Additional information on the CDC program, including income requirements, benefits, and providers can be found at: www.michigan.gov/childcare.

YOU MAY QUALIFY FOR CHILD CARE ASSISTANCE IF YOU ARE:

- A family with low income.
- A licensed foster parent requesting care for foster children.
- A recipient of a protective services case participating in a treatment plan.
- A recipient of Family Independence Program (FIP) or Supplemental Security Income (SSI).
- A FIP applicant doing a required work participation program activity.
- A Migrant farmworker.
- Homeless.

APPLICATION INSTRUCTIONS:

Please complete each step below. The application can also be used as an electronic form that you can complete on your computer and print out. If you need help with reading, writing, or hearing, or have other special needs, please tell us by contacting your local MDHHS office. If you need an interpreter, we may be able to help you.

- Read all instructions carefully and answer **all** questions in the application completely. If the question does not apply to you, mark it with "NA" (not applicable). **You must answer all of the questions before your application can be processed.**
- If you need more room, print the file named "[CDC Application- Additional Space](#)" and include that with this application. The file can be found at: www.michigan.gov/childcare.
- Provide proof of all the information requested in this application. A list of [acceptable forms of proofs](#) can be found at www.michigan.gov/childcare. Copies of original documents should be sent in with this application. **Do not send in original documents**, you may not receive them back. Information includes:
 - Proof of identification for each adult and child in your family. Please note that you do not have to provide your Social Security Number (SSN). However, it can be helpful for the eligibility process.
 - Proof of your residence.
 - Proof of your income and employment.
- Carefully read the "Rights and Acknowledgements" section of this form located on Page 7. Sign and date Page 7.
- Take the completed application and proofs to your local MDHHS county office or mail, fax or use the online application at www.mibridges.michigan.gov. A list of county offices can be found at: [MDHHS County office list](#). Get a receipt when you submit your application for your records. You can also mark the date you submitted your application in the box at the top of this page. Keep this page for your records.

The application will be assigned to a MDHHS benefit specialist, who will work with you to gather all the information needed to see if you qualify for CDC benefits. You may receive a request for more information to help us determine your eligibility for the CDC program. It may take up to 30 days for you to hear if you qualify for benefits. More information on the application process can be found at the [CDC child care website](#).

The completion of this application does not guarantee you will receive child care assistance. If you qualify for CDC benefits, you will need to select a child care provider for your children. If you need help finding a CDC provider, please visit [Great Start to Quality](#) website for a list of available providers.

If you have questions about completing this application or have problems getting the information you need, please contact your local MDHHS office.

Turn to the next page to begin the application.

For additional assistance, please contact your local MDHHS Office

**State of Michigan
Child Development and Care (CDC) Program Application**

SECTION 1: APPLICANT INFORMATION

Tell us about you and where you live.

- Include proof of your identity. A list of acceptable proofs can be found at: www.michigan.gov/childcare
 Include proof of your residence. A list of acceptable proofs can be found at: www.michigan.gov/childcare

Last Name				First Name				Middle Name							
Other Names You Might Be Known As				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				Birth Date (MM/DD/YYYY)				Social Security # (SSN) (optional)			
Check where you live: <input type="checkbox"/> House/Apartment/Mobile Home <input type="checkbox"/> Shared House/Apartment/Mobile Home <input type="checkbox"/> Homeless <input type="checkbox"/> Other (List)															
Address															
City				State				County				Zip Code			
Mailing address (if different from above or PO Box)															
City				State				County				Zip Code			
Home Phone				Cell Phone				Work Phone				TTY#			
What is your preferred spoken language?				What is your preferred written language?				Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed															
Are you or anyone in your household a migrant farmworker? Yes <input type="checkbox"/> No <input type="checkbox"/>															
Ethnicity (optional) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino				Race (optional) <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native – Enter tribe name <input type="checkbox"/> Pacific Islander or Native Hawaiian <input type="checkbox"/> White											
I need child care services for (check all that apply): <input type="checkbox"/> Work <input type="checkbox"/> High School or GED Completion <input type="checkbox"/> Education/Training/Employment Preparation <input type="checkbox"/> PATH program or other approved activity <input type="checkbox"/> Treatment for Health or Social Condition (explain):						I need study time for (check all that apply). Include the # of hours you need weekly. <input type="checkbox"/> High School or GED Completion # Hours Weekly: <input type="checkbox"/> Education # Hours Weekly:									
Have you ever received child care assistance from the CDC program? <input type="checkbox"/> Yes <input type="checkbox"/> No															
If yes, when?				Where? (City)				(County)							
Is either parent active duty U.S. Military? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who?						Is either parent active duty or reserve National Guard? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who?									

