



Si quisiera recibir este material en español
sírvese llamar al 1-888-214- KIDS (5437).

Redetermination Form

Care 4 Kids ▪ 1344 Silas Deane Hwy ▪ Rocky Hill, CT 06067-1339

DEAF AND HEARING IMPAIRED INDIVIDUALS MAY USE TTD/TTY LINE 1-877-455-9169

It is time to complete your redetermination for the Care 4 Kids Program. Here is what you need to do:

- FILL OUT THIS THREE-PAGE REDETERMINATION FORM. IF YOU HAVE ANY QUESTIONS OR NEED HELP, CALL **1-888-214-KIDS (5437)**.
- COLLECT THE INFORMATION YOU NEED TO SEND BACK WITH THIS REDETERMINATION FORM.
- HAVE EACH CHILD CARE PROVIDER YOU USE FILL OUT THE PINK TWO-PAGE PARENT PROVIDER AGREEMENT FORM, ALSO CALLED A PPA. IF YOUR PROVIDER IS NEW TO THE CARE 4 KIDS PROGRAM, THE PROVIDER ALSO NEEDS TO FILL OUT A W-9 FORM AND RETURN IT WITH THE COMPLETED PPA. IF YOU HAVE MORE THAN ONE PROVIDER OR NEED ANOTHER PPA OR W-9 FORM, CALL **1-888-214-KIDS (5437)**.
- IF YOU NEED HELP FINDING A LICENSED CHILD CARE PROVIDER, CALL THE CHILD CARE **INFOLINE** AT **211** OR **1-800-505-1000**.
- SEND YOUR **COMPLETED REDETERMINATION FORM, THE PINK PPA AND COPIES** OF THE INFORMATION WE REQUESTED TO THE ABOVE CARE 4 KIDS ADDRESS. DO NOT SEND ORIGINALS OF REQUESTED INFORMATION. CARE 4 KIDS WILL NOT RETURN ORIGINAL DOCUMENTS. BE SURE TO PUT ENOUGH POSTAGE ON YOUR ENVELOPE.

CHECKLIST DO NOT FORGET TO SEND IN ALL THE INFORMATION ASKED FOR *:

- **PROOF OF INCOME, LIKE PAYCHECK STUBS OR COPIES OF SOCIAL SECURITY OR OTHER BENEFITS CHECKS OR AWARD LETTERS**
- **CHILD SUPPORT DOCUMENTS, IF NECESSARY**

* IF YOU DO NOT HAVE ALL YOUR INFORMATION NOW, SEND IN THE REDETERMINATION FORM WITH THE INFORMATION YOU HAVE AND SEND THE REST OF THE INFORMATION IN AS SOON AS YOU HAVE IT.

Section 1: Head of Household Information (Tell us who you are) ◀

THE HEAD OF HOUSEHOLD IS THE PARENT OR AN ADULT RESPONSIBLE FOR THE CHILD(REN). IF THE PARENT IS UNDER THE AGE OF 18 AND LIVING WITH AN ADULT, THE ADULT IS CONSIDERED THE HEAD OF HOUSEHOLD AND MUST COMPLETE AND SIGN THIS REDETERMINATION FORM.

Care 4 Kids Family ID _____

HAVE YOU EVER APPLIED FOR CASH, MEDICAL OR FOOD STAMP ASSISTANCE FROM THE **DEPARTMENT OF SOCIAL SERVICES (DSS)**? IF **YES**, WHAT IS YOUR DSS CLIENT ID NUMBER? _____ Care 4 Kids Family ID _____

First name _____ Middle Initial _____ Last name _____ Date of Birth _____

Address _____ Apt _____

City _____ State _____ Zip _____ Home phone _____ Work phone _____

Social Security Number (optional) _____

Sex: Female Male Marital Status: Married Single Separated

Race: (circle all that apply) **AA** - American Indian/Alaskan Native **A** - Asian **B** - Black
NP - Native Hawaiian/Pacific Islander **W** - White **U** - Unknown

Hispanic: Yes No Marque aquí si desea recibir cartas y formularios en español.
(Check here if you want to receive letters and forms in Spanish.)

