DHS
Oregon Department of Human Services
Children, Adults and Families
Child Care Program

Application for Employment Related Day Care Program (ERDC)

Do you have a physical or mental impairment that makes it difficult for you to communicate? If so, you can get forms and notices in the following alternate format, please mark the one you want:

☐ Not requested ☐ Audio tape ☐ Braille
☐ Computer disk ☐ Large print ☐ Oral presentation

Contact your worker or the receptionist for more information.

Please read these instructions *before* filling out this application.
Answer *all* questions. Do not write in the shaded areas.

To contact our office

If you have questions or changes to report, contact our office:

Name:
Address:
Phone:

Who should complete this application

This application is for the Employment Related Day Care Program (ERDC). It is for child care benefits only. Families seeking cash, food or medical benefits should not use this application.

How do I apply for ERDC

1. Complete this application and turn it in to your local office.
2. Give proof of eligibility.
3. Have an interview with a worker in person or by phone.

How do I prove eligibility

You will need to give proof of your income. The following are examples. Bring or send those that apply to you.

→ Pay stubs or employer statements of gross pay
→ Worker's compensation check
→ Latest award letter from Social Security or Veteran's Administration
→ Court order stating amount of child support or alimony
→ Records of income from self-employment
→ Last year's tax statement, if self-employed
→ Student Financial Aid Award letter
→ Records for property and other income sources

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(Continued from page 1)

If your child has a disability, you may qualify for a higher child care payment rate. Your child must have a disability that requires extra care. To see if you qualify, you must complete and return a ***Special Need Child Care Rate Request*** form (DHS 7486).

If your child is older than age 11, you may still qualify for child care help. Your child must meet certain requirements. Talk to your worker to see if you qualify.

Applicant rights

You have the right to talk to your worker or a person in charge.
You have the right to request a hearing if you disagree with the decision on your application.

Client responsibilities

If you get ERDC, you must report the following changes ***within 10 days of occurrence:***

- → Changes in child care providers
- → Changes in employment status
- → Changes in mailing address or residence
- → When someone moves in or out
- → Changes in the source of income or rate of pay

A client assigned to the ***Simplified Reporting System*** must report changes by the 10th of the following month after the change happens. Your worker will explain these changes to you.

To continue getting benefits, you must reapply by completing the ***Employment Related Day Care*** **(ERDC)** ***Re-Application and Supplemental Nutritional Assistance Program*** **(SNAP)** ***Application*** form (DHS 7476) or ***Application for Services*** (DHS 0415F).

You must help the Department of Human Services (DHS) if your case is chosen for review.

You must agree to use a child care provider that meets DHS listing requirements.

Tear off this page and keep it for your records

The Department of Human Services (DHS) will not discriminate against anyone. This means DHS will help all who qualify. DHS will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons.

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Agency use only			
Program:	Agency:	Case number:	Worker ID:
Case name:			FILE

1. Name (last, first, middle initial): | Other names used: | Do you plan to stay in Oregon? ☐ Yes ☐ No

Home address: | City: | State: | ZIP: | Home phone number:

Mailing address (if different from home address): | City: | State: | ZIP: | Message or work number:

If you do not speak or read English: Which language do you speak? Which language do you read? Do you need an interpreter? ☐ Yes ☐ No

2. List all people living with you, even if you are not applying for them. If you need more room, attach another sheet.

***Racial-ethnic heritage** - We ask for this information to help us follow Federal Civil Rights laws. Title VI of the Civil Rights Act of 1964 allows us to do this. You can choose not to give this information. It will not affect your eligibility for services. (Select one or more for each person below) **W** - White **H** - Hispanic or Latino **B** - Black **I** - American Indian/Alaska Native **A** - Asian **P** - Pacific Islander/Native Hawaiian

** **Providing a Social Security number (SSN)** is voluntary when applying for ERDC.

Name (last, first, M.I.)	Relationship	Social Security number**	Date of birth	Sex	Does this child need care	U.S. citizen	Need extra care due to disability	Racial-ethnic heritage* (circle)
	Self			☐M ☐F	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	W B A H I P
				☐M ☐F	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	W B A H I P
				☐M ☐F	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	W B A H I P
				☐M ☐F	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	W B A H I P
				☐M ☐F	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	W B A H I P
				☐M ☐F	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	W B A H I P

3. Are your children's immunization (shot) records up-to-date? ☐ Yes ☐ No

If not, contact your doctor or local health department for more information. You must agree to meet state immunization guidelines to get child care benefits.

4. Does anyone work? (Students include work study) ☐ Yes ☐ No **If yes,** complete below.

List each job for each person who works or is self-employed. **Attach proof** of income received last month and current month. If this is a new job, list date work started: _____

If self-employed, check here ☐	Job #1	Job #2	Job #3
Person working:			
Employer's name and phone number:			
Hourly pay:	$	$	$
If you are not paid by the hour, explain your income here:			
Hours (per week):			
How often paid (weekly, monthly):			
Pay dates:			
Tips per week:			
Draws/overtime pay/bonuses/commissions:	$	$	$
Will this income continue?	☐ Yes ☐ No*	☐ Yes ☐ No*	☐ Yes ☐ No*
*If income will change, give the reason for the change here:			
New amount:	$	$	$
Date of the change:			

5. Please list information about your work schedule and care providers.

Usual work hours: From: _____ a.m. / p.m. To: _____ a.m. / p.m.
Usual work days: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thu. ☐ Fri. ☐ Sat. ☐ Sun.
Other schedule (describe): _____

Care provider: _____ **Phone number:** _____
Second provider: _____ **Phone number:** _____

6. Does anyone get money from any other source?... ☐ Yes ☐ No If yes, complete below. **Attach proof.**

Some examples are:
- Unemployment compensation
- Student income/money for school
- Social Security
- Veterans benefits
- Child support
- Interest income
- Worker's compensation
- Loans/gifts
- Winnings

Name of person who received other money	Source of other money	How often paid	Amount of each payment	Amount this month	Will this income continue
			$	$	☐ Yes ☐ No*
			$	$	☐ Yes ☐ No*
			$	$	☐ Yes ☐ No*

* If income will change, give the new amount. What is the reason for the change and when it will change?

7. Is anyone a student in college, trade school or other training programs?..... ☐ Yes ☐ No
If yes, attach a copy of your Financial Aid Award Letter.

Name of student:	☐ Undergraduate ☐ Graduate	Credit hours per week:	Name of school/training program:
	☐ Undergraduate ☐ Graduate		

8. Does anyone have medical coverage besides the Oregon Health Plan? ..... ☐ Yes ☐ No
If no, is it offered through anyone's job? ..... ☐ Yes ☐ No

9. Do you need to get away from an abusive situation? ..... ☐ Yes ☐ No

I have read the information attached to this application. By signing this application, I swear under penalty of perjury I have given true and complete information. I realize that making false statements or hiding information may subject me to state and federal penalties. I authorize release of my child support records from the Department of Justice (DOJ), Division of Child Support (DCS) to DHS.

If you have provided your SSN for other programs, DHS may use your SSN to prepare aggregate information or reports requested by funding sources for the program you apply for or receive benefits from. DHS may use your SSN to conduct quality assessment and improvement activities.

Full signature of applicant:	Date:
Full signature of spouse or partner:	Date:

Agency use only

Date of request:	Date pended:	Date approved:	Date denied:

Client referred to:
☐ CC Resource & Referral ☐ Headstart ☐ DHS ☐ SPD ☐ SED ☐ VRD ☐ Other:

Comments: