DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF CHILD CARE SERVICES (BCCS)
Child Care Assistance Program

www.guamchildcare.com
671-735-7344 / 7256

APPLICATION FOR CHILD CARE ASSISTANCE OVERVIEW

To be eligible for assistance, your family must:

- Have an accepted service need (reason for child care)
- Meet the income guidelines
- Live in Guam; child(ren) needing childcare must be U.S. Citizen or a Permanent Resident

HOW TO APPLY

1. Applicants MUST have a completed application with all supporting documents relevant to your case.
2. Submit the complete application packet at the BCCS office or via email to: childcare@dphss.guam.gov.
3. Upon receipt of the application, an interview will be conducted in person or through telephone.
4. Applications for assistance will be processed based on the date of completion.

WHAT HAPPENS NEXT

- DPHSS - BCCS will determine your eligibility – based on your need, household income, and family size.
- An eligibility specialist will contact you directly regarding the status of your application.

REQUIRED DOCUMENTS TO DETERMINE ELIGIBILITY FOR CHILD CARE ASSISTANCE		
CHILD CARE APPLICATION FORMS:		
NEW	RENEWAL	
		Child Care Application
		Child Care Provider Data Form
APPLICANT & CO-APPLICANT:		
	N/A	Valid Picture ID (Driver's License, Guam ID, Passport, Permanent Residency, other)
		Employment Verification
		Employment Check Stubs (at least 60 days from application submission date)
		Leave and Earnings Statement (LES) / Military Orders (if applicable)
		If Self-Employed: • Business License & most recent Income Tax Return (1040, 1120, GRT, or other tax forms) • Department of Revenue & Taxation (DRT) Clearance Form • Self-Employment Income Form
		School Schedule (after add/drop period)
		Unearned Income (i.e. Pension, VA, Social Security Awards, School Grant Awards, Rental Income)
		Child/Alimony Support Certification / Absent Parent Statement of Support
ALL HOUSEHOLD MEMBERS:		
	N/A	Social Security Card
	N/A	Birth Certificate or U.S. Passport
		Mayor's Verification
		GHURA Summary Report
ADDITIONAL DOCUMENTS:		
You may be requested to provide additional documents that may be used to support your application materials.		

DATE RECEIVED

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CHILDCARE ASSISTANCE APPLICATION FORM

Please complete all sections of this application. Missing or inaccurate information can delay eligibility determination.

☐NEW ☐RENEWAL ☐ REOPEN ☐HOMELESS

Section 1. APPLICANT INFORMATION

NAME (Last, First, M.I.)	SOCIAL SECURITY	BIRTH DATE (mm/dd/yy)	ETHNICITY	GENDER (M/F)	Relationship to child/children
Applicant					
Co-applicant					

Street Address	Apt No.	Village	State	Zip code
Mailing Address	Apt No.	Village	State	Zip code

Primary Phone Number	Secondary Phone Number	Email	☐ Check this box if your family's combined assets exceed $1,000,000

Section 2. CHILD(REN) INFORMATION

Please ensure to list ALL children in your household. Children needing childcare must be U.S. Citizens or a legal Permanent Resident.
If you have more children and need additional space, please fill out another application form and complete Section 1 and 2 only.

NAME (Last, First, M.I.)	SOCIAL SECURITY	BIRTH DATE (mm/dd/yy)	ETHNICITY	GENDER (M/F)	U.S. CITIZEN	DISABILITY	CHILD CARE REQUESTED
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Section 3. ABSENT PARENT INFORMATION (must be completed if single parent household)

ABSENT PARENT'S NAME	NAMES OF CHILD(REN)	PROVIDES CHILD SUPPORT?
		☐Yes ☐No Amount: ____________
		☐Yes ☐No Amount: ____________
		☐Yes ☐No Amount: ____________

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Section 4. HOUSEHOLD INFORMATION

a.	Is your family experiencing homelessness or does not have a fixed, regular, and adequate nighttime residence?	☐Yes ☐No
b.	Does any parent/caregiver of the child(ren) have a permanent disability that requires full-time accommodation?	☐Yes ☐No
c.	Is any parent/caregiver currently on active duty in the U.S. Military or a member of a Military Reserve unit?	☐Yes ☐No
d.	Is your household experiencing prolonged economic recovery following a territory declared state of emergency?	☐Yes ☐No

Section 5. NEED FOR CHILD CARE ASSISTANCE

*If there is no absent parent for the child(ren), BOTH parents or legal guardians will need to provide supporting documents as applicable.

