



### AT-RISK CHILD CARE CHECKLIST

The following information **must** be received by the Coalition 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 process by the Coalition prior to child(ren) starting at the child care provider. Please do not fax referrals directly to child care providers.**

Name of Parent(s)/Guardian: \_\_\_\_\_

Email of Parent(s)/Guardian: \_\_\_\_\_

Name(s) of child(ren): \_\_\_\_\_

\_\_\_ **Type of Authorization** - Initial, Redetermination, or Transfer (Paid in full receipt needed)

\_\_\_ **Complete name of referring worker, organization name, address, & contact number**

\_\_\_ **Section A: Family/Child Information**

- Complete name of parent or guardian, SSN# (optional), date of birth, ethnicity / race, marital status. If two parent household information of other parent should be included
- Complete address including city, state, zip code, contact number
- Complete child name, SSN# (optional), date of birth, gender, and race for each child in family

\_\_\_ **Section B: Eligibility**

- At-Risk status checked
- Verification of U.S. Citizen or Qualified Alien
- Verification of Age
- Comments (Fee waiver form if applicable)

\_\_\_ **Section C: Authorization**

- Total hours of care needed per week
- Dates of authorization not to exceed 6 months

\_\_\_ **Section D: Authorizing Signatures**

- Must have Signature of Referring Worker
- Must have parent/guardian signature

- Have parent create a Family Portal account at <https://familyservices.floridaeearlylearning.com/>
- Submit proof of employment with four weeks of current pay stubs or Verification of Employment (VOE) (if applicable) with referral

**Please complete the following information (Please Print):**

Child Care Provider: \_\_\_\_\_  
 Provider Address: \_\_\_\_\_  
 Provider Phone Number: \_\_\_\_\_

Referring Worker Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email \_\_\_\_\_

Attn: Admin Assistance  
 Fax number 863-577-2469