DCC-600
(R. 11/23 [09/22])
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # ___________
Date ___________

Employee Child Care Assistance Partnership Application and Contract

Section I. Must [To] be completed [only] by the employer

Please provide the following information from your records:

1. Employee name ______________________________

2. Is this person currently employed by you? ☐Yes ☐No

3. Date hired [Date of most recent hiring]___________ Date first paid ______________

4. [Hourly pay rate ________Overtime rate _________Anticipated hours per week ________Day of week paid_________Shift premium __________

5.] Is the employee's share of taxes deducted from gross wages? ☐ Yes ☐No

5. Gross monthly income [6. Is the employee's hourly pay rate scheduled to change? ☐ Yes ☐ No If yes, the pay rate will change to _________________beginning on _________________and will be reflected in the check the employee will receive on___________________.]

[7. Are wages paid] ☐weekly, ☐ every two weeks, ☐ twice a month, ☐ monthly, ☐ other]______________________________

6. [8.] If employed for two or more months, list the wages that have been paid during the previous two months or provide and attach two months of paystubs. For self-employed individuals, please attach the most recent tax return or recent business records.

Date Received	Hours	Gross Wages	*Tips	Date Received	Hours	Gross Wages	*Tips
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

7. [9.] Employee title ______________________________

8. [10.] Does the business have less than fifty (50) employees working more than thirty-five (35) hours per week? ☐Yes ☐No

9. [11.] Industry of the business ______________________________

10. [12.] Contribution amount towards employee's child care cost __________ monthly [, ☐weekly ☐ every two weeks, ☐ twice a month, ☐ other☐]

11. Start date of contribution___________ End date of contribution __________________

[Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state and federal law, including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.]

Employer/business name ______________________________Phone (_____) ______________

Physical address ________________________ City____________________State _______ County_______________ Zip ___________

Mailing address _________________________City____________________State _______ Zip ___________

DCC-600
(R. 11/23 [09/22])
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # ____________
Date _________________

Email address ____

Total number [amount] of employees _____________

Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state law, KRS 199.990(8), including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.

Name and title of individual completing this section ____

Signature ____

DCC-600
(R. 11/23 [09/22])
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # ____________
Date ________________

Section II. Must [To] be completed [only] by the employee

Please list all adult household members and all sources of income:[.]

Household Member	Relationship	Job Title [Source of Income]	Source of Income [Amount of Gross Income]	Gross Monhtly Income [Frequency of Income]

Please list all dependent household members and all sources of income:

Household Member	Relationship	Date of Birth	Source of Income	Gross Monthly Income	Is child care needed? Y or N

How many child care programs are needed?___________

Are you or a household member currently working for an employer other than that specified in Section I? If yes, you **must** attach proof. Proof could be a check stub from the current month or a written statement from the employer.

[Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state and federal law, including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge. I agree to pay the remaining child care costs not covered by the employer and state match.]

Name ____ Phone (_____) __________________

Physical address ______________________________________ City ______________________ State __________

DCC-600
(R. 11/23 [09/22])
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # ____________
Date ________________

County______________________Zip __________

Mailing address ____ City ________________________State ________ Zip ___________

Email address____

Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state law, KRS 199.990(8), including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.

Signature ____

Print Name ____

DCC-600
(R. 11/23 [09/22])
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # ____________
Date ________________

Section III. Must [To] be completed [only] by the child care provider

If using multiple providers, please complete Section III of this form for each provider.

Please state the commercial rate of care for the child(ren) for whom care is to be provided through this program:

Weekly Rate: __________ Child's name [and DOB]:_________________________________[Billing cycle:]____________
Daily Rate:____________ Date of Birth:_______________________________________

Start date: ___________End date:_______

Weekly Rate: __________ Child's name [and DOB]:_________________________________[Billing cycle:]____________
Daily Rate:____________ Date of Birth:_______________________________________

Start date: ___________End date:_______

Weekly Rate: __________ Child's name [and DOB]:_________________________________[Billing cycle:]____________
Daily Rate:____________ Date of Birth:_______________________________________

Start date: ___________End date:_______

Weekly Rate: __________ Child's name [and DOB]:_________________________________[Billing cycle:]____________
Daily Rate:____________ Date of Birth:_______________________________________

Start date: ___________End date:_______

Weekly Rate: __________ Child's name [and DOB]:_________________________________[Billing cycle:]____________
Daily Rate:____________ Date of Birth:_______________________________________

Start date: ___________End date:_______

[Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state and federal law, including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.]

Child care provider/business name ____CLR # ______________________

Licensee name ________________________________ Phone (____)________________

Physical address ____City ______________________State ________

County________________ Zip ________________________________

Mailing address ____________________________City__________________State__________Zip ____________________

Email address____

Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state law, KRS 199.990(8), including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.

DCC-600
(R. 11/23 [~~09/22~~])
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # ____________
Date ________________

Name and title of individual completing this section ____

Signature ____