



STATE OF ILLINOIS  
DEPARTMENT OF HUMAN SERVICES

**REQUEST FOR REDETERMINATION INFORMATION**

Child Care Case #: \_\_\_\_\_

Date of Notice: \_\_\_\_\_

Approval Ending Date: \_\_\_\_\_

Reason for Child Care: \_\_\_\_\_

Client: \_\_\_\_\_

Caseload Code: \_\_\_\_\_

Provider(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your eligibility for CHILD CARE needs to be redetermined at this time. Please complete and return this form to us at the address listed below. If we do not receive this information within 10 business days, your child care will be CANCELED. If you are having problems filling out this form, please contact us.

**IF YOU'RE EMPLOYED, ATTACH COPIES OF YOUR 2 MOST RECENT PAYSTUBS.**

**IF YOU'RE ATTENDING A TANF REQUIRED ACTIVITY, ATTACH A COPY OF YOUR CURRENT RSP.**

**IF YOU'RE ATTENDING SCHOOL, ATTACH A COPY OF YOUR SCHOOL SCHEDULE AND MOST RECENT REPORT CARD.**

**IF YOU'RE A TEEN PARENT ATTENDING HIGH SCHOOL/GED, ONLY A COPY OF YOUR SCHOOL SCHEDULE IS NEEDED.**

List a phone number where we can reach you during the day:

**FOR OFFICE USE:** \_\_\_\_\_ 1) Work/On-the-job Training for TANF and Non-TANF  
REASON FOR \_\_\_\_\_ 2) TANF Education/Training Activity or Teen Parent in High School/GED  
CHILD CARE \_\_\_\_\_ 3) TANF Work & Education/Training Activity or Teen Parent Work & High School/GED  
\_\_\_\_\_ 4) Non-TANF Education & Training

**TYPE OF EDUCATION/TRAINING** \_\_\_\_\_ 1) High School or GED \_\_\_\_\_ 4) 2 Year College Degree  
**CURRENTLY ATTENDING** \_\_\_\_\_ 2) Other Below Post-Secondary \_\_\_\_\_ 5) 4 Year College Degree  
(Check One) \_\_\_\_\_ 3) Occupational/Vocational

**WORK INFORMATION**

Employer/Company Name	Job Title
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Address	City	State	Zip Code
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Phone Number	Ext.	Date you started this job:
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Is this a new job since your last application/redetermination?  YES  NO

If YES, your previous employer's name:	Date previous job ended:
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I earn (before taxes): COMPLETE ONE  
\_\_\_\_\_ per hour \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year

I get paid (check one): _____ 1) Weekly _____ 2) Every 2 Weeks _____ 3) Twice a Month _____ 4) Monthly	Number of Hours Worked Weekly:
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Be sure to complete the information on pages 2, 3 & 4 and MAIL OR HAND DELIVER (DO NOT FAX) to:

**Illinois Action For Children – Child Care Assistance Program**  
1340 S. Damen Avenue, 3rd Floor, Chicago, IL 60608  
Phone (312) 823-1100 Fax (312) 823-1200

Case Name:

**WORK SCHEDULE:** Please give a typical work schedule (circle am or pm)

Does your schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Do you receive health insurance from your employer?  YES  NO

How long does it take to travel from the child care provider to work?

**SCHOOL/TRAINING/TANF-REQUIRED ACTIVITY INFORMATION**

School Name/Training Program			Phone Number		
Address		City	State	ZipCode	

How long does it take to travel from the child care provider to school?

**SCHOOL SCHEDULE:** Please complete the following schedule (circle am or pm)

Does your schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Is the other parent or stepparent of any of the children living in your home?  
 NO (Go to Family Information on page 3)  YES (Complete the section below)

**OTHER PARENT/STEPARENT INFORMATION**

Is the other parent or stepparent working?  YES  NO  
 Is the other parent or stepparent attending school?  YES  NO  
 If the other parent/stepparent is not working or in school, why can't he/she care for the child(ren)?

