



Department of Planning & Community & Economic Development

## Community Development Division

215 Martin Luther King Jr Blvd, Ste. 300

Mailing Address:

P.O. Box 2627

Madison, Wisconsin 53701-2627

Phone: (608) 266-6520

Fax: (608) 261-9626

[www.cityofmadison.com](http://www.cityofmadison.com)

Child Care  
Community Resources  
Community Development Block Grant  
Madison Senior Center

Dear Family,

Thank you for reaching out to the City of Madison.

The first steps of the application process are to

**Apply to Wisconsin Shares:** Visit [www.access.wi.gov](http://www.access.wi.gov) to apply. If you've already applied, please send us the complete case summary, including all pages.

**Residency Requirement:** You must be a resident of Madison. Please provide a current lease or mortgage statement. (Find property information here: [City of Madison Property Information](#)). If you are receiving housing assistance, please provide proof.

**Income Verification:** Provide the last six weeks of income for all adults living in your household. If you are not working, please provide proof of your source of income like SSI, Child Support, Alimony statement, etc.

**Single-Adult Household:** If only one adult resides in the household, we need a copy of your child support order or court custody documents. (You can access child support services here: [Wisconsin Child Support](#)).

**Provider Accreditation:** Your childcare provider must be city accredited. You can verify this here: Childcare Finder. <https://childcarefinder.wisconsin.gov/>

**Additional Information:** If there are any special circumstances or issues, you'd like us to consider, please provide a brief note. If possible, include supporting documentation.

**Please note:**

- We do not backdate funding or pay off current balances owed to providers.
- Applications are processed in the order they are received.
- The application process can take up to 6 weeks once we receive all the required documents.

Please review and complete the forms below.

Important: Do not send photos of documents. Please fax or email documents *in PDF format only*.

If you have questions, please e-mail at [childcareassistance@cityofmadison.com](mailto:childcareassistance@cityofmadison.com).

Sincerely,

Child Care Unit



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**APP**

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## CHILD CARE ASSISTANCE APPLICATION

### APPLICANT INFORMATION

|                                     |  |
|-------------------------------------|--|
| Name of Applicant (Parent/Guardian) |  |
| Check One:                          | <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Legal Custodian |
| Address (Street, Apt. /Unit.)       |  |
| (City, State, Zip)                  |  |
| Telephone                           |  |
| E-mail Address                      |  |

### LIST THE FULL NAMES OF ALL FAMILY MEMBERS (LIST PARENTS/GUARDIANS FIRST)

| NAME<br>(LIST PARENTS/GUARDIANS FIRST) | DATE OF<br>BIRTH | LIVES WITH<br>APPLICANT                                  | RELATIONSHIP<br>TO APPLICANT | CHILD CARE<br>NEEDED                                     | CURRENT PROVIDER |
|--|------------------|--|------------------------------|--|------------------|
|  |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |
|  |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |
|  |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |
|  |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |
|  |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |
|  |                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |

### INCOME INFORMATION

LIST ALL INCOME INFORMATION IDENTIFIED BELOW FOR EACH PARENT/GUARDIAN RESIDING IN THE HOUSEHOLD.

|                                       | APPLICANT'S GROSS<br>MONTHLY INCOME | ALLOWABLE DEDUCTIONS   |
|---------------------------------------|-------------------------------------|--|
| Wages/Salary (applicant)              | \$                                  | Health Insurance Premiums \$   |
| Wages/Salary (other adult)            | \$                                  | Dental Insurance Premiums \$   |
| Net Income From Self-Employment       | \$                                  | Vision Insurance Premiums \$   |
| Food Shares                           | \$                                  | Medical Payment Plan Paid To \$  |
| Social Security                       | \$                                  | Child Support Payments \$  |
| Public Assistance (W-2)               | \$                                  | Shelter expense \$   |
| Pensions & Annuities                  | \$                                  | <b>Does your child have special needs?</b> Please List below. Include documents. |
| Unemployment Compensation             | \$                                  |  |
| Worker's/Disability Compensation      | \$                                  |  |
| Alimony (not child support)           | \$                                  |  |
| Veteran's Pensions                    | \$                                  |  |
| <b>TOTAL (COMBINED) FAMILY INCOME</b> | \$                                  |  |

**EMPLOYMENT AND SCHOOL OR TRAINING INFORMATION**

PLEASE PROVIDE EMPLOYMENT AND SCHOOL OR TRAINING INFORMATION (IF APPLICABLE) FOR YOURSELF AND OTHER ADULT (18+) **HOUSEHOLD MEMBERS**. IF THERE ARE ADDITIONAL ADULT HOUSEHOLD MEMBERS EMPLOYED OR IN SCHOOL/TRAINING, PLEASE ATTACH AN EXTRA SHEET AND SUPPLY THE INFORMATION REQUESTED FOR EACH MEMBER.

|                              |  |
|------------------------------|--|
| Name of Applicant (Employee) |  |
| Employer                     |  |
| School or training agency    |  |
|                              |  |
|                              |  |

|                              |  |
|------------------------------|--|
| Name of Applicant (Employee) |  |
| Employer                     |  |
| School or training agency    |  |
|                              |  |
|                              |  |



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**ROI**

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**STATEMENT OF UNDERSTANDING FOR CITY OF MADISON CHILD CARE ASSISTANCE**

**THE FOLLOWING STATEMENTS MUST BE INITIALED. INITIALS INDICATE THAT YOU UNDERSTAND EACH PARAGRAPH.**

**INITIALS**

I understand that the information on this application is confidential.

