State of Montana
Department of Public Health and Human Services
Early Childhood and Family Support Division
http://www.bestbeginnings.mt.gov

BEST BEGINNINGS
CHILD CARE SCHOLARSHIP PROGRAM
Application and Attachment Information

Application

Best Beginnings Child Care Scholarship Application. The scholarship helps you cover the cost of your child care expenses.

- Includes *frequently asked questions and an application checklist*

Attachments Included in Packet

The following attachments are included with the application packet. You may need to complete them to receive a Best Beginnings Child Care Scholarship. Please refer to the application checklist for information regarding each attachment.

ATTACHMENT A: Adult Household Member Information *(2 copies enclosed)*
ATTACHMENT B: Child Household Member Information *(2 copies enclosed)*
ATTACHMENT C: Child Care Service Plan

Attachments Not Included in Packet

The following attachments are not included with the application packet. You may need to complete them to receive a Best Beginnings Child Care Scholarship. Each attachment is available through your Child Care Agency. Forms are also available at childcare.mt.gov.

ATTACHMENT D: Work Verification
ATTACHMENT E: School / Training Verification
- *ONLY need for student applicants*

ATTACHMENT F: Self-Employment Income Verification
- *ONLY need if self-employed*

ATTACHMENT G: Child Support Compliance Verification
- *ONLY need if there is an absent parent*

ATTACHMENT H: Good Cause Exemption
- *ONLY need if claiming good cause*

Supplemental Information Included in Packet

The following information regarding the Best Beginning Scholarship Program is important for you to know.

SUPPLEMENT 1: Reporting Requirements
SUPPLEMENT 2: Right to Appeal (Fair Hearings) Procedures

Submitting Your Scholarship Application Materials

Families seeking child care assistance should complete the following steps.

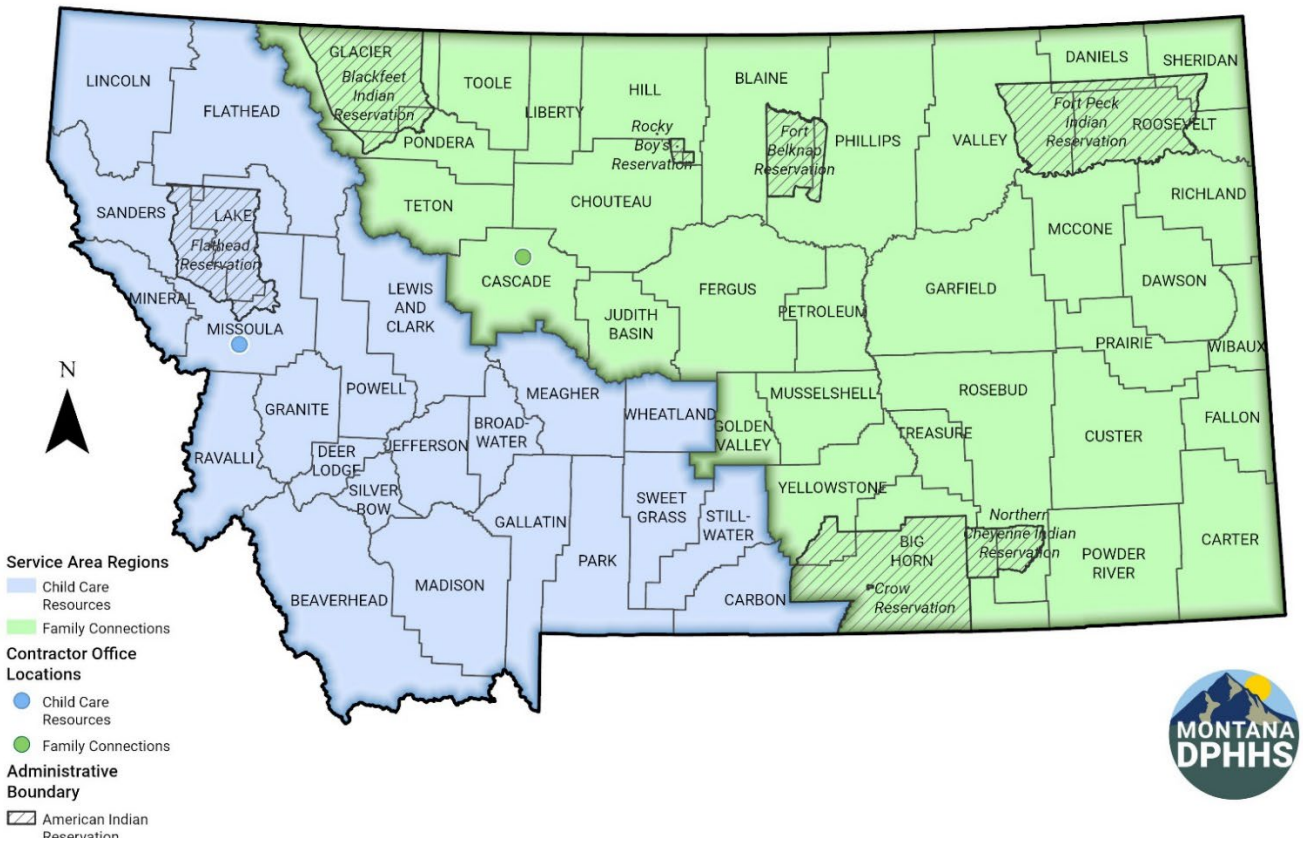
Step 1: Complete the Best Beginnings Child Care Scholarship Application.
Step 2: Complete applicable application attachments.
Step 3: Submit your completed application materials to your county's child care agency.

