

**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. ESSENTIAL CRITICAL INFRASTRUCTURE WORKER INFORMATION**

Do you provide essential critical infrastructure work in one of the areas below related to COVID-19 in acute care hospital settings?

Yes  No

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

- |  |   |
|--|---|
| <input type="radio"/> Nurses, LPN, RN, APRN  | <input type="radio"/> Mental Health-Social Worker, Counselors |
| <input type="radio"/> Nursing Assistants - Medical Assistants, Aides, Personal Care Attendants | <input type="radio"/> Laboratory Staff                        |
| <input type="radio"/> Emergency Medical Technicians  | <input type="radio"/> Janitorial Services                     |
| <input type="radio"/> Nutritional Staff  | <input type="radio"/> Other _____                             |
| <input type="radio"/> Therapists - OT, PT, Respiratory   |   |

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: \_\_\_\_\_

**3. 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
					<input type="radio"/> Child's Home <input type="radio"/> Provider's Home <input type="radio"/> Type III Center	<input type="radio"/> Full Time <input type="radio"/> Part Time		Name: _____ Address: _____ Phone #: _____ TIPS Provider#: _____	<input type="radio"/> Grandparent <input type="radio"/> Sister/Brother <input type="radio"/> Aunt/Uncle <input type="radio"/> Other _____
					<input type="radio"/> Child's Home <input type="radio"/> Provider's Home <input type="radio"/> Type III Center	<input type="radio"/> Full Time <input type="radio"/> Part Time		Name: _____ Address: _____ Phone #: _____ TIPS Provider#: _____	<input type="radio"/> Grandparent <input type="radio"/> Sister/Brother <input type="radio"/> Aunt/Uncle <input type="radio"/> Other _____
					<input type="radio"/> Child's Home <input type="radio"/> Provider's Home <input type="radio"/> Type III Center	<input type="radio"/> Full Time <input type="radio"/> Part Time		Name: _____ Address: _____ Phone #: _____ TIPS Provider#: _____	<input type="radio"/> Grandparent <input type="radio"/> Sister/Brother <input type="radio"/> Aunt/Uncle <input type="radio"/> Other _____
					<input type="radio"/> Child's Home <input type="radio"/> Provider's Home <input type="radio"/> Type III Center	<input type="radio"/> Full Time <input type="radio"/> Part Time		Name: _____ Address: _____ Phone #: _____ TIPS Provider#: _____	<input type="radio"/> Grandparent <input type="radio"/> Sister/Brother <input type="radio"/> Aunt/Uncle <input type="radio"/> Other _____

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

**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:**

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

<b>Name of Household Designee 1:</b>	<b>Date of Birth:</b>	<b>Relationship to Head of Household:</b>	<b>Date:</b>
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**Residential Address of Household Designee 1:**

<b>Name of Household Designee 2:</b>	<b>Date of Birth:</b>	<b>Relationship to Head of Household:</b>	<b>Date:</b>
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**Residential Address of Household Designee 2:**

<b>Name of Household Designee 3:</b>	<b>Date of Birth:</b>	<b>Relationship to Head of Household:</b>	<b>Date:</b>
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**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:**

X

**Date:**

**PLEASE RETURN THE COMPLETED APPLICATION FOR CHILD CARE ASSISTANCE TO:**

**CCAP Household Eligibility**

**Email:** [LDOECOVID19support@la.gov](mailto: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

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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

Nurse, LPN, RN, APRN

Therapist - OT, PT, Respiratory

Nursing Assistant - Medical Assistant, Aide, Personal Care Attendant

Mental Health-Social Worker, Counselor

Emergency Medical Technician

Laboratory Staff

Nutritional Staff

Janitorial Services

Other \_\_\_\_\_

\_\_\_\_\_  
Signature of Hospital Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Hospital Representative

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address