Date Received by CAPS

Georgia Department of Human Resources
CHILD CARE REFERRAL & APPLICATION FOR SUPPLEMENTAL SUPERVISION
_____ County Department of Family and Children Services

A. FOSTER CHILD INFORMATION (To be completed by SSCM)

First Name	MI	Last Name	Sex	Date of Birth	Social Security Number	Child in School	Child in Pre-K	Child in Head Start	Child has a disability

Ethnicity (check one): ☐ Hispanic ☐ Not Hispanic

Race (check one): White Black/African American ☐ Asian
☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

B. FOSTER CARE PLACEMENT INFORMATION (To be completed by SSCM)

Foster Parent's Name	Address	Home Phone
		Work Phone #

If an informal childcare provider has been chosen, check all that apply:

☐ Relative of Child	☐ Care provided in child's home	☐ CRC completed
☐ Non-Relative	☐ Care provided in provider's home	☐ CPS screening completed
		☐ Approved by Foster Care

All changes in the child's placement and child care arrangements MUST be reported to the child care case manager within 5 working days.

_____ _____ _____
Signature of Foster Care Case Manager **Date** **Case Load ID #**

C. CHILD CARE PROVIDER INFORMATION (To be completed by the SSCM or Foster Parent)

Reason Care is Needed:

Days and Hours Care is Needed:

Date to begin CAPS:_____

Name, Address and Phone # of Childcare Provider:

Phone # :

D. ELIGIBILITY DETERMINATION (To be completed by the CAPS case manager)

1. Family Unit Size ____
2. UAS Code (check one):
   ☐ 555 (Pre-K) ☐ 557
3. Provider is:
   ☐ Licensed, Commissioned, or Exempt
   ☐ Registered
   ☐ Informal- Relative of Child
   ☐ Informal- Non-Relative
4. Rate Within DFCS Maximum? ☐ Yes ☐ No
   Cost of care if not within maximum $_____
5. Application Disposition: ☐ Approved ☐ Denied
6. Official Certification Period:
   _____ to _____

Comments:

_____ _____ _____
Signature of CAPS Case Manager **Date** **CAPS Case Load ID #**