

C. Tell Us About Your Child Care Needs

Foster parents' work/school schedule (use multiple lines if the schedule changes throughout the week).

Parent 1

Start Time (Indicate AM/PM)	End Time (Indicate AM/PM)	Circle Days of the Week this schedule is for:
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN

Parent 2

Start Time (Indicate AM/PM)	End Time (Indicate AM/PM)	Circle Days of the Week this schedule is for:
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN

Child in Foster Care School Schedule

Start Time (Indicate AM/PM)	End Time (Indicate AM/PM)	Circle Days of the Week this schedule is for:
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN

Child Care Provider Information (use multiple lines for multiple providers)

Provider Name	Address	Circle Days of the Week this provider is used:
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN
		MON TUE WED THU FRI SAT SUN

Signature

Signature of Foster Parent (required)

Date

Foster Care Case Management or Child Placing Agency

My signature on this application certifies that the child(ren) in foster care for whom child care assistance is requested are in the custody of the Secretary of the Kansas Department for Children and Families (DCF). It also certifies that child care is needed due to the foster family's verified work or school schedule, and that the below stated agency has obtained and has on file the necessary verification to support the request for child care assistance. The agency also has obtained verification of the citizenship and date of birth for each child whom child care assistance is requested. All documentation must be maintained and cannot be destroyed until after the child care assistance case has been closed for 36 months and must be made available to DCF in the event of an audit.

Name of Foster Care Case Management/Child Placing Agency

Name of Case Management/Agency Representative (Printed)

Phone Number

Signature of Case Management/Agency Representative

Date