REASON CARE IS NEEDED	INFORMATION REQUIRED
☐ Working	-Pay stubs for at least 60 days from application submission date for each job you hold -Armed Services Pay (Leave and Earnings Statements) 60 days from application submission date -Verification of Employment
☐ Self-employed	-Business License & most recent Income Tax Return (1040, 1120, GRT or other tax forms) -Department of Revenue & Taxation (DRT) Clearance Form -Self-Employment Income Form *(calculated from one year prior to application submission date)*
☐ Looking for work	-Proof of seeking employment or job search
☐ Attending school	-School schedule (after add/drop period)
☐ Job training program	-Job training registration / schedule
☐ Medically unable to work	-Medical record and/or clearance that proves inability to work
☐ Protective services	"Protective Services" are services provided to any child who is a ward of the courts or living in protective conditions who is confirmed to: • be in foster care as ordered by the court • have been abused or neglected • have been threatened with abuse or neglect • child of essential service worker(s) under a Governor declared State of Emergency ** Please contact our office regarding documents required*

Section 6. HOUSEHOLD INCOME

*Attach copies of income indicated. Please refer to Section 5 for detailed information of documents required for submission.

GROSS MONTHLY INCOME (before deductions such as taxes)	APPLICANT	OTHER PARENT / CAREGIVER
EARNED INCOME		
☐ Salaries, wages, tips, etc.	$	$
☐ Armed Services Pay (Leave and Earnings Statements)	$	$
☐ Self-Employment	$	$
☐ Stipends	$	$
UNEARNED INCOME		
☐ Dividend, Interest, or Trust Fund Income	$	$
☐ Retirement Benefits	$	$
☐ Social Security (SSA)(SSI)	$	$
☐ Veteran's Benefits	$	$
☐ Rental Income	$	$
☐ School Grant Awards	$	$
☐ Child Support / Alimony	$	$
OTHER SOURCES OF INCOME		
☐ Explain:	$	$
☐ Explain:	$	$
TOTAL GROSS MONTHLY INCOME	**$**	**$**

I certify that the information provided on this application is true and complete to the best of my knowledge. The information provided will remain confidential to DPHSS-BCCS. I understand the possibility of criminal charges for misrepresenting or concealing facts that determine eligibility.

Signature: ____________________________________ Date: ________________

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VOLUNTARY REFERRAL TO SERVICES

If you are in need of additional family support, would you like a referral to services in the community for any of the following services:

☐Employment	☐Job Training Program	☐GED Completion	☐Financial Assistance	☐Disability Assistance
☐Homelessness	☐Substance Abuse	☐Domestic Violence	☐Early Intervention	☐Emotional Support

CONSENT TO RECEIVE NOTIFICATIONS VIA EMAIL OR SMS

The Bureau of Child Care Services would like to keep you updated about our program's latest information, news updates, and upcoming calendar events to keep families engaged with our services. If you agree to receive notifications by email or SMS, please acknowledge your consent by clicking the checkbox below. You may withdraw your consent to receive notifications at any time by contacting our office.

☐ I authorize my consent for the Bureau of Child Care Services, through GuamWebz, to send me notifications via email or SMS.

RIGHTS, RESPONSIBILITIES, and AUTHORIZATION

MY RIGHTS

I have the right to:

- Have my records kept confidential.
- Discuss any action regarding my case with my worker or his/her supervisor if I am dissatisfied.
- Be notified at least 15 calendar days in advance before my benefits is discontinued.
- Ask for a fair hearing if I am dissatisfied with any action of the Division of Children's Wellness, Department of Public Health and Social Services and to ask anyone I want to help me get a fair hearing. Any person I choose may represent my case at the hearing.

MY RESPONSIBILITIES

I am responsible to report any of the following changes in my household within 10 calendar days from the time I learn of the change:

- My new address if I move or change my mailing address.
- Changes in employment, education, or training status.
- Changes in the cost of child/dependent care or child care arrangement(s)/provider(s).
- Changes in my household composition.

IF I DO NOT REPORT, AND I RECEIVE MORE ASSISTANCE THAN I SHOULD HAVE, I MAY HAVE TO PAY BACK TO THE GOVERNMENT. IF I FAIL TO REPORT ANY OF THE ABOVE CHANGES ON PURPOSE, THIS IS CONSIDERED FRAUD UNDER STATE AND LOCAL LAWS. IF I AM FOUND GUILTY OF INTENTIONAL PROGRAM VIOLATION, I WILL BE INELIGIBLE TO PARTICIPATE IN THE PROGRAM FOR ONE YEAR FOR THE FIRST VIOLATION, TWO YEARS FOR THE SECOND VIOLATION, AND PERMANENTLY FOR THE THIRD VIOLATION.