Section 2: Children Information (Tell us about all the children living in your home) ◀

TABLE A: CHILDREN WHO NEED CHILD CARE

- IN THIS SECTION, PLEASE LIST ONLY THOSE CHILDREN WHO NEED CHILD CARE ASSISTANCE FROM THIS PROGRAM.
- TO BE ELIGIBLE, MOST CHILDREN MUST BE UNDER AGE 13. CHILDREN WITH SPECIAL NEEDS MAY BE ELIGIBLE UP TO AGE 19. SPECIAL NEEDS MAY INCLUDE A PHYSICAL OR MENTAL IMPAIRMENT, A SEVERE BEHAVIORAL DISTURBANCE OR DEVELOPMENTAL DELAY. SPECIAL NEEDS MUST BE CONFIRMED BY A HEALTH CARE PROFESSIONAL AND THE CHILD MUST NEED EXTRA SUPERVISION, CARE OR ASSISTANCE IN THE CHILD CARE SETTING.
- ALL CHILDREN IN CARE 4 KIDS MUST BE UP-TO-DATE ON THEIR SHOTS (*immunizations*).
- BY LAW WE NEED TO ASK YOUR CHILD'S RACE. IDENTIFY YOUR CHILD'S RACE BY CIRCLING **ALL THE RACES THAT APPLY** IN THE COLUMN "RACE OF CHILD" IN **TABLE A**.

KEY - AA - AMERICAN INDIAN/ALASKAN NATIVE A - ASIAN B - BLACK NP - NATIVE HAWAIIAN/PACIFIC ISLANDER W - WHITE U - UNKNOWN

First name, middle initial, last name	Date of birth	Relationship of child to Head of Household	Sex	Is this child Hispanic?	Social Security Number (<i>optional</i>)	Is this child a US citizen?	Does this child have special needs?	Race of child	Is this child up to date with shots?
1.			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	AA NP A W B U	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	AA NP A W B U	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	AA NP A W B U	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	AA NP A W B U	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	AA NP A W B U	<input type="checkbox"/> YES <input type="checkbox"/> NO

TABLE B: CHILDREN UNDER 18 IN HOME WHO DO NOT NEED CHILD CARE

- PLEASE LIST ANY OTHER CHILDREN UNDER 18 LIVING IN YOUR HOME WHO DO NOT NEED CHILD CARE.

First name, middle initial, last name	Date of birth	Sex	Relationship of child to Head of Household	Social Security Number (<i>optional</i>)
1.		<input type="checkbox"/> M <input type="checkbox"/> F		
2.		<input type="checkbox"/> M <input type="checkbox"/> F		

Do any of the children listed above have their own children living in your home? Yes No

If YES, please list the names of the under 18 parent(s) and the name(s) of their children:

Under 18 Parent(s): _____ Child/ren: _____

Section 3: Adult Information (Tell us about all other adults living in your home) ◀

- PLEASE LIST **ALL** OTHER ADULTS **OVER 18**, EXCLUDING YOURSELF, LIVING IN YOUR HOME. INCLUDE YOUR SPOUSE AND ANY RELATIVES AND NON-RELATIVES WHO LIVE IN YOUR HOME.
- IF MORE SPACE IS NEEDED, PLEASE WRITE THE INFORMATION ON ANOTHER PIECE OF PAPER AND ATTACH IT TO THE REDETERMINATION FORM.

TABLE C: ADULTS IN THE HOME OTHER THAN THE HEAD OF HOUSEHOLD

First name, middle initial, last name	Date of birth	Sex	Relationship to Head of Household	Social Security Number (optional)	Is this person unable to provide child care because of a disability?	Is this person a parent of child living in the home?
1.		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO Name of child _____
2.		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO Name of child _____

Section 4A: Child Support Received (Tell us about Child Support you receive) ◀

- THIS SECTION ONLY APPLIES TO THE CHILDREN LISTED IN **TABLE A** FOR WHOM YOU ARE REQUESTING ASSISTANCE. IF A PARENT OF ANY OF THESE CHILDREN IS NOT IN THE HOME, YOU MUST PURSUE CHILD SUPPORT FROM THAT PARENT. WE DO NOT COUNT CHILD SUPPORT PAYMENTS AS INCOME. CHILD SUPPORT PAYMENTS WILL NOT CHANGE YOUR ELIGIBILITY OR LOWER YOUR BENEFITS.
- IF YOU DO NOT HAVE COURT ORDERED CHILD SUPPORT, WE WILL REFER YOU TO THE DSS - BUREAU OF CHILD SUPPORT ENFORCEMENT (BCSE). THIS SERVICE IS FREE FOR CARE 4 KIDS RECIPIENTS.

