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DS NUMBER (office use only)

You are required to contact the Child Care Subsidy Service Centre if there is any change to your circumstances after you have applied. For more information call the toll free number 1-888-338-6622 or visit the web site (http://www.mcf.gov.bc.ca/childcare/application.htm).

1. Applicant Information

Form section 1: Applicant Information. Fields include: APPLICANT'S LAST NAME, FIRST, MIDDLE, GENDER (MALE/FEMALE), BIRTH DATE, SOCIAL INSURANCE NUMBER, PRIMARY PHONE, SECONDARY PHONE, HOME ADDRESS, CITY/TOWN, POSTAL CODE, MAILING ADDRESS, CITY/TOWN, POSTAL CODE, and a question about government disability benefits.

2. Applicant's Status in Canada

Form section 2: Applicant's Status in Canada. Fields include: Is this your first time applying? (NO/YES), Canadian Citizen, Permanent Resident of Canada, and Convention Refugee/Person in Need of Protection. Includes a note to submit a photocopy of proof of status.

3. Applicant's Need for Child Care Check [] any that apply. If your need changes call 1-888-338-6622.

Form section 3: Applicant's Need for Child Care. Multiple choice options: I am currently employed or self-employed, I am currently attending an educational institution, I am currently participating in a Ministry of Social Development referred employment-related program, and I am currently looking for work. Each option has associated fields for dates, times, and contact information.

3. Applicant's Need for Child Care continued

<input type="checkbox"/> I currently have a medical condition. A medical doctor must confirm that the condition interferes with your ability to care for your child(ren) who require child care. Have a medical doctor complete a Medical Condition form (CF2914) for you to submit with this application.
<input type="checkbox"/> I/We have been referred by a Ministry of Children and Family Development or delegated Aboriginal Agency social worker. Your social worker must arrange or recommend child care under the <i>Child, Family and Community Service Act</i> . Have your social worker complete and submit a referral (CF2044) on your behalf. You must also complete and submit this application, along with any supporting documents.
<input type="checkbox"/> My/Our child(ren) attend(s) a licensed preschool program

4. Applicant's Marital Status — If your marital status changes call 1-888-338-6622.

- I am single, separated, divorced, or widowed — Go to Section 6.
- I am married or living in a marriage-like relationship and my spouse resides with me — Complete this section with your spouse's information
NOTE: If you are a foster parent applying for subsidy for a foster child, go to Section 7

Is this the first time you've indicated that you have a spouse when applying? NO YES
If yes, submit a photocopy of one (1) piece of government issued identification for your spouse.

SPOUSE'S LAST NAME		FIRST	MIDDLE
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (YYYY/MM/DD)	SOCIAL INSURANCE NUMBER	Does your spouse receive government disability benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, submit a photocopy of benefit statement

5. Spouse's Need for Child Care Check any that apply. If your spouse's need changes call 1-888-338-6622.

<input type="checkbox"/> My spouse is currently employed or self-employed. If employed, submit photocopies of your spouse's last two pay slips If self-employed, submit Self Employment form (CF2568).			
PLACE OF EMPLOYMENT or NAME OF BUSINESS	START DATE (YYYY/MM/DD)	END DATE if known	PHONE ()
DAYS/WEEK: <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN	HOURS/DAY From: _____ To: _____		
Does your spouse have a second job, at the present? <input type="checkbox"/> NO <input type="checkbox"/> YES — attach a separate copy of this page, with this portion completed with details of that job.	Does your spouse's schedule vary? <input type="checkbox"/> NO <input type="checkbox"/> YES — Submit a typical work schedule.		
<input type="checkbox"/> My spouse currently attends an educational institution Submit photocopies of proof of registration, class schedule and any funding.			
NAME OF INSTITUTION (SCHOOL)	START DATE (YYYY/MM/DD)	END DATE	PHONE ()
DAYS/WEEK: <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN	HOURS/DAY From: _____ To: _____		
<input type="checkbox"/> My spouse currently participates in a Ministry of Social Development referred employment-related program Submit a copy of your spouse's Employment Plan. If your spouse is participating in another type of employment related program complete the section "My spouse is currently looking for work".			
NAME OF PROGRAM	START DATE (YYYY/MM/DD)	END DATE if applicable	PHONE ()
<input type="checkbox"/> My spouse is currently looking for work. Indicate the time spent looking for work.			
START DATE (YYYY/MM/DD)	END DATE if applicable	HOURS/DAY From: _____ To: _____	
DAYS/WEEK: <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN	Keep a record of your spouse's work search activities as you will be asked to supply proof of his/her activities. Note: In a two parent family, only you or your spouse (not both) may be seeking employment to be eligible for child care subsidy.		
<input type="checkbox"/> My spouse currently has a medical condition. A medical doctor must confirm that the condition interferes with your spouse's ability to care for your child(ren) who require child care. Have a medical doctor complete a Medical Condition form (CF2914) and return it to you to submit with this application.			

6. Income Test If your income changes call 1-888-338-6622.

Do any of the following circumstances apply to your situation?

Receive Child in the Home of a Relative (CIHR) or Extended Family Program (EFP) assistance; foster parent applying for a foster child; or care for a child under a court ordered temporary or interim custody order with MCFD.

- NO → Complete the rest of this section YES → Go to Section 7.

APPLICANT

SPOUSE

<p>What are your sources of income? Check <input checked="" type="checkbox"/> any of the boxes that apply. Submit proof of income. Include photocopies of two most recent pay slips or income statements for regularly received income and periodic income.</p>	
<input type="checkbox"/> Employment Income <input type="checkbox"/> Self-employment income (submit CF2568) <input type="checkbox"/> Employment Insurance benefits <input type="checkbox"/> Income Assistance or Band Assistance <input type="checkbox"/> Worksafe BC <input type="checkbox"/> Federal benefits (CPP, Survivors benefits, CPP disability) <input type="checkbox"/> Training or living allowance <input type="checkbox"/> Grants/bursaries/scholarships <input type="checkbox"/> Other investment, interest <input type="checkbox"/> Spousal and/or child support received.... \$ _____ avg/month <input type="checkbox"/> Tips \$ _____ avg/month <input type="checkbox"/> Income from Dependent Adults.....\$ _____ /month <input type="checkbox"/> Rental Income (room/board/suite) \$ _____ /month <input type="checkbox"/> Other income \$ _____ /month	<input type="checkbox"/> Employment Income <input type="checkbox"/> Self-employment income (submit CF2568) <input type="checkbox"/> Employment Insurance benefits <input type="checkbox"/> Income Assistance or Band Assistance <input type="checkbox"/> Worksafe BC <input type="checkbox"/> Federal benefits (CPP, Survivors benefits, CPP disability) <input type="checkbox"/> Training or living allowance <input type="checkbox"/> Grants/bursaries/scholarships <input type="checkbox"/> Other investment, interest <input type="checkbox"/> Spousal and/or child support received.... \$ _____ avg/month <input type="checkbox"/> Tips \$ _____ avg/month <input type="checkbox"/> Income from Dependent Adults.....\$ _____ /month <input type="checkbox"/> Rental Income (room/board/suite) \$ _____ /month <input type="checkbox"/> Other income \$ _____ /month

7. List all children who require child care

If this is your first time applying submit a photocopy of one (1) piece of government issued identification for each child (i.e. Birth Certificate or Care Card). If you have more than two children requiring child care, submit a separate copy of this page.

If you have shared custody for any child requiring care, complete the "Time Of Day & Days Required" section only for the time the child is in your custody.

CHILD'S LAST NAME	FIRST	BIRTH DATE (YYYY/MM/DD)	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
Check <input checked="" type="checkbox"/> any boxes that apply to this child <input type="checkbox"/> receive CIHR or EFP assistance (submit proof) <input type="checkbox"/> Foster Child		<input type="checkbox"/> Temporary/Interim Custody order <input type="checkbox"/> Child with Special Needs (submit Special Needs CF2951)	If this child attends school, check one: <input type="checkbox"/> Kindergarten <input type="checkbox"/> Grade 1 and up		
Child Care Provider (submit Child Care Arrangement CF2798)	START DATE (YYYY/MM/DD)	END DATE (YYYY/MM/DD)	# OF HOURS/ DAY	# OF DAYS/ WEEK	# OF DAYS/ MTH (max.20)
TIME OF DAY & DAYS CARE IS REQUIRED (check any that apply) <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Weekends <input type="checkbox"/> Before School <input type="checkbox"/> After School			Time from: _____ to _____ <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN		

