DEPARTMENT of EDUCATION
Louisiana Believes

CHILD CARE ASSISTANCE PROGRAM (CCAP)
PANDEMIC PROTECTIVE SERVICES CRISIS APPLICATION-CCAP22C

1. HEAD OF HOUSEHOLD IDENTIFYING INFORMATION: This form should be completed by the head of household or other household member (presently employed in an acute medical profession) who is responsible for paying child care costs. Applicants certified under this provision will receive 12 months of child care subsidy.

PLEASE PRINT ALL INFORMATION

Last Name:	First Name:		Middle Initial:
Home Address Street:			Apt. No.:
City:	Parish:		ZIP:
Mailing Address Street:		P.O. Box:	Apt. No.:
City:	Parish:		ZIP:
Email:	Home Phone: ( )	Work Phone: ( )	Other Phone: ( )

2. Do you certify that your family assets do not exceed $1,000,000? O Yes O No

3. ESSENTIAL CRITICAL INFASTRUCTURE WORKER INFORMATION

Do you provide essential critical infrastructure work in one of the areas below related to COVID-19 in acute care hospital settings?
O Yes O No

If Yes, check the areas that apply to you below:

O Nurses, LPN, RN, APRN
O Nursing Assistants - Medical Assistants, Aides, Personal Care Attendants
O Emergency Medical Technicians
O Nutritional Staff
O Therapists - OT, PT, Respiratory
O Mental Health-Social Worker, Counselors
O Laboratory Staff
O Janitorial Services
O Other ______________________

Please identify the name of the facility, a contact person, and a contact number for your employer. Attach a letter verifying your job title on the company's letterhead. No income verification needed until redetermination.

Facility Name or Name of Employer: ______________________

Contact Person: ______________________

Phone Number: ______________________

Email Address: ______________________

4. CHILDREN NEEDING CARE: Please have your selected Child Care Provider complete this section.

Name of Child (Last, First)	Date of Birth	Age	Gender	Race	Type of Care (One Per Child)	Type of Care Needed	Total Hours Needed Each Week	Contact Information of the Provider	Provider/Child Relationship
					O Child's Home O Provider's Home O Type III Center	O Full Time O Part Time		Name:______ Address:______ Phone #:______ TIPS Provider#:______	O Grandparent O Sister/Brother O Aunt/Uncle O Other ______
					O Child's Home O Provider's Home O Type III Center	O Full Time O Part Time		Name:______ Address:______ Phone #:______ TIPS Provider#:______	O Grandparent O Sister/Brother O Aunt/Uncle O Other ______
					O Child's Home O Provider's Home O Type III Center	O Full Time O Part Time		Name:______ Address:______ Phone #:______ TIPS Provider#:______	O Grandparent O Sister/Brother O Aunt/Uncle O Other ______
					O Child's Home O Provider's Home O Type III Center	O Full Time O Part Time		Name:______ Address:______ Phone #:______ TIPS Provider#:______	O Grandparent O Sister/Brother O Aunt/Uncle O Other ______

1. State what language is the primary language spoken at the home? ______________________
2. **SPECIAL NEEDS:** Does any child, under age 18, need specialized child care because of a physical, mental, or emotional condition?
   O Yes O No If yes, list name(s):______________________
   Does this child have an Individualized Education Plan (IEP)? O Yes O No Does your family have IFSP? O Yes O No
3. Is any child receiving SSI or other disability benefits? O Yes O No

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4. HOUSEHOLD DESIGNEE: As the Head of Household, you are automatically a Household Designee. A Household Designee is an adult who is designated in writing by you to drop off and pick up a child(ren) from a CCAP provider and check the child(ren) in and out of care using the Tracking of Time Services (TOTS), when applicable or keep by paper attendance including name of child, date, time in and time out. You may designate up to three adults in addition to yourself as Household Designees by listing them below and providing the requested information. These Household Designees will be authorized to drop off and pick up the child(ren) from the CCAP provider.

I hereby designate the following individuals as Household Designees:

Name of Head of Household:	**Date of Birth:**	**Head of Household/Household Designee:**	**Date:**
Residential Address of Head of Household:			

Name of Household Designee 1:	Date of Birth:	Relationship to Head of Household:	Date:
Residential Address of Household Designee 1:			

Name of Household Designee 2:	Date of Birth:	Relationship to Head of Household:	Date:
Residential Address of Household Designee 2:			

Name of Household Designee 3:	Date of Birth:	Relationship to Head of Household:	Date:
Residential Address of Household Designee 3:			

By signing below as the Household Designee, I certify that:

(1) I am not the CCAP child care provider for the above-named household.

(2) I do not provide care for the above child(ren) needing care; nor are my household designees employed by the child care facility.

(3) I do not live with the above-named household's home-based child care provider.

4. **CONFIDENTIALITY:** Information provided by you in order to obtain CCAP certification shall be confidential and shall not be released without your written consent, except for program administration, evaluation and improvement, and to agencies and officials as allowed by law.

5. **DISCRIMINATION:** The Louisiana Department of Education (LDOE) does not discriminate in the delivery of services. This means you will not be treated differently from others because of your race, color, sex, age, disability, religious beliefs, nation of origin or political beliefs.

6. ____ (initial) I authorize LDOE and its employees to disclose information and/or records to the provider listed above. I understand this may include and is not limited to requesting verification, providing a status for my application, and discussing any payments and records maintained by or on the behalf of LDOE. LDOE retains the discretion to decide if particular records or information are within the scope of this waiver; and that LDOE has no control over how the recipient will use or disseminate my information. I agree to release and hold harmless LDOE from any and all claims of action or damages of any kind arising from, or in any way connected to, the release or use of any information or records pursuant to this waiver.

5. SIGNATURE: By signing below, I certify that I have read and understand my rights and responsibilities. I also certify that all information given on this application form is true and correct, and I understand that any willful omission or falsification of information required in this application is justification for the denial of my application.

Signature of Applicant:	**Date**:
X	

PLEASE RETURN THE COMPLETED APPLICATION FOR CHILD CARE ASSISTANCE TO:

CCAP Household Eligibility
Email: LDOECOVID19support@la.gov
P.O. Box 260037
Baton Rouge, LA 70826
Fax: 225-376-6049
Voter Registration: If you wish to vote, you may do so online.

HOSPITAL'S LETTERHEAD

Date: _____

To: Louisiana Department of Education
Child Care Assistance Program
PO Box 260037
Baton Rouge, LA 70826

I certify that _____, works for _____ in the capacity checked below.
Printed Name of Staff Printed Name of Hospital

- O Nurse, LPN, RN, APRN
- O Nursing Assistant - Medical Assistant, Aide, Personal Care Attendant
- O Emergency Medical Technician
- O Nutritional Staff
- O Other _____
- O Therapist - OT, PT, Respiratory
- O Mental Health-Social Worker, Counselor
- O Laboratory Staff
- O Janitorial Services

_____ _____
Signature of Hospital Representative Date

_____
Printed Name of Hospital Representative

_____
Phone Number

_____
Email Address