1. Do you have a **court order** for Child Support payments for any of the children who need child care assistance from this program? YES NO **If YES**, list the child and child's parent below:

Name of the child from Table A	Name of parent (first and last) of the child

If **NO**, are you trying to get Child Support through BCSE? YES NO

2. Are you trying to get Child Support on your own through private legal means? YES NO

If **YES**, please send in proof that you receive or are pursuing court ordered Child Support.

3. Do you have a reason not to pursue Child Support? Explain: _____

Section 4B: Child Support Paid (Tell us about Child Support you pay) ◀

If you or another adult living in your home pays Child Support for a child who does not live with you, that amount may be reduced from your income when determining income eligibility for assistance. Do any adults in your home pay Child Support? YES NO

If **YES**, payment is made to _____ payment is made by _____

What is/(are) the name(s) of the child(ren) being paid for? _____

How much is paid? \$ _____ per _____ (time period) date payments started _____

Please send us proof that you pay Child Support.

Section 5: Work/Education/Training Activities ◀

- PLEASE LIST ALL PARENTS AND OTHER ADULTS, INCLUDING YOURSELF, WHO ARE WORKING, IN TRAINING OR IN SCHOOL. INCLUDE PARENTS OR OTHER PERSONS RESPONSIBLE FOR THE CHILDREN IN THE HOME AND THEIR SPOUSES.
- BE SURE TO INCLUDE WORK, TRAINING OR SCHOOL INFORMATION. ALSO, FILL OUT INFORMATION AND SCHEDULE FOR EACH ACTIVITY (*i.e., working, in training, in school*) A PARENT/ADULT PARTICIPATES IN.

1. Name of Parent or Other Adult: _____

Type of Activity: Work Education High School Self-Employed Training
 Other(*describe*) _____ Do you work from home? Yes No

Name of Employer/Program/School _____ Phone _____

Address _____ City _____ State _____ Zip _____

Start Date of Work/Program/School: _____ Name of Employment Services Case Manager, if any : _____

Parent/Adult Schedule by day

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Start time*	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
End time*	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM

* - Fill-in the time you are required to start the activity and the time the activity ends including meal and break times

If work days or hours of work vary, please explain: _____

How long does it take you to **get to** this activity **from the** child care setting? _____

How long does it take you to **get from** this activity **to the** child care setting? _____

Do you take public transportation to or from this activity? Yes No

2. Name of Parent or Other Adult: _____

Type of Activity: Work Education High School Self-Employed Training
 Other(*describe*) _____ Do you work from home? Yes No

Name of Employer/Program/School _____ Phone _____

Address _____ City _____ State _____ Zip _____

Start Date of Work/Program/School: _____ Name of Employment Services Case Manager, if any : _____

Parent/Adult Schedule by day

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Start time*	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
End time*	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM

* - Fill-in the time you are required to start the activity and the time the activity ends including meal and break times

If work days or hours of work vary, please explain: _____

How long does it take you to **get to** this activity **from the** child care setting? _____

How long does it take you to **get from** this activity **to the** child care setting? _____

Do you take public transportation to or from this activity? Yes No

activity information and schedule

activity information and schedule

Section 6: Income Information (Tell us about your family income) ◀

- PLEASE LIST ALL THE INCOME YOUR FAMILY RECEIVES INCLUDING:
 - GROSS EARNINGS **BEFORE TAXES OR DEDUCTIONS** FOR ALL PARENTS AND ADULT FAMILY MEMBERS IN YOUR HOME
 - UNEARNED INCOME **BEFORE DEDUCTIONS** FOR ALL ADULTS & CHILDREN IN YOUR HOME (SUCH AS SSI, SOCIAL SECURITY, ETC.)

