Continuity of Care Application

A new parent/caretaker must complete the Continuity of Care Form to request continued child care for a child following a family event, which directly results in a change to the child's primary parent/caretaker.

Section A: Child Information

Child's First Name	Middle Initial	Child's Last Name	Suffix (Jr., Sr., etc.)
County / Record Number (if known)	**Date of Birth**	**Social Security Number** (if known)	**Telephone**
/	/ /	— —	( ) —

Section B: New Parent / Caretaker Information

Your First Name	Middle Initial	Your Last Name	Relationship to Child
County / Record Number (if applicable)	**Date of Birth**	**Social Security Number**	**Telephone**
/	/ /	— —	( ) —
Gender	**Race**	**Ethnicity**	**Marital Status**
☐ Male ☐ Female ☐ Unknown		☐ Hispanic ☐ Non-Hispanic	
Mailing Address			**Apartment/Suite**

City	State	Zip Code	Zip Ext (if known)	County

Section C: Income Eligibility (REQUIRED)

Is your family's annual income below 85 % of the State Median Income? SEE ATTACHED INCOME GUIDELINES

☐ Yes ☐ No

Does your family have assets that exceed $1 million?

☐ Yes ☐ No

Section D: Signature and Affirmation (REQUIRED)

I affirm that I have read or had this statement read to me in full and that all information I have given is true, correct and complete to the best of my ability, knowledge and belief. I understand that my statement is made subject to 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and I can be penalized by fine, imprisonment or subsidized child care ineligibility for making any false statements that may affect my eligibility status. I understand that if I receive subsidized child care for which I was not eligible, I will be required to pay back the cost of child care I received in error.

X_____ _____

NEW Parent/Caretaker Signature — Date

Section E: INTERNAL USE ONLY (To be completed by a CCIS Representative)

Representative First Name	Middle Initial	Representative Last Name	Suffix (Jr., Sr., etc.)

New Case Created	County / Record Number Used	Continuity of Care Established	Redetermination Date
☐ Yes ☐ No	/	☐ Yes ☐ No	