ALABAMA DEPARTMENT OF HUMAN RESOURCES/
CHILD CARE MANAGEMENT AGENCY
CHILD CARE SUBSIDY REFERRAL FORM

DATE: _____ **TYPE OF REFERRAL:** Health Care Provider / First Responder

To Be Completed by Applicant:

APPLICANT INFORMATION:

Parent Name:		Spouse Name (if applicable):	
Date of Birth:	Race:	Date of Birth:	Race:
SSN (optional):	Sex:	SSN (optional):	Sex:
Employer Name:		Employer Name:	
Employer Address:		Employer Address:	
Employer Phone #:		Employer Phone #:	
Residential Address:			
City:	County:	State:	Zip Code:
Email Address:		Phone #:	

APPLICANT'S OCCUPATION / JOB TITLE: _____

Check the box that describes your eligibility as a health care provider or first responder:

- ☐ Physician or an employee in a physician's office
- ☐ Dentist or an employee in a dentist's office
- ☐ Mental health worker
- ☐ Nurse
- ☐ Chiropractor or an employee in a chiropractor's office
- ☐ Physical therapist or an employee in a physical therapist's office
- ☐ Occupational therapist or an employee in an occupational therapist's office
- ☐ Employee of a nursing home
- ☐ Medical waste disposal employee
- ☐ Employee of a hospital
- ☐ Employee of a medical clinic
- ☐ Employee of a residential health care facility
- ☐ Employee of an adult day care center
- ☐ Employee of a blood bank
- ☐ Employee of a congregate-care facility
- ☐ Employee of an assisted living facility
- ☐ Pharmacist or pharmacist technician
- ☐ Home health employee or aide
- ☐ Employee of medical wholesale of medical distribution company
- ☐ Employee of a medical supply or medical equipment manufacturer or provider
- ☐ Emergency medical technician, paramedic, or ambulance care assistant
- ☐ Employee of a law enforcement agency
- ☐ Employee of a fire prevention and response agency
- ☐ Veterinarian or an employee in a veterinarian's office
- ☐ 911 call center employee
- ☐ Other - Explain: _____

CHILDREN NEEDING CARE:

Name	Date of Birth	Race	Sex	SSN (Optional)	Amount of Care (FT/PT)*

*FT = Full Time Care more than 25 hours per week; PT = Part Time Care for 25 hours or less of care per week

DATE CARE NEEDS TO START:_____

NAME OF LICENSED CHILD CARE PROVIDER:_____

ADDRESS OF LICENSED CHILD CARE PROVIDER:_____

ADDITIONAL INFORMATION:_____

I certify the information given is true and correct to the best of my knowledge. I understand that in order to be eligible for this child care assistance program, I must meet the definition of a health care provider or first responder as defined by the Alabama Department of Human Resources and I must enroll my child/children at a licensed child care facility that chooses to participate on the Child Care Subsidy Program.

Printed Name of Applicant (Parent) | Signature of Applicant (Parent) | Date

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To Be Completed by Employer's Authorized Designee:

I certify the applicant is employed at this company in the occupation / job title listed on this referral and meets the eligibility as a health care provider or first responder as indicated on the referral. The information given is true and correct to the best of my knowledge.

Printed Name of Employer's Authorized Designee | Signature of Employer's Authorized Designee

Job Title of Employer's Authorized Designee | Date

Instruction to Employer's Authorized Designee: Submit the completed referral form via email to childcare.subsidy@dhr.alabama.gov. Referral forms submitted directly from the applicant will not be accepted.

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DO NOT WRITE BELOW THIS SECTION

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The following child(ren) _____

were enrolled at_____on_____

CMA Worker's Name | CMA Worker's Signature

ALABAMA DEPARTMENT OF HUMAN RESOURCES

CHILD CARE SUBSIDY PROGRAM

Revised April 1, 2021

FORM TITLE: DEPARTMENT OF HUMAN RESOURCES/CHILD CARE MANAGEMENT AGENCY CHILD CARE SUBSIDY REFERRAL FORM

PURPOSE: The purpose of this form is for Health Care Providers and First Responders to obtain a referral from your Employer's Authorized Designee for the Alabama Department of Human Resources Child Care Subsidy Program. The eligible population for this referral includes: physicians, dentists, mental health workers, nurses, chiropractors, physical therapists, veterinarians, hospitals/clinics, clinical staff, nursing homes, residential health care facilities, adult day care centers, blood banks, congregate-care facilities, assisted living facilities, elder care, medical wholesale and distribution, home health workers and aides, medical supply and equipment manufacturers and providers, medical waste disposal, hazardous waste disposal, police officers