COMMUNITY COORDINATED CARE FOR CHILDREN, INC.
AT-RISK CHILD CARE CHECKLIST

The following information **must** be received by 4C in order to ensure that the request for child care services is processed. Please initial the line next to each item to verify that the information has been provided. **Referral must be received and processed by 4C prior to child(ren) starting at the child care provider. Please do not fax referrals directly to child care providers**.

Name of parent/guardian(s): _____

Name(s) of child(ren): _____

_____ **Type of Authorization –** New, Reenroll, Redetermination

_____ **Complete name of referring worker, email, unit #, address**

_____ **Section A: Client / Family Information**

- Complete name of parent or guardian, SSN#, date of birth, ethnicity / race, marital status. If married, information for spouse should be included.
- Complete address including city, state, zip code, home / work phone numbers

_____ **Section B: Eligibility**

- 'At-Risk' box should be marked, along with PI or PS
- In Home, Out of Home or Foster Care
- If a fee waiver is being requested (FOSTER CARE/NON-RELATIVE ONLY), complete fee waiver, reason number, and attach copy of Shelter Order containing child(rens) name(s).
- Purpose of Services

_____ **Section C: Authorization**

- Total hours of care needed per week
- Complete name, SSN#, date of birth, gender, race, and child care provider selected must be provided for each child for whom care is needed. Each referral can contain up to three children.
- Dates of authorization
- Comments regarding care needed (i.e. evening /week-end care)

_____ **Section D: Authorizing Signatures**

- Must have signature of Referring Worker, Supervisor, and Director (if applicable)

It is the responsibility of the referring worker to contact the child care provider chosen and verify that space is available for the child(ren). Please complete the following information:

Child Care Provider: _____

Provider Address: _____ Provider Phone Number: _____

Name of staff member verifying space for child: _____

Date & Time of contact with Provider: _____

PLEASE PRINT:

Referring Worker Name: _____

Phone Number: _____ Email: _____

Supervisor Name: _____

Phone Number: _____ Email: _____

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