Application materials are available online or at your region's child care agency. Use the map and contact information below to submit your application materials to the appropriate agency.

Child Care Agencies

The following map shows the Child Care Agency for your county. Please contact them for assistance with your application.

Effective as of 10/1/24



Region 1	**Child Care Resources** 2409 Dearborn Ave., Suite L Missoula, MT 59801	Office: (406) 728-6446 Toll Free: (800) 728-6446 Fax: (406) 549-1189
Region 2	**Family Connections** 410 Central Ave., Suite 402 Great Falls, MT 59401	Office: (406) 761-6010 Toll Free: (800) 696-4503 Fax: (406) 262-7075

For more information, visit https://dphhs.mt.gov/ecfsd/childcare/childcareagencies

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Best BEGINNINGS SCHOLARSHIP
SCHOLARSHIP APPLICATION

1. *PRIMARY REASON THAT YOU ARE APPLYING FOR CHILD CARE ASSISTANCE?*

What is your household makeup? ☐ Single parent ☐ Two parent	Are you a teen parent? ☐ Yes ☐ No
Do you ☐ Own ☐ Rent ☐ Live with relatives ☐ Live with someone else ☐ Other _____	
Do you live in an… ☐ Apartment ☐ House ☐ Mobile Home ☐ Other _____ If other please specify, for example, hotel, motel, camp ground, shelter	
What is the primary reason that you need child care assistance? ☐ Work hours ☐ School hours ☐ Other:	
Have you ever requested or received child care assistance before? ☐ Yes ☐ No If yes, when? Where? (city/county/state)	
Have you ever been disqualified from receiving child care assistance? ☐ Yes ☐ No If yes, when? Where? (city/county/state)	
Are you a SNAP participant? ☐ Yes ☐ No	

2. *WHO IS THE RESPONSIBLE PARTY?*

This is the applicant who is requesting child care assistance and assumes responsibility for following the program rules and requirements, including penalties and repayment of any overpaid benefits.

- Include *proof of identity*, such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate
- Include *proof of your residence*, such as one of the items listed above or a copy of a recent utility bill, rental lease, or mortgage agreement

LAST NAME:	FIRST NAME:			MIDDLE NAME:
OTHER NAMES YOU MIGHT BE KNOWN AS OR HAVE USED IN THE PAST:			E-MAIL ADDRESS:	
ADDRESS (physical):				
CITY:	STATE	ZIP	COUNTY:	TRIBAL RESERVATION:
MAILING ADDRESS (if different):				
CITY: Click or tap here to enter text.	STATE	ZIP	COUNTY:	TRIBAL RESERVATION:
PRIMARY PHONE ☐ Cell ☐ Home ☐ Work ☐ Other _____			SECONDARY PHONE ☐ Cell ☐ Home ☐ Work ☐ Other _____	
What is your primary spoken language?			Do you need an interpreter? ☐ Yes ☐ No	
MILITARY STATUS ☐ Not in the Military ☐ Active Duty US Military ☐ National Guard / Military Reserve				