Persons with Income →	Name _____	Name _____	Name _____	Name _____
Wages	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)
Self-employment	\$ _____ per week or month (circle one)	\$ _____ per week or month (circle one)	\$ _____ per week or month (circle one)	\$ _____ per week or month (circle one)
SSI	\$ _____ per month	\$ _____ per month	\$ _____ per month	\$ _____ per month
Social Security	\$ _____ per month	\$ _____ per month	\$ _____ per month	\$ _____ per month
Alimony	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)
Unemployment Compensation	\$ _____ per month	\$ _____ per month	\$ _____ per month	\$ _____ per month
Other Income <i>(e.g. pensions, worker's compensation(wc), veterans benefits (vb), dividends/interest (di) (if over \$600/year)</i>	\$ _____ from: pension, wc, va, di (circle one) * per wk bwk sm mo (circle one)	\$ _____ from: pension, wc, va, di (circle one) * per wk bwk sm mo (circle one)	\$ _____ from: pension, wc, va, di (circle one) * per wk bwk sm mo (circle one)	\$ _____ from: pension, wc, va, di (circle one) * per wk bwk sm mo (circle one)
Child Support <i>(not included when determining income eligibility)</i>	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)	\$ _____ * per wk bwk sm mo (circle one)

* per: **weekly** (wk), **bi-weekly** (bwk), **semi-monthly** (sm), **monthly** (mo)

 **NOTE: PLEASE SEND COPIES OF YOUR MOST RECENT PAYCHECK STUB(S) WITH THIS REDETERMINATION.**

- If you are paid **once a week**, SEND COPIES OF THE LAST FOUR PAYCHECK STUBS.
- If you are paid **every other week or twice a month**, SEND COPIES OF THE LAST TWO PAYCHECK STUBS.
- If you are paid **once a month**, SEND A COPY OF THE LAST PAYCHECK STUB.
- If you are **self-employed**, SEND A COPY OF YOUR MOST RECENT STATE OR U.S. TAX RETURN, INCLUDING THE SCHEDULES OR YOUR MOST RECENT QUARTERLY STATE OR U.S. TAX FILING.

Do you receive Food Stamps? YES NO

Do you receive housing assistance? YES NO

Do you receive child care assistance from another source? YES NO

If YES, from whom: _____ How much? \$ _____ How often? _____

Section 7: Parent's Rights & Responsibilities ◀

- PLEASE READ THE FOLLOWING SECTION CAREFULLY OR HAVE IT READ TO YOU. IF THERE IS ANYTHING YOU DO NOT UNDERSTAND, YOU MAY CALL **CARE 4 KIDS** AT **1-888-214-KIDS (5437)** AND ASK THAT IT BE EXPLAINED TO YOU.
- WHEN YOU HAVE READ THE SECTION OR HAD IT READ TO YOU, PLEASE SIGN IN THE SPACE PROVIDED AT THE BOTTOM OF THIS PAGE.
- YOU HAVE CERTAIN RIGHTS AND THERE ARE CERTAIN RULES YOU NEED TO FOLLOW.
- YOU HAVE THE RIGHT TO FILE AN APPLICATION, WITHDRAW AN APPLICATION OR DISCONTINUE YOUR PARTICIPATION IN **CARE 4 KIDS** AT ANY TIME. YOU HAVE THE RIGHT TO CHOOSE ANY ELIGIBLE CHILD CARE PROVIDER.
- YOU HAVE THE RIGHT TO BE TREATED FAIRLY BY **CARE 4 KIDS** WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX OR SEXUAL ORIENTATION, MARITAL STATUS, NATIONAL ORIGIN, ANCESTRY, AGE, POLITICAL BELIEFS OR DISABILITY. YOU HAVE THE RIGHT TO REQUEST FORMS AND NOTICES IN SPANISH. ALL NON-ENGLISH SPEAKING PARTICIPANTS HAVE THE RIGHT TO THE SERVICES OF AN INTERPRETER.
- YOU HAVE THE RIGHT TO ASK FOR A REVIEW OF ANY DECISION MADE BY **CARE 4 KIDS** ON YOUR APPLICATION/ENROLLMENT. YOU HAVE THE RIGHT TO SPEAK TO A SUPERVISOR OR MEDIATOR AND THE RIGHT TO REQUEST A HEARING FROM THE DEPARTMENT OF SOCIAL SERVICES (DSS).

