At-Risk Child Care Application and Authorization

AUTHORIZATION: X **INITIAL AUTHORIZATION** ☐**REDETERMINATION**

FROM (Print Worker Name)	☐ Broward County Sheriff ☐ Family Strengthening - Diversion Program	Phone	Cell Phone	Fax Number

SECTION A: CLIENT/FAMILY INFORMATION

Social Security Number	(Print) Last Name First Name MI	☐PARENT ☐ RELATIVE☐ FOSTER ☐ OTHER	Date of Birth	Gender	Race
Social Security Number	Spouse or other Parent (if applicable) (Print): Last Name First Name MI		Date of Birth	Gender	Race
Address City State Zip		Day Time Phone No.	FAHIS/investigation intake No.		

Marital Status: If there is NO spouse enter Marital Status Single Married ☐Widowed ☐ Separated

Biological Parent (If different from above)	Social Security Number (Optional)	Date of Birth	Gender	Race
Address	City State	Zip Code	Day Phone	

SECTION B: ELIGIBILITY

I. Status: **AT RISK:** PI ☐ PS ☐ FC ☐Diversion

PLACEMENT LOCATION: In Home ☐ Out of Home: Relative / Non-Relative ☐ Foster Care

II. Purpose of Care (Check One): ☒ Protection (No Verification Required)

Gross Monthly Total Family Income (In Home Services Only):_______________ **ATTACH DOCUMENTATION IF AVAILABLE**

SECTION C: AUTHORIZATION FOR CHILDREN

Child care services are authorized for this client for approved activity(ies). The minimum hours of care per child includes______ _____hours of care per week for reasonable transportation time.

Children Authorized for Care: (0 thru 9 years of age) (Please provide birth verification)

Name	SSN	DOB	Race/Gender	Minimum Hours of Care/Week	Child is covered by Rilya Wilson Act (Check one)
					☐ Yes No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

CARE AUTHORIZATION FROM: _______________ through _______________

Comments: _______________

AUTHORIZING SIGNATURE(S): I hereby certify that the information provided above is correct. Applicant Signature: _______________ Phone: _______________ Date: _______________

Authorizing Worker: _______________ Phone: _______________ Date: _______________

Supervisory Approval: _______________ Phone: _______________ Date: _______________

ELC Staff: _______________ Date: _______________

THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM RECEIPT DATE