DCC-600
(R. 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. 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 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

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_____

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.

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

9. Employee title _____

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

11. Industry of the business _____

12. Contribution amount towards employee's child care cost _____ ☐weekly, ☐ every two weeks, ☐ twice a month,☐ monthly,☐ other_____

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 _____ Zip _____

Mailing address _____ City_____State _____ Zip _____

Total amount of employees _____

Name and title of individual completing this section _____

Signature _____

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Section II. To be completed only by the employee

Please list all household members and all sources of income.

Household Member	Relationship	Source of Income	Amount of Gross Income	Frequency of Income

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.

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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 (_____)_____

Mailing address _____ City _____ State _____ Zip _____

Signature _____

Print Name _____

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

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

Rate: _____ Child's name and DOB:_____ Billing cycle:_____

Rate: _____ Child's name and DOB:_____ Billing cycle:_____

Rate: _____ Child's name and DOB:_____ Billing cycle:_____

Rate: _____ Child's name and DOB:_____ Billing cycle:_____

Rate: _____ Child's name and DOB:_____ Billing cycle:_____

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 _____ Zip _____

Name and title of individual completing this section _____

Signature _____