I UNDERSTAND AND AGREE THAT:

- I MUST REPORT ANY CHANGES IN MY SITUATION TO **CARE 4 KIDS** WITHIN 10 DAYS OF THE CHANGE, INCLUDING BUT NOT LIMITED TO CHANGES IN ADDRESS, INCOME, HOUSEHOLD SIZE, CHILD CARE PROVIDER, HOURS OF EMPLOYMENT OR TRAINING, ADDITIONAL HOURS OF CARE, ETC.
- **CARE 4 KIDS** MAY VERIFY THE INFORMATION I HAVE GIVEN ON THIS FORM INCLUDING CONTACTING MY EMPLOYER DIRECTLY.
- I UNDERSTAND THAT IF I AM ELIGIBLE FOR **CARE 4 KIDS**, BENEFITS WILL NOT BEGIN ANY EARLIER THAN 15 DAYS BEFORE THE DATE THE REDETERMINATION FORM IS RECEIVED.
- THE INFORMATION ON THIS FORM IS CONFIDENTIAL. DSS OR ITS AGENT WILL ONLY USE THIS INFORMATION TO ADMINISTER A DSS PROGRAM. INFORMATION MAY BE SHARED WITH OTHERS AS PERMITTED BY LAW.
- **CARE 4 KIDS** EMPLOYEES MAY PROVIDE MY CHILD CARE PROVIDER WITH INFORMATION ABOUT MY ELIGIBILITY FOR **CARE 4 KIDS** AND THE AMOUNT OF THE **CARE 4 KIDS**' PAYMENT.
- ON REQUEST, **CARE 4 KIDS** MAY BE REQUIRED TO PROVIDE INFORMATION ON PROGRAM APPLICANTS AND PARTICIPANTS TO LAW ENFORCEMENT OFFICIALS.
- THE CHILD CARE ARRANGEMENT IS BETWEEN MY PROVIDER AND ME. DSS AND **CARE 4 KIDS** ARE NOT RESPONSIBLE FOR THE CHILD CARE ARRANGEMENT.
- **CARE 4 KIDS** MAY NOT PAY THE FULL AMOUNT CHARGED BY MY PROVIDER. I AM RESPONSIBLE FOR PAYING ALL ADDITIONAL PROVIDER CHARGES.
- PROVIDERS MUST MEET STATE HEALTH, SAFETY AND LICENSING REQUIREMENTS TO BE ELIGIBLE FOR PAYMENT.
- I MAY BE REQUIRED TO REPAY ANY BENEFITS RECEIVED IN ERROR, INCLUDING ADMINISTRATIVE ERRORS. I MAY BE SUBJECT TO CRIMINAL PROSECUTION FOR FRAUD IF I KNOWINGLY SUPPLY ANY FALSE INFORMATION TO **CARE 4 KIDS** OR FAIL TO REPORT CHANGES ON TIME. I ALSO MAY BE DISQUALIFIED FROM THE PROGRAM.
- ASSISTANCE MAY BE DENIED OR DISCONTINUED IF I REFUSE OR STOP PURSUING CHILD SUPPORT PAYMENTS.
- TO REMAIN ELIGIBLE, I MUST COOPERATE WITH DSS IN QUALITY CONTROL REVIEWS.

Head of Household needs to read & sign: I HAVE READ MY RIGHTS AND RESPONSIBILITIES OR HAVE HAD IT READ TO ME IN A LANGUAGE I UNDERSTAND. I CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

HEAD OF HOUSEHOLD SIGNATURE _____ DATE _____

DID ANOTHER PERSON HELP YOU FILL OUT THIS FORM? YES NO

IF YES, NAME: _____

SIGNATURE _____

Mail this Redetermination to: Care 4 Kids ▪ 1344 Silas Deane Hwy ▪ Rocky Hill, CT ▪ 06067-1339

THE CARE 4 KIDS PROGRAM IS SPONSORED BY THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES.
ALL DEPARTMENT OF SOCIAL SERVICE PROGRAMS ARE ADMINISTERED IN A NON-DISCRIMINATORY MANNER,
CONSISTENT WITH EQUAL EMPLOYMENT OPPORTUNITIES AND AFFIRMATIVE ACTION REQUIREMENTS.