Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

Eric Friedlander
SECRETARY

275 East Main Street, 5W-A
Frankfort, Kentucky 40621
Phone: (502) 564-7042
Fax: (502) 564-7091

February 7, 2024

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

Re: 922 KAR 2:165 agency amendment

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of issues raised by 922 KAR 2:165 and incorporated material, the Department for Community Based Services proposes the attached agency amendment. If you have any questions, please feel free to contact Laura Begin at Laura.Begin@ky.gov.

Sincerely,

Lucie Estill

Lucie Estill
Staff Assistant
Office of Legislative and Regulatory Affairs

Agency Amendment

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

922 KAR 2:165. Employee Child Care Assistance Partnership.

Page 9
Section 9(1)(a)
Line 11

After "Contract",", insert "02/24".
Delete "11/23".

Page 9
Section 9(1)(b)
Line 12

After "Action",", insert "02/24".
Delete "11/23".

Incorporated material
DCC-600

A question has been added to indicate if the applicant has any ownership in the employer business and the name of the employer has been included on page 2. The date has been revised.

DCC-605

An option to state that the program application has been amended is being included. The date has been revised.

DCC-600
(R. 02/24)
922 KAR 2:165

COMMONWEALTH OF KENTUCKY

Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care
275 East Main Street, 3C-F
Frankfort, KY 40621
Email: PartnershipChildCare@ky.gov; Phone: 1-844-209-2657; Fax: 502-564-3464

For Office Use Only:
Contract # _____
Date _____

Employee Child Care Assistance Partnership Application and Contract

Section I. Must be completed by the employer

Please provide the following information from your records:

1. Employee name _____

2. Is this person currently employed by you? ☐Yes ☐No

3. Date hired _____ Date first paid _____

4. Is the employee's share of taxes deducted from gross wages? ☐ Yes ☐No

5. Gross monthly income _____

6. If employed for two or more months, list the wages that have been paid during the previous two months or provide and attach two months of paystubs. For self-employed individuals, please attach the most recent tax return or recent business records.

Date Received	Hours	Gross Wages	*Tips	Date Received	Hours	Gross Wages	*Tips
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

7. Employee title _____

8. Does the business have less than fifty (50) employees working more than thirty-five (35) hours per week? ☐Yes ☐No

9. Industry of the business _____

10. Contribution amount towards employee's child care cost _____monthly

11. Start date of contribution _____ End date of contribution _____

12. Does your employee have any ownership in the business? ☐Yes ☐No

Employer/business name _____Phone (____) _____

Physical address _____ City_____State _____

County_____ Zip _____

Mailing address _____City_____State _____ Zip _____

Email address _____ Total number of employees _____

Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state law, KRS 199.990(8), including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.

Name and title of individual completing this section _____

Signature _____

DCC-600
(R. 02/24)
922 KAR 2:165

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Section II. Must be completed by the employee

Please list all adult household members and all sources of income:

Household Member	Relationship	Employer	Job Title	Source of Income	Gross Monthly Income

Please list all dependent household members and all sources of income:

Household Member	Relationship	Date of Birth	Source of Income	Gross Monthly Income	Is child care needed? Y or N

How many child care programs are needed? _____

Are you or a household member currently working for an employer other than that specified in Section I? If yes, you **must** attach proof. Proof could be a check stub from the current month or a written statement from the employer.

Name _____ Phone (____) _____

Physical address _____ City _____ State _____

County _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____

Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state law, KRS 199.990(8), including fines, imprisonment, or both. I certify that the information contained in this form is true and correct to the best of my knowledge.

Signature _____

Print Name _____

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Contract # _____
Date _____

Section III. Must be completed by the child care provider

If using multiple providers, please complete Section III of this form for each provider.

Please state the commercial rate of care for the child(ren) for whom care is to be provided through this program.