Continue to Next Page

For additional assistance, please contact your local MDHHS Office

SECTION 2: LIST ALL PERSONS LIVING IN YOUR HOME

Tell us about all the adults living in your home. Fill out the [CDC Application- Additional Space sheet](#) if you need extra space. You can find that sheet at www.michigan.gov/childcare.

List all additional adult members of your household. Include family members who do not live with you, but are expected to return to your home. You do not need to list the person applying.

Name (First, Middle, Last):

Date of Birth	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive SSI benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name (First, Middle, Last):

Date of Birth	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive SSI benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name (First, Middle, Last):

Date of Birth	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive SSI benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Tell us about all the children living in your home. Fill out the [CDC Application- Additional Space sheet](#) if you need extra space. You can find that sheet at: www.michigan.gov/childcare

List all the children in your house.

Children:

List all children under the age of 18 in your home, or who may be returning to your home.

Include proof of each child's age. A list of acceptable proofs can be found at: www.michigan.gov/childcare

Child Name (First, Middle, Last):

Date of Birth	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive SSI benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Parent Name	Living at home with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?	Address, if different?	Parent's Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> In Prison <input type="checkbox"/> Military <input type="checkbox"/> Deceased <input type="checkbox"/> Absent for other reason		
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Parent Name	Living at home with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?	Address, if different?	Parent's Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> In Prison <input type="checkbox"/> Military <input type="checkbox"/> Deceased <input type="checkbox"/> Absent for other reason		
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Does child receive child support? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, from whom? <input type="checkbox"/> Father <input type="checkbox"/> Mother	Who receives the child support?	How much support is received each month? \$
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Does the child need child care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Name	Provider ID(if known)
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Continue to Next Page.

For additional assistance, please contact your local MDHHS Office

SECTION 2 (Continued):

Child Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive SSI benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent Name, if different than Child above	Living at home with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?	Address, if different than Child above		Parent's Status: <input type="checkbox"/> Married <input type="checkbox"/> Military <input type="checkbox"/> Divorced <input type="checkbox"/> Deceased <input type="checkbox"/> Separated <input type="checkbox"/> Absent for other reason <input type="checkbox"/> In Prison	
Parent Name, if different than Child above	Living at home with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?	Address, if different than Child above		Parent's Status: <input type="checkbox"/> Married <input type="checkbox"/> Military <input type="checkbox"/> Divorced <input type="checkbox"/> Deceased <input type="checkbox"/> Separated <input type="checkbox"/> Absent for other reason <input type="checkbox"/> In Prison	
Does child receive child support? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, from whom? <input type="checkbox"/> Father <input type="checkbox"/> Mother		Who receives the child support?	How much support is received each month? \$	
Does the child need child care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Name			Provider ID (if known)	

Child Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receive SSI benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent Name, if different than Child above	Living at home with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?	Address, if different than Child above		Parent's Status: <input type="checkbox"/> Married <input type="checkbox"/> Military <input type="checkbox"/> Divorced <input type="checkbox"/> Deceased <input type="checkbox"/> Separated <input type="checkbox"/> Absent for other reason <input type="checkbox"/> In Prison	
Parent Name, if different than Child above	Living at home with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?	Address, if different than in Child above		Parent's Status: <input type="checkbox"/> Married <input type="checkbox"/> Military <input type="checkbox"/> Divorced <input type="checkbox"/> Deceased <input type="checkbox"/> Separated <input type="checkbox"/> Absent for other reason <input type="checkbox"/> In Prison	
Does child receive child support? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, from whom? <input type="checkbox"/> Father <input type="checkbox"/> Mother		Who receives the child support?	How much support is received each month? \$	
Does the child need child care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Name			Provider ID (if known)	

SECTION 3: OTHER INFORMATION (Check all that apply)

<input type="checkbox"/>	I only need child care to participate in an activity required by MDHHS Protective Services.
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SECTION 4: INCOME INFORMATION (Complete subsections A-C below)

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For additional assistance, please contact your local MDHHS Office

SECTION 4.A: EMPLOYMENT INCOME (Wages)

List all income for you and members living in your house. Fill out the CDC Application- Additional Space sheet if you need extra space. You can find that sheet at: www.michigan.gov/childcare.

