

## Colonial Early Education Program (CEEP) Purchase of Care Information

Dear Colonial Families,

We feel that it is important to keep our families informed regarding options available to them. Attached you will find information about Purchase of Care (POC)/Subsidized Child Care, which is offered through the Delaware Department of Health and Social Services (DHSS). Here at the Colonial Early Education Program (CEEP), qualifying families may confidentially use POC to pay for all or part of their Typical Peer Tuition. Our POC Site ID number is: 1710472400.

If you are interested in applying to receive Purchase of Care for your child or children, please read the attached information. If your family qualifies for Purchase of Care, and your child is accepted into CEEP, please submit a copy of your "Form 626-Subsidized Child Care Client Agreement" (a sample Form 626 is attached) to Dorothy Wiggins, Leach School secretary. If you have any questions, please contact Mrs. Wiggins at (302) 429-4096 or [Dorothy.wiggins@colonial.k12.de.us](mailto:Dorothy.wiggins@colonial.k12.de.us).

Sincerely,

*Dawn E. Alexander*

Dawn E. Alexander, M. Ed.  
Preschool Expansion Coordinator



# Delaware Health and Social Services

## Where to go, what to document, and what to bring when applying for Purchase of Care:

There are two Delaware Division of Health and Social Services (DHSS) Offices that serve our Colonial School District area:

- Families who live North of Interstate 295 should visit the **DeLaWarr State Service Center** at 500 Rogers Road, New Castle, DE 19720; the phone number is 302-577-3814.
- Families who live South of Interstate 295 should visit the **Churchman’s Corporate Center** at 84 Christiana Road, Suite B, New Castle, DE 19720; the phone number is 302-395-6740.

KEEP THIS SHEET WITH THIS INFORMATION IN A SAFE PLACE. This is YOUR personal information/check sheet:

- Our Colonial Early Education Program POC Site ID number is: 1710472400.
- Be sure to write down the name of the Social Worker with whom you met for future reference. My social worker’s name is: \_\_\_\_\_.
- Ask for a photocopy of the paper application and/or verification that you applied.

**To apply for Purchase of Care/Subsidized Child Care, bring the following items to your local Delaware Division of Health and Social Services office:**

Check here for each item submitted	Date that item was submitted to DHSS	Item needed:
		Proof of Delaware residency
		Proof of lawful citizenship status
		Proof of earned family income; proof of last four weeks wages
		Proof of family income from SSI, unemployment, pensions, social security checks, and child support
		If you are self-employed, bring tax returns or records
		Social security numbers for all that are applying for benefits
		Proof of schedule for work, school attendance, or training
		Proof of medical needs or special needs
		Proof of cooperation with child support



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

DIVISION OF  
SOCIAL SERVICES

**SUBSIDIZED CHILD CARE  
CLIENT AGREEMENT**

NAME OF CLIENT \_\_\_\_\_

SERVICE AUTHORIZATION EFFECTIVE DATE \_\_\_\_\_

SERVICE AUTHORIZATION EXPIRATION DATE \_\_\_\_\_

As a participant in the Division of Social Services Purchase of Care Service Program, I understand the following:

1. That I may be required to pay a portion of the cost of my child's child care expense. The fee is based on my income and family size. The fee I must pay for each child is shown below.
2. That if my child is absent the Division of Social Services (DSS) will pay my child care provider up to 5 absent days per month. I understand that I must pay my portion of the fee for the same number of absent days per month that the DSS pays.
3. That I must report within 10 days changes that affect either my need for subsidized child care or income. I must report changes that affect me, my spouse, my child(ren) s other parent living in my household, or child(ren) if applicable:

<ul style="list-style-type: none"> <li>• Got a job.</li> <li>• Lost Job. Have changed or taken a new job.</li> <li>• Have taken a second job.</li> <li>• No longer work a second job.</li> <li>• Receive public assistance, social security, child support, VA benefits, etc.</li> <li>• Received an increase or decrease in wages of \$75 more a month.</li> </ul>	<ul style="list-style-type: none"> <li>• Received an increase or decrease in public assistance, Social security, child support, VA benefits, etc. of \$ 75 or more a month.</li> <li>• Enrolled in an education or training class.</li> <li>• No longer enrolled in an education or training class.</li> <li>• Completed training.</li> <li>• No longer need Special Needs' child care.</li> </ul>
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4. That I must also report changes that may or may not affect my need for service or my income:

- Marital Status                      • Family size                      • Address

5. As a participant in the DSS Subsidized Child Care Program I further understand:

- That if I plan to change my child care provider within the authorization period indicated above that I will notify my worker at least 5 care days before moving my child so that a new authorization can be processed.
- That I will notify my current provider of my intent to move my child at least 5 care days before moving my child/ren.
- That I may be responsible for payment to my child care provider at the provider's private fee if I fail to be redetermined eligible for service.
- That my provider may charge me a late pickup fee, returned check fee and field trip fees. That I am not responsible for any other provider fees not included in the Child Care Contract or Certificate.
- I will be required to reimburse the Division of Social Services for payment made for my child/ren if I continue to use childcare when I was not eligible to receive the service.
- That I may experience a disruption in my child care service if I fail to respond to DSS Attendance Quality Control inquiries.
- That this service will automatically end on the expiration date unless I contact my worker for an appointment before the service expiration date above.

In consideration for the payment made by the DSS, I hereby release the Division from any claim or cause of action and agree that I will not hold the Division liable for any injury, illness, or disease resulting to my child(ren) that may arise out of or during the course of service.

Adult Parent Minor Parent	Caretaker Relative Minor Parent/Caretaker Relative	DSS Worker	Date
Children in Care	MCI#	Provider Name	Estimated Daily Fee (may change)