Weekly Rate:_____ Child's name:_____
Daily Rate:_____ Date of Birth:_____
Start date: _____ End date:_____

Weekly Rate:_____ Child's name:_____
Daily Rate:_____ Date of Birth:_____
Start date: _____ End date:_____

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Weekly Rate:_____ Child's name:_____
Daily Rate:_____ Date of Birth:_____
Start date: _____ End date:_____

Weekly Rate:_____ Child's name:_____
Daily Rate:_____ Date of Birth:_____
Start date: _____ End date:_____

Child care provider/business name _____ CLR # _____

Licensee name _____ Phone (____) _____

Physical address _____ City _____ State _____

County _____ Zip _____

Mailing address _____ City _____ State_____ Zip _____

Email address _____

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Name and title of individual completing this section _____

Signature _____

DCC-600
(R. 02/24 [~~11/23~~])
922 KAR 2:165

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Please provide the following information from your records:

1. Employee name _____

2. Is this person currently employed by you? ☐Yes ☐No

3. Date hired _____ Date first paid _____

4. Is the employee's share of taxes deducted from gross wages? ☐ Yes ☐No

5. Gross monthly income _____

6. If employed for two or more months, list the wages that have been paid during the previous two months or provide and attach two months of paystubs. For self-employed individuals, please attach the most recent tax return or recent business records.

Date Received	Hours	Gross Wages	*Tips	Date Received	Hours	Gross Wages	*Tips
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

7. Employee title _____

8. Does the business have less than fifty (50) employees working more than thirty-five (35) hours per week? ☐Yes ☐No

9. Industry of the business _____

10. Contribution amount towards employee's child care cost _____monthly

11. Start date of contribution _____ End date of contribution _____

12. Does your employee have any ownership in the business? ☐Yes ☐No

Employer/business name _____Phone (____) _____

Physical address _____ City_____State _____

County_____ Zip _____

Mailing address _____City_____State _____ Zip _____

Email address _____ Total number of employees _____

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Signature _____

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Household Member	Relationship	Date of Birth	Source of Income	Gross Monthly Income	Is child care needed? Y or N

How many child care programs are needed? _____

Are you or a household member currently working for an employer other than that specified in Section I? If yes, you **must** attach proof. Proof could be a check stub from the current month or a written statement from the employer.

Name _____ Phone (____) _____

Physical address _____ City _____ State _____

County _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____

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Child's name:_____
Date of Birth:_____

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Start date: _____ End date:_____
Child's name:_____
Date of Birth:_____

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Daily Rate:_____
Start date: _____ End date:_____
Child's name:_____
Date of Birth:_____

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Daily Rate:_____
Start date: _____ End date:_____
Child's name:_____
Date of Birth:_____

Weekly Rate:_____
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Start date: _____ End date:_____
Child's name:_____
Date of Birth:_____

Child care provider/business name _____ CLR # _____

Licensee name _____ Phone (____) _____

Physical address _____ City _____ State _____

County _____ Zip _____

Mailing address _____ City _____ State_____ Zip _____

Email address _____

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Date _____

Employee Child Care Assistance Partnership Notice of Action

Your application to participate in the Employee Child Care Assistance Partnership was:

☐Approved ☐Amended ☐Denied ☐Terminated

The reason for this is

_____

Effective _____ through (unless terminated) _____

Business contribution (monthly) _____

State match _____

Employer/business name _____

Physical address _____City_____State _____Zip _____

Employee name _____

Physical address _____City_____State _____Zip _____

Child care provider/business name _____

Physical address _____City_____State _____Zip _____
Child's name _____Care start date _____Care end date _____
Approved employer contribution amount _____Approved state contribution amount _____

Child care provider/business name

Physical Address _____City_____State _____Zip _____
Child's name_____Care start date_____Care end date _____
Approved employer contribution amount _____Approved state contribution amount _____

If you are dissatisfied with this decision, you may request an administrative hearing within thirty (30) days from the Office of the Ombudsman and Administrative Review, Quality Advancement Branch, 275 East Main Street, 2 E-O, Frankfort, KY 40621.

DCC-605
(R. 02/24 [11/23])
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Physical address _____City_____State _____Zip _____

Employee name _____

Physical address _____City_____State _____Zip _____

Child care provider/business name _____

Physical address _____City_____State _____Zip _____
Child's name _____Care start date _____Care end date _____
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