Attach copies of proofs below to the application.

Proof of work schedule and all income for the most current 30 days, such as wages, tips, commissions and bonuses. A list of acceptable proofs can be found at: www.michigan.gov/childcare.

Person Employed	Employer Name	Job Title/Type of Work	
Employer's Address	Work Telephone #	Will employment continue? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If new job, first date of paycheck:	Day of week pay is received:	Most recent paycheck date:	
Work Schedule	Wednesday (AM/PM)	Average # of hours expected to work: # Hours Per	Total Monthly Income \$
Sunday (AM/PM)	Thursday (AM/PM)		
Monday (AM/PM)	Friday (AM/PM)		
Tuesday (AM/PM)	Saturday (AM/PM)		
Rate of pay \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____	How often are you paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Other	Do you receive a bonus or commission? <input type="checkbox"/> Bonus <input type="checkbox"/> Commission If YES, how much?	
Do you work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No How often?	Do you receive extra tips? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, average tips \$ _____ Per <input type="checkbox"/> Shift <input type="checkbox"/> Week		

Person Employed	Employer Name	Job Title/Type of Work	
Employer's Address	Work Telephone #	Will employment continue? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If new job, first date of paycheck:	Day of week pay is received:	Most recent paycheck date:	
Work Schedule	Wednesday (AM/PM)	Average # of hours expected to work: # Hours Per	Total Monthly Income \$
Sunday (AM/PM)	Thursday (AM/PM)		
Monday (AM/PM)	Friday (AM/PM)		
Tuesday (AM/PM)	Saturday (AM/PM)		
Rate of pay \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other _____	How often are you paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Other	Do you receive a bonus or commission? <input type="checkbox"/> Bonus <input type="checkbox"/> Commission If YES, how much?	
Do you work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No How often?	Do you receive extra tips? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, average tips \$ _____ Per <input type="checkbox"/> Shift <input type="checkbox"/> Week		

SECTION 4.B: SELF-EMPLOYMENT

Complete this section if you or someone in your house is self-employed.

Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property. Attach copies of proofs below to the application:

All self-employment income and expenses, such as federal tax returns or business ledgers. A list of acceptable proofs can be found at: www.michigan.gov/childcare.

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For additional assistance, please contact your local MDHHS Office

SECTION 4.B: SELF-EMPLOYMENT (Continued)

Person Employed	Business Name	Type of Work	
Business Address	Business Phone #	Start Date	Date of last paycheck
Estimated hours of self-employment work per day? Sunday Monday Tuesday Wednesday Thursday Friday Saturday		Total Monthly Income (Before expenses) \$	

Person Employed	Business Name	Type of Work	
Business Address	Business Phone #	Start Date	Date of last paycheck
Estimated hours of self-employment work per day? Sunday Monday Tuesday Wednesday Thursday Friday Saturday		Total Monthly Income (Before expenses) \$	

SECTION 4.C: UNEARNED INCOME

Income Type	Name of person receiving income	How often received?	Amount	Expected to continue?	Date expecting (if not receiving now)
<input type="checkbox"/> Money from friends or relatives, etc.			\$		
<input type="checkbox"/> Social Security benefits			\$		
<input type="checkbox"/> Unemployment compensation			\$		
<input type="checkbox"/> State Disability Assistance (SDA)			\$		
<input type="checkbox"/> Pension/retirement benefits			\$		
<input type="checkbox"/> Worker's compensation			\$		
<input type="checkbox"/> Child support			\$		
<input type="checkbox"/> Education grants or loans			\$		
<input type="checkbox"/> Gaming distribution (lottery)			\$		
<input type="checkbox"/> Income/payments from a tribe (tribal GA, land claims, casino profit sharing, etc.)			\$		
<input type="checkbox"/> Housing assistance			\$		
<input type="checkbox"/> Disability benefits			\$		
<input type="checkbox"/> Crops and farm income			\$		
<input type="checkbox"/> Veteran's benefits			\$		
<input type="checkbox"/> Military allotments			\$		
<input type="checkbox"/> Land contract, mortgage or rental income Name of tenant:			\$		
<input type="checkbox"/> Other			\$		

SECTION 5: ASSETS

Does the family have total assets that exceed one million dollars?

Yes No

For additional assistance, please contact your local MDHHS Office

SECTION 6: RIGHTS, ACKNOWLEDGEMENTS, AND SIGNATURE

By signing, you agree to the following:

1. **APPLICATION:** I understand that I have the right to file an application at any time, including prior to any meeting with MDHHS. My application must be approved or denied within 30 days from when it is received by the MDHHS.
2. **NON-DISCRIMINATION:** I understand that if I believe I have been discriminated against because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, gender identity, handicap, or political beliefs, I have the right to file a complaint with the Secretary, Department of Health and Human Services in Washington, D.C.
3. **PROGRAM BENEFITS:** I understand that my child or children must be approved for the CDC program before I will receive assistance with child care expenses. I am responsible for all child care expenses that are not paid by the CDC program, including child care expenses collected while my eligibility for the CDC program is being determined.
4. **REPORTING REQUIREMENTS:** I understand that I need to report the following changes within 10 calendar days to my MDHHS specialist:
 - Change in provider’s or child care setting
 - Residence
 - Household members
 - When the program group’s income exceeds the eligibility income scale for the family size
 - If assets exceed one million dollars
 - I understand that if I do not report these changes, or make false or misleading statements, I can be prosecuted for fraud or perjury.
 - If I report a change that results in my benefits being reduced, the reduction may occur before I am notified.
 - I will contact my MDHHS specialist if I have any questions about whether to report a change.
5. **REPAYMENT OF BENEFITS:** I understand if my provider or I are overpaid by the Department for any reason, the extra money will have to be repaid. If I or someone representing me intentionally provides information that results in an overpayment, I could be prosecuted for fraud.
6. **PROGRAM PENALTIES:** I understand that if I violate any of the program rules, I may be disqualified from the program for six (6) months, 12 months, or a lifetime.
7. **HEARINGS:** I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to ask for an Administrative Hearing. To request information about an Administrative Hearing, I can call my local MDHHS office, or send a written request for an Administrative Hearing to my local MDHHS office.
8. **AFFIDAVIT:** I swear that all the information I have written on this form or told to a MDHHS specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. If I have intentionally left out any information or given false information that causes me to receive benefits I am not entitled to, or more benefits than I am entitled to, I understand that I can be prosecuted for fraud.
9. **RELEASE OF INFORMATION:** I authorize the Department to provide information to my child care provider(s) if I am approved for CDC services, when there are changes in my case information previously given to the provider, or when my application for CDC program is denied, withdrawn, or closed. I also authorize MDHHS or any child care provider that may provide care for my child(ren) to release information necessary to determine my right to benefits under any other local, state or federal program. I authorize the Social Security Administration to give the Department all information necessary to determine my eligibility for the CDC program.
10. **COMPUTER CROSS-CHECKING:** I understand that the Department may check with federal, state and private agencies to make sure the information I provide on this application is correct. This may include check wages, income, unemployment benefits, income tax refunds, Social Security benefits and numbers, immigration status, etc.
11. **CDC PROVIDERS:** The child care I select must be provided in Michigan by either a licensed child care center, licensed group child care home, registered family child care home, or an enrolled unlicensed provider who provides care in the home where the child lives, or a family member who meets relative status to the child and who provides the care in his/her home.
 - I understand that my provider is not employed by the State of Michigan. My provider receives a payment that is issued on my behalf by the MDE.
 - If I choose an unlicensed provider, he or she will not be enrolled in the CDC program or will not receive payment:
 - If he or she, or any adult reported as living in the provider's home, is on the central registry as a perpetrator on a substantiated Children’s Protective Services case or has been charged or convicted of certain disqualifying crimes.
 - If he or she has not completed the GSQ Orientation requirement (referred to as the Great Start to Quality Orientation). Any care provided prior to his/her training date will be not paid by the State of Michigan.
12. **Review:** My records may be selected for review. If selected, a State of Michigan representative might call me and other people in order to verify my eligibility for the CDC program.

SIGNATURE: I HAVE READ AND UNDERSTAND ALL PARTS OF THIS FORM.

Signature of applicant or representative	Date of signature	Telephone #
Signature of Witness	Date of signature	

Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a MDHHS office in your area. This form is issued under authority of Public Act 280 of 1939. Completion of this form is voluntary. However, if it is not completed, your eligibility cannot be determined and you will not receive child care services.

For additional assistance, please contact your local MDHHS Office