FOR OFFICE USE ONLY	CS _____ CE_____		HoH Name		Date Received
	Begin Date	End Date	Reason	Determination Date	Determined By

3a. FAMILY MEMBERS – Adult Household Members

List all required Adult Household Members (Age 18 and up) as related to the child(ren) for whom a scholarship is requested:

- *Biological, adoptive parent or stepparent of an intact family, regardless of living arrangements. This would include incarcerated parents or parents working and living out of town.*
- *Parent by common law marriage*
- *Parent joined by a common child*
- *Adult acting in loco parentis*

List optional Adult Household Members (Age 18 and up), only if you want them included in eligibility determination

- *Adult sibling, age 18 and over [no Child Support Services Division [CSSD] requirement]*
- *Aunt or Uncle*
- *Grandparent or Great Grandparent*
- *Parent's Significant Other*

ATTACHMENT A: Adult Household Member Information must be completed for all adults listed below

Relationship to you, the applicant	Name (First, Middle, Last)	Working	Hours per Month	Attending School	Hours per Month
SELF		☐ Yes ☐ No		☐ Yes ☐ No	
		☐ Yes ☐ No		☐ Yes ☐ No	
		☐ Yes ☐ No		☐ Yes ☐ No	

3b. FAMILY MEMBERS - Child Household Members, Living in the Home

Minor Household Members (Age 17 and under)

Minor sibling(s), age 17 and under, including stepbrother, stepsister, half-brother and half-sister;

- *Child receiving Temporary Assistance for Needy Families [TANF] Cash benefits, or other subsidy, as a member of the household*

ATTACHMENT B: Child Household Member Information must be completed for all children listed below.

- *Include proof of each child's relationship to you, such as birth certificate, adoption record, legal guardianship statement*
- *Include proof of each child's age, such as their birth certificate*
- *Include proof of citizenship or immigration status for each child in need of child care assistance, such as birth certificate, an adoption record, or an INS Card*

Please check "Child has Disability" below

- If you have a child with an IEP or 504 in school, enrolled or referred to Part C (Montana Milestones) or Part B (IDEA)

Relationship to you, the applicant	Name (First, Middle, Last)	Attending School	Receiving Child Support	Need Child Care	Child has Disability?
		☐ 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

4. *PROVIDER INFORMATION*

List the provider where your children attend child care.
If the provider is a relative: Please indicate and describe the relationship.
Days / Times of child care: Please indicate the days and times that care is needed.
Child Name: If you have multiple providers and more than one child, please indicate which child attends which provider.

Provider Name	Provider Address	Phone Number	Relative	Relationship	Days / Times of Child Care	Child Name
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

5. *ASSETS*

Does your household have family assets over one million ($1,000,000)? ☐ Yes ☐ No

6. *EARNED INCOME*

List all EARNED income received by you, the applicant and all members of your family.

- Include income received by family members temporarily absent from your home
- Include proof of earned income:
  - ATTACHMENT D: Work Verification

If you or someone in your family is self-employed:

- Complete ATTACHMENT F: Self-Employment Income Verification.

Name ○ of individual earning income	Source of Income ○ Including employer name	Gross Monthly Amount (before deductions)

7. *UNEARNED INCOME*

List all *UNEARNED* income received by you, the applicant and all members of your family.

- Include income received by family members temporarily absent from your home
- Include proof of unearned income, such as a check stub, signed letter from Employer, or income tax records
- Examples of unearned income to include:
  - Child Support
  - Veteran's Benefits
  - Student Loans
  - Unemployment Insurance
  - Social Security
  - Interest / Dividends
  - Insurance Benefits
  - SSI
  - Tribal Payments

Name ○ of individual earning income	Source of Income	Gross Monthly Amount (before deductions)

8. *DEDUCTIONS*

- **Child Support** - Paid out, for children not living in the home. Include proof of child support payments.