Other Parent/Stepparent Last Name	First Name
Social Security Number	Date of Birth

**WORK INFORMATION**

Employer/Company Name	Job Title		
Address	City	State	Zip Code

Phone Number Ext. Date they started this job:

Is this a new job since the last application/redetermination?  YES  NO

If YES, previous employer's name: Date previous job ended:

They earn (before taxes): COMPLETE ONE  
 \_\_\_\_\_ per hour \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year

They get paid (check one):  1) Weekly  2) Every 2 Weeks  
 3) Twice a Month  4) Monthly Number of Hours Worked Weekly:

Case Name:

**WORK SCHEDULE:** Please give a typical work schedule (circle am or pm)

Does their schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

Do they receive health insurance from their employer? YES NO

How long does it take to travel from the child care provider to work?

**SCHOOL/TRAINING/TANF-REQUIRED ACTIVITY INFORMATION**

School Name/Training Program				Phone Number			
Address			City		State		Zip Code

How long does it take to travel from the child care provider to school?

**SCHOOL SCHEDULE:** Please complete the following schedule (circle am or pm)

Does their schedule vary? Please Explain: _____ _____		MON	TUE	WED	THU	FRI	SAT	SUN
	FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm
	TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm

**FAMILY INFORMATION**

What is your family size? \_\_\_\_\_ How many adults are in your family? \_\_\_\_\_  
 How many children are in your family? \_\_\_\_\_ How many children are receiving child care? \_\_\_\_\_  
 Family means the applicant (you); the biological, step or adoptive parent of any children requiring child care who are living in your household; and your biological or adoptive children living in the same household. Other persons who are related to you by blood or law may also be counted if they rely on you for 50% or more of their support.

**INCOME INFORMATION:** Enter the MONTHLY income for all family members counted in family size. If the income does not apply, write "N/A".

TYPE OF INCOME	CLIENT	FAMILY MEMBERS	FOR OFFICE USE
<b>Gross Employment Income:</b> including tips. Enter any self-employment income below. <b>Attach copies of 2 most recent pay stubs for each person.</b>			
<b>Self-Employment Income</b>			
<b>Child Support Received</b>			
<b>TANF Cash Assistance</b>			
<b>Other Federal Cash Income:</b> For example, Social Security payments and railroad benefits.			
<b>Other Monthly Income:</b> For example, interest income, royalties, pensions, annuities, alimony, ongoing monthly adoption assistance, unemployment compensation, DCFS payments, veteran's pension, survivor's benefits, and permanent disability payments.			
<b>SUBTOTAL</b>			
<b>MINUS: Child Support Paid by Applicant's Family</b>			
<b>TOTAL</b>			

Case Name:

**Housing Cash Assistance Including Vouchers With Specific Cash Value:**

(For Federal reporting, does not count when totaling Monthly Family Income)

**FOR OFFICE USE: PARENT CO-PAYMENT**

**LIST THE CHILDREN CARED FOR BY EACH PROVIDER** If your children go to school, preschool, or Headstart during the day, list only the hours that they are with the child care provider. (This is not a Provider Change Form.)

**#1 Provider Name:**

CHILD'S NAME	AGE		MON	TUE	WED	THU	FRI	SAT	SUN
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am

**#2 Provider Name:**

CHILD'S NAME	AGE		MON	TUE	WED	THU	FRI	SAT	SUN
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am

**#3 Provider Name:**

CHILD'S NAME	AGE		MON	TUE	WED	THU	FRI	SAT	SUN
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am
		FROM	am	am	am	am	am	am	am
		TO	am	am	am	am	am	am	am

I certify that:

- All of the above statements are true;
- The information provided is true, correct and accurate;
- The information provided will be disclosed only for administrative purposes and that I may be required to verify the information I have provided;
  - I understand that I am responsible for paying a share of my child care costs (parent co-payment) to my provider and that failure to do so may result in the loss of child care benefits;
  - I understand that I have the right to appeal and to have a fair hearing of a grievance;
- I understand that giving false information or failure to correct information can result in referral for prosecution for fraud.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_