CHILD'S LAST NAME	FIRST	BIRTH DATE (YYYY/MM/DD)	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
Check <input checked="" type="checkbox"/> any boxes that apply to this child <input type="checkbox"/> receive CIHR or EFP assistance (submit proof) <input type="checkbox"/> Foster Child		<input type="checkbox"/> Temporary/Interim Custody order <input type="checkbox"/> Child with Special Needs (submit Special Needs CF2951)	If this child attends school, check one: <input type="checkbox"/> Kindergarten <input type="checkbox"/> Grade 1 and up		
Child Care Provider (submit Child Care Arrangement CF2798)	START DATE (YYYY/MM/DD)	END DATE (YYYY/MM/DD)	# OF HOURS/ DAY	# OF DAYS/ WEEK	# OF DAYS/ MTH (max.20)
TIME OF DAY & DAYS CARE IS REQUIRED (check any that apply) <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Weekends <input type="checkbox"/> Before School <input type="checkbox"/> After School			Time from: _____ to _____ <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN		

8. List all dependent adults and/or children living in your household, not already indicated on this form

The number of dependants in the household may affect your amount of subsidy. Attach additional sheets as needed. If this is your first time listing this person on your application, submit identification for the person.

DEPENDANT'S LAST NAME		FIRST	MIDDLE
<input type="checkbox"/> MALE	BIRTH DATE (YYYY/MM/DD)	SOCIAL INSURANCE NUMBER (If Applicable)	Does this person receive government disability benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, submit a photocopy of the benefit statement.
<input type="checkbox"/> FEMALE			

DEPENDANT'S LAST NAME		FIRST	MIDDLE
<input type="checkbox"/> MALE	BIRTH DATE (YYYY/MM/DD)	SOCIAL INSURANCE NUMBER (If Applicable)	Does this person receive government disability benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, submit a photocopy of the benefit statement.
<input type="checkbox"/> FEMALE			

9. Declaration

Applicant: I confirm the information supplied by me is true and complete. I understand that:

- I am required to promptly supply information to the Child Care Subsidy Program if there is a change to any of the information I have provided in this application or to any subsequently provided information.
- It is an offence under the *Child Care Subsidy Act* to supply false or misleading information.
- Subsidy may be paid from the first day of the month in which the application is completed, or the date child care begins, whichever is later. I am responsible for child care fees prior to this date.
- Information contained in this document may be reviewed, audited and verified as provided by Section 5 of the *Child Care Subsidy Act*. I consent to the verification of information provided regarding this application, or any updated or subsequently provided information. I also consent to the collection of verifying information from third parties. Information may be verified with any person or source, for the purpose of determining or auditing my eligibility for Child Care Subsidy.

Consent to share information

As the applicant, do you consent to the disclosure of information to your spouse, as identified on this form, relating to this application or your eligibility for child care subsidy by the Child Care Subsidy Service Centre?

- Yes.** Share information with my spouse. If I wish to withdraw this consent, I may do so at any time by writing to the Child Care Subsidy Service Centre.
- No.** Do not share any information about this application or my eligibility with my spouse.

APPLICANT'S NAME (please print)	APPLICANT'S SIGNATURE	DATE SIGNED (YYYY/MM/DD)

Spouse Consent

I consent to the verification of information provided by the applicant regarding myself in this application, or any updated or subsequently provided information. I also consent to the collection of verifying information from third parties. Information may be verified with any person or source, for the purpose of determining or auditing my eligibility for Child Care Subsidy.

SPOUSE'S NAME (please print)	SPOUSE'S SIGNATURE	DATE SIGNED (YYYY/MM/DD)

**Once completed, please fax or mail to the Child Care Subsidy Service Centre.
Keep a copy for your records.**

If you are faxing your application, please clearly print your name and your social insurance number on each page of this form.

**Toll Free Fax 1-877-544-0699
Toll Free Phone 1-888-338-6622**

Mailing Address
Child Care Subsidy Service Centre
PO Box 9953 Stn Prov Govt
Victoria BC V8W 9R3