I understand that I must reside in the City of Madison to receive City of Madison Child Care Assistance and must continue residing in the City of Madison to receive that assistance. The child receiving funds must reside with parent, in the city of Madison.

I certify that the information on this application given in connection with it is a true and complete representation of facts according to the best of my knowledge and belief.

I understand that I must provide correct information. Incorrect or untruthful information is consider fraud and subject to prosecution. If I am found to have intentionally violated the program rules, my child care subsidy will be permanently suspended and I will be required to pay back the funds.

I understand that I'm required to verify my income on a regularly scheduled basis and that I must inform the Child Care Unit of ANY changes within 5 business days from the day they occur. Child care office can take up to 6 weeks to update the change.

I understand that it is my responsibility to get all necessary documents to the child care unit at the city of Madison.

I understand that I'm required to send documents that are clear and complete. I will not send photos or copy and paste documents on email. (Documents should be faxed or sent as PDF files or via regular USPS.)

I understand that I can access my WI shares case through [access.wisconsin.gov](http://access.wisconsin.gov) & report changes, check, renew benefits and view my letters.

I understand that Dane County Human Services will not release any information to the City of Madison. It is my responsibility to get the documents to the city of Madison.

Failure to return requested information before the deadlines or notification of any change can result in delays or forfeiture of benefits. This can also include your case being closed. It may take up to 6 weeks to process the application after we have all the necessary documents.

I give the City of Madison Community Development Division the right to verify information on this application. This includes speaking to my school, training center, employer, child care provider, property owner, government agencies (except Dane County Human services), etc.

I understand that if I feel that the rules of eligibility as stated in the Madison General Ordinance 3.12(9)(g) have not been fairly applied in my case, I may file a request for an appeal of the decision by requesting an administrative review in writing to the Child Care manager within thirty (30) days of receipt of the decision.

I have received a copy and agree to abide by the Obligations of Families Receiving Child Care Assistance from the City of Madison.

\* I grant permission to \_\_\_\_\_ (if needed) to share information with the City of Madison child care unit only during the application and review process.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, the undersigned, hereby give permission to any governmental agency or department, to release to the City of Madison Community Development Division Child Care Unit, any information concerning my case for the last 6 months (from today's date). This includes the Social Security Administration, Community Development Authority (CDA Housing), educational, financial and health care institutions, employers, residential lessor and child care providers.

I grant any release of information of financial status, medical history, present address, wage or benefit record, and my use of agency resources/ services and associated costs incurred.

**THIS INFORMATION SHALL BE USE WITHIN THE BOUNDS OF PROFESSIONAL CONFIDENTIALITY.**

*\*If Applicable.*

**Applicant's Name (print)**



**Applicant's Signature**



**Date**



**This form is valid until next review date.**



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**EMP**

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### EMPLOYMENT/PAYROLL VERIFICATION STATEMENT

*(THIS FORM IS TO BE COMPLETED BY THE EMPLOYER/REPRESENTATIVE)*

To Whom It May Concern:

The employee indicated below is a candidate for City of Madison Child Care Assistance. In order to determine eligibility we must verify employment information. This information will be use within the bounds of professional confidentiality. As the employer representative, please complete the following information. Fax the completed form to (608) 261-9626. If you have questions, please contact the Child Care Scholarship Coordinator, via e-mail at [childcareassistance@cityofmadison.com](mailto:childcareassistance@cityofmadison.com).

#### *Employee's Name: →*

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Hire Date  | <input type="checkbox"/> Change in Schedule Date |  |
| End Date  |  |  |
| Number of Hours Scheduled Per Week  |  |  |
| Rate of Pay Per Hour  |  | \$ _____ /per hour   |
| Weekly Work Schedule (e.g. M-F, 8am-4:30 pm)  |  |  |
| Date of (check one) <input type="checkbox"/> First <input type="checkbox"/> Next Paycheck |  |  |
| Employee is Paid  |  | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly          |
| Employee's Medical Insurance Premium  |  | \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly |
| Employee's Dental Insurance Premium   |  | \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly |
| Child Support Deduction   |  | \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly |

#### *Employer's Name: →*

|                                      |  |
|--------------------------------------|--|
| <b>Employer Information</b>          |  |
| Employer Identification Number (EIN) |  |
| Address (Street)                     |  |
| (City, State, Zip)                   |  |
| Telephone                            |  |
| E-mail                               |  |

#### *Individual Completing This Form*

|                                     |                               |
|-------------------------------------|-------------------------------|
| Name                                |                               |
| Position/Title                      |                               |
| Telephone (if different from above) | <input type="checkbox"/> Same |
| E-mail (if different from above)    | <input type="checkbox"/> Same |

As the employer/employer representative, I certify that the information completed above and given in connection with it is true and a complete representation of facts to the best of my knowledge.

-----  
Signature

-----  
Date