Type of Expense (deduction)	Name of Individual Being Paid	Gross Monthly Amount

9. *HERE ARE YOUR RIGHTS AND RESPONSIBILITIES*

	a. I have the right to choose my child care provider. The scholarship will only pay a child care provider that is licensed, registered, or certified.
	b. I will pay a monthly co-payment to the child care provider. If I have an unpaid co-payment, I will be ineligible when I re-apply for the scholarship until receipts of unpaid copayments are received.
	c. I understand that child care providers may set their own rates. Providers may charge in addition to the child care program co-payment obligation. I am responsible for any amount over and above the state reimbursement rates and any registration and activity fees not paid by the Best Beginnings Child Care Scholarship.
	d. I have the right to appeal any loss of scholarship. I will submit a request for a fair hearing within 90 days of receiving the notice regarding the loss of scholarship.
	e. I have a right to receive a monthly EOB (Explanation of Benefits), which shows the care that has been paid for by the state.
	f. I understand that my Best Beginnings Scholarship will be terminated if my family becomes ineligible or if program funds become unavailable.
	g. I understand my child must be living with me for child care to be paid for under the Best Beginnings Child Care Scholarship.
	h. I will be notified of changes that reduce my child care scholarship. A letter will be mailed 15 days before any loss of benefits.
	i. **Reporting Change in Provider:** I will report a change in child care provider to my counties' Child Care Agency within one business day. *Failure to report may mean that the provider will not receive a payment under the scholarship.* The payment start date for the new provider will be the date the change is reported.
	j. **Reporting a Change in Activity Requirements:** I must report a job loss to my counties' Child Care Agency within 10 calendar days. *Failure to report within the required 10 calendar may mean that you don't receive a full grace period.*
	k. **Reporting a Change in Address:** I will report a change in address to my counties' Child Care Agency within 10 calendar days. *Failure to report may mean that you don't receive timely notice on changes to eligibility.*
	l. **Repayment**: Anyone who causes an improper payment to a provider by withholding information about any of the above changes will be required to repay the amount of the improper payment. Repayment must be current with the Business and Fiscal Services Division.
Instructions: Please initial all above requirements.	

10. *AUTHORIZATION TO RELEASE INFORMATION / REQUEST FOR VERIFICATION*

Certain information is needed to determine eligibility. This includes residency, relationship of applicant to children, school attendance, household composition, income, and other circumstances relevant to the need for child care. The Department or this Child Care Agency may request information about any of the issues involved in the Best Beginnings Eligibility Application Packet. You have the responsibility to provide any additional information necessary to determine eligibility. If you are not able to gather the requested information by yourself, your department representative may be able to help you. Because this is your confidential information, you must give permission for your Child Care Agency representative to help you.

***Please Note**: This release does not authorize Child Care Agency staff to obtain any HIPAA-protected information on the behalf of the child(ren), parent(s), or provider(s).

11. *APPLICANT & SPOUSE/OTHER ADULT – Please initial option 1 or 2 and sign below*

OPTION 1: Applicant	OPTION 2: Applicant
___ I give the Department and the Child Care Agency permission to gather information that is necessary to determine eligibility for my family and me. This authorization expires one year from the date this application is signed. I understand that I can revoke this consent in writing at any time.	___ **I DO NOT** wish to sign an authorization to release information. I understand that because of confidentiality issues, the Department and the Child Care Agency will not be able to help in gathering information necessary to determine eligibility. I choose to provide the necessary documentation myself.
OPTION 1: Spouse/Other Adult	**OPTION 2: Spouse/Other Adult**
___ I give the Department and the Child Care Agency permission to gather information that is necessary to determine eligibility for my family and me. This authorization expires one year from the date this application is signed. I understand that I can revoke this consent in writing at any time.	___ **I DO NOT** wish to sign an authorization to release information. I understand that because of confidentiality issues, the Department and the Child Care Agency will not be able to help in gathering information necessary to determine eligibility. I choose to provide the necessary documentation myself.

I hereby affirm that the statements made in this application are accurate, complete, and true to the best of my knowledge. I understand that I must periodically re-apply for assistance and that my eligibility will be re-determined at that time.

_____ _____

Applicant (or Authorized Representative) Signature *Date*

_____ _____

Spouse/Other Adult (or Authorized Representative) Signature *Date*