REDETERMINATION LETTER

CCIS of Dauphin County
110 North 26th Street
Harrisburg, PA 17103

Worker Name: DAVID J.
Phone Number: (717) 555-1111

MARY A. SAMPLE
123 MAIN ST
HARRISBURG, PA 17103-2021

CO RECORD
22 0999999

Date: 03/20/2008

Dear MARY A. SAMPLE,

You must submit information to our office **no later than 05/01/2008** in order to maintain your eligibility for subsidized child care.
You may update your information using the enclosed Redetermination Summary Form OR you may update your information online.
If you have any questions about what proof you must submit for changes or require assistance in completing your Redetermination Packet, please contact our office immediately.

INSTRUCTIONS FOR UPDATING INFORMATION USING THE ENCLOSED FORM:

The form gives you the most current information you reported to our office. Please review the information on the form carefully.

If there are NO CHANGES to the information on the form:
• Sign the form;
• Provide proof of pay received for 4 weeks out of the past 6 weeks; and
• Return ALL PAGES OF THE FORM to our office.

If there are CHANGES to the information on the form:
• Note the changes directly on the form;
• Sign the form;
• Provide proof of the changes you noted;
• Provide proof of pay received for 4 weeks out of the past 6 weeks; and
• Return ALL PAGES OF THE FORM to our office.

INSTRUCTIONS FOR UPDATING INFORMATION ONLINE:

If you would prefer to update your information online you must:
• Go to www.compass.state.pa.us and click on "I Get Services Now;"
• In the "Renew Benefits" section, click "Continue;"
• Choose "A Subsidized Child Care Redetermination;" and click "Continue;"
• Type in the following 3 items in the spaces provided on the web page:
  1. Your Social Security Number*; and
     **NOTE: If you have never reported your Social Security Number to the CCIS, you will be unable to update your information online.*
  2. Your County/Record Number: 22/0999999; and
  3. Your family's Redetermination Date: 05/01/2008.
• Click "Continue," then compare the information online to the information shown on the enclosed Redetermination Summary Form;
• Update any information that has changed or add information as needed by following the online directions;
• Click “Submit” when you are finished updating your information online;
• Provide proof of the changes you made or of the information you added online;
• Provide proof of pay received for 4 weeks out of the past 6 weeks.

If you need help while updating your information online, click on "Help."

If you or your spouse have a disability and do not receive disability payments, you must also submit a Medical Assessment Form completed by a licensed physician or psychologist.

If you are receiving subsidy for a foster child, you must submit written verification by the county children and youth agency indicating whether the child continues to be a foster child.

Sincerely,

CCIS of Dauphin County

Correspondence ID: 3999999-1
Co/Record #22/0999999

Redetermination Summary Form

Please make any corrections to printed information by writing the correct information in the gray row directly underneath the information you need to correct. If you need to add additional family members, please add their information in the extra two rows at the end of each section. If you need to remove a family member, please cross out their information.

Last Name	First Name	MI	Sffx	Relationship to you	Sex	DOB	SSN	Citizen? Yes	Citizen? No	Race	Ethnicity
SAMPLE	MARY	A		SELF	F	09/04/1985	111-22-3333	X		White	Non-Hispanic

Demographic Information

Last Name	First Name	MI	Sffx	Relationship to you	Sex	DOB	SSN	Citizen? Yes	Citizen? No	Race	Ethnicity
SAMPLE	JANEY	M		Daughter	F	02/03/2006		X		White	Hispanic

Address & Telephone Information

Address	City	State	Zip Code	County
123 MAIN ST	HARRISBURG	PA	17113-3130	Dauphin

Phone Type	Phone Number	Best Time to Call
Work	(717) 555-2222	
	( )	
Home	(717) 555-2222	WHENEVER
	( )	

Email Address

Parent/Caretaker Employment and Wage Information

Name of Parent/Caretaker	Employer Name and Address	Type (Employment or Self-Employment)	Annual Income	Date Received	Hours per Week
MARY A. SAMPLE	PENN DOT	Employment	$ 20,000.00	04/22/2007	40
			$		

Parent/Caretaker Education/Training Information

Name of Parent/Caretaker participating in an Education/Training program	School Name	Type of School (Elementary, Middle, Senior High, College, Vocational/Technical, Trade)	Hours per Week/ Schedule	Education or Training

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Redetermination Summary Form

Disability Information

Information in the following section pertains to all of the family members with a disability.

If a parent or caretaker in your home has a disability and does not receive disability payments, a medical assessment form must be attached. The medical assessment must be completed by a licensed physician. A copy of the medical assessment form is available at your local CCIS.

Name	Type	Dev. Age (In Months)	Onset Date	Able to care for child	Able to work	End Date

Immunization Information

Child's Name	Is this child immunized? (yes, pending/90 days or no)	Good Cause Exemption (yes or no)	Good Cause Reason (religious or medical)
JANEY M. SAMPLE	Yes		

Other Income and Deductions

Please attach proof of all income and expenses. For employment income please provide proof of pay received for 4 weeks out of the past 6 week period. For self employment, please include a copy of your most recent tax return. For unearned income provide a copy of a check, check stub, or other documentation. Income includes, but is not limited to: money received for babysitting children, room and board, rent money received, Social Security, SSI, child support, Unemployment or Worker's Compensation, money for college or training, dividends or interest earned, pensions, commissions and union pay received. Medical expenses include doctor bills, hospital bills, health care premiums, medication expenses, bills for prosthetic devices and/or bills for durable medical equipment. Medical expenses must have been incurred within the past 90 days and must be expected to continue for the next 6 months.

Other Income

Name of Person with Income	Type/Source of Income (see options above)	Amount of Income	Date Received	How often is the Income Received

Deductions

Name of Person with an Expense	Type/Source of Expense (Medical Deduction, Child Support or Alimony)	Amount of Expense	Date Expense Incurred	How often does the Expense occur

Other DPW Benefits

Do you receive:

Housing Assistance	Food Stamps	Federal Cash Income
No	No	No

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Redetermination Summary Form

Affidavit

I swear or affirm that I have read or have had this redetermination packet and summary form read to me in full. By my signature, I attest that all information I have given is true, correct and complete to the best of my ability, knowledge and belief. Also I have received a written copy of my rights and responsibilities. I understand that information contained in this form may be cross referenced with the Department of Public Welfare Programs. Further, I understand that I can be penalized by fine or imprisonment or subsidized child care ineligibility by making any false statements or for my failure to report any changes that may affect my eligibility status.

Parent/Caretaker Signature	Date
Parent/Caretaker Signature	Date

To be completed by the CCIS Only

Family continues to be eligible from ☐

Family is no longer eligible ☐

CCIS Representative Signature	Date
CCIS Representative Supervisor Signature	Date

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