Arkansas Department of Human Services

Early Childhood Education and Out of School Time Program Assistance

CHANGE REPORT/REDETERMINATION FOR ELIGIBILITY

Casehead Name _____Social Security Number _____ County _____

Address _____ City _____ Zip Code _____

Home Phone/Cell _____ Message Phone _____

Email Address _____

Check the appropriate box indicating type of change and complete all information in that section

☐ **Check this box if you have no household changes to report.**

☐ **Household Eligibility Unit Change**

Add/Remove	Social Security #	First Name Mi Last Name	Date of Birth	Child Care Needed?	Relationship	Date no longer in household?
☐ Add ☐ Remove				☐ Yes ☐ No		
☐ Add ☐ Remove				☐ Yes ☐ No		
☐ Add ☐ Remove				☐ Yes ☐ No		
☐ Add ☐ Remove				☐ Yes ☐ No		

☐ **Authorized Representative:** If you want to choose someone to represent you, please complete the following information. If you name an authorized representative, this person will be able to talk to the DHS worker on your behalf. ***CCDF Program Participant (child care provider) CANNOT be listed as authorized representative***

Name of Authorized Representative: _____Home or Cell Phone: _____

☐ **Employment Change**

☐ Took new job: New Employer: _____ Start Date: _____

☐ No longer employed. Date of termination: _____

☐ Increase of hours to _____ per week ☐ Decrease of hours to _____per week

☐ **Income:** ☐ increase ☐ decrease in income to $ _____received ☐ weekly ☐ every 2 weeks ☐ twice monthly ☐ monthly

How many hours do you work per week? _____

☐ **Work/School Schedule**

EMPLOYMENT INFORMATION:

Name:	**List work schedule below (List actual start/end times for each day)**						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Employer:							
Start date:	**Average Weekly Hours:**	**Estimated Daily Travel Time:**	**Working Status:** ☐Full Time ☐Part Time ☐Temporary ☐Seasonal				
Name:	**List work schedule below (List actual start/end times for each day)**						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Employer:							
Start date:	**Average Weekly Hours:**	**Estimated Daily Travel Time:**	**Working Status:** ☐Full Time ☐Part Time ☐Temporary ☐Seasonal				

☐ **Education/ Job Skills Training**

☐ Added class(es). I am now taking _____ hours. ☐ Dropped class(es) I am now taking _____ hours.

☐ No longer attending school as of _____.

SCHOOL INFORMATION:	☐**Currently attending GED program** ☐**Currently attending high school** ☐ **Currently attending Higher Education or Job Skills Training Program**						
Name:	**List school schedule below (List actual start/end times for each day)**						**Estimated Daily Travel Time:**
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
School:							
Start Date: **End Date:**	**Hours Enrolled:** **Student Status:** ☐ full time ☐ part time **Major or course of study:**						
Name:	**List school schedule below (List actual start/end times for each day)**						**Estimated Daily Travel Time:**
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
School:							
Start Date: **End Date:**	**Hours Enrolled:** **Student Status:** ☐ full time ☐ part time **Major or course of study:**						

☐ **CCDF Program Participant (child care provider) change** A change of CCDF Program Participant (child care provider) may require a redetermination of eligibility. Payments to the new CCDF Program Participant (child care provider) are your responsibility until the change is processed. The following information is required ten (10) calendar days prior to the date of change:

- Child Care Arrangement Form and
- Change Form

Name of New Child Care Provider: _____Start Date: _____

Last day of attendance at previous Child Care Provider: _____

☐**Child Care Services**

Add/Remove	Child's Name	Start Date	End Date	Type of Services Requested
☐ Add ☐ Remove				☐Full Day ☐Night ☐Weekend ☐ Half-Time ☐Part-Time
☐ Add ☐ Remove				☐Full Day ☐Night ☐Weekend ☐ Half-Time ☐Part-Time
☐ Add ☐ Remove				☐Full Day ☐Night ☐Weekend ☐ Half-Time ☐Part-Time
☐ Add ☐ Remove				☐Full Day ☐Night ☐Weekend ☐ Half-Time ☐Part-Time

☐ **Other** explain): _____

_____

***Change/Redetermination Certification:**

I certify that I have read and understand my Rights and Responsibilities. I authorize DHS to collect information from other sources to determine my eligibility for assistance. I authorize any source DHS deems necessary to determine eligibility to release information concerning me. I certify under penalty of perjury and fraud that all information I have supplied is true and correct. I understand that giving false information or withholding information may result in denial, termination, or disqualification of child care assistance or criminal prosecution, and the repayment of financial assistance made on my behalf.

Signed: _ _____ **Date:** _ _____

If you have any questions, please contact , Family Support Specialist, Phone: or Email:

IN ORDER TO ENSURE CHANGES ARE RECEIVED, YOU MUST MAIL, EMAIL, OR FAX THIS FORM TO YOUR FAMILY SUPPORT SPECIALIST OR HAND DELIVER THEM. NOTE: *CHANGE FORMS FROM OTHER PROGRAMS ARE NOT VALID FOR CHILD CARE ASSISTANCE CASES.*
Comments/Narration (DHS Use Only):