MY AUTHORIZATION

I permit the Department to check any information on this application to verify that I am eligible for assistance.

I agree to provide the necessary documents to verify the statements on this application. If documents are not available, I agree to give the name of person(s) or organization(s) (such as doctor, employer, State or Federal Agency) whom the Department may contact for information about the member(s) of my household that may be needed to show that we are eligible for help.

I agree to cooperate with the Department if our case is selected for an audit or Quality Control review.

Signature of Applicant	Date
Signature of Co-applicant	Date

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ADDITIONAL DPHSS RESOURCES FOR FAMILIES

CHILD PROTECTIVE SERVICES (CPS)

Receives and investigates reports of child abuse and neglect. Provides crisis intervention, removal and placement, initiation of court intervention, and case management services.

Tel: 475-2653/72 • Fax: 475-3203

COMMUNITY HEALTH CENTERS (CHC)

Provides comprehensive primary medical care to all ages by appointment or walk-in, regardless of ability to pay. Services include: child health, well child services, vision, hearing, immunizations, fluoride varnish, prenatal care, family planning, pregnancy test, and cancer and STD screening.

Northern Region (Dededo) Tel: 635-4410
Southern Region (Inarajan) Tel: 828-7604
Central Region (Mangilao) Tel: 735-7102 / 73 / 61

DIVISION OF ENVIRONMENTAL HEALTH (DEH) PROCESSING CENTER SECTION

DEH Processing Center Section accepts, reviews, and processes applications for the issuance of health certificates, controlled substances registrations, sanitary permits, and disinterment/reinterment documents.

Tel: 922-2533 / 29 / 30 / 31 / 32

IMMUNIZATION PROGRAM

Provides immunizations for childhood preventable diseases for all children birth -18 years of age.

Tel: 735-7143 • Fax: 734-1475 • TTY: 477-0500

PROJECT BISITA I FAMILIA

Provides home visiting services to support women during pregnancy and after birth. Supports include positive parenting skills such as child development, health, and safety.

Tel: 735-7104/634-7408 • Fax: 735-7097

MATERNAL CHILD HEALTH (MCH) CLINIC

Provides free medical services to vulnerable populations (i.e., well child care to low-income children under age 5 and prenatal care/family planning to women of childbearing age) as well as those with diseases (e.g., STD/HIV, TB) which pose a threat to the community.

Tel: 735-7121 • Administrative Office Tel: 735-7105

MEDICAID PROGRAM

Provides medical care for persons receiving welfare benefits including low-income individuals and families who meet the Medical Categorically Needy Expansion income and resource guidelines. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) also provided by Medicaid.

Tel: 735-7274 • Fax: 735-7092

MEDICAL SOCIAL SERVICES

Provides services to patients and/or families who are experiencing social, emotional, psychological or financial problems related to illness, disabling condition, disability, and its incapacitating effects or high-risk pregnancy including counseling, medical consultation, referral, and crisis intervention.

Tel: 735-7351/7168/7356 • Fax: 735-7103

OFFICE OF VITAL STATISTICS

Mandated by law to register, certify, and maintain records of vital events that occur on Guam to include the processing of birth, marriage, death certificates, and other vital certificates.

Tel: 922-2510 • Tel: 300-9263 / 64 / 65 / 70

PUBLIC ASSISTANCE PROGRAMS

Facilitates the following programs: Temporary Assistance for Needy Families (TANF), Aid to the Permanently and Totally Disabled Persons (APTD), Aid to the Blind (AB), Old Age Assistance (OAA), General Assistance (GA), and Supplemental Nutrition Assistance Program (SNAP).

SNAP Office Mangilao Tel: 735-7245
MIP/ Welfare Dededo Tel: 635-7411
Inarajan Tel: 828-7542

WORK PROGRAM SECTIONS (WPS)

Under WPS are the Job Opportunities and Basic Skills (JOBS) Program and the Guam Employment and Training Program (GETP). JOBS is designed to help TANF recipients become financially independent so they may be able to support their family on their own. The GETP provides free referral services, employment and training opportunities for SNAP recipients to improve their financial situations, minimizing their present and future need for assistance.

Tel: 735-7267 / 735-7344 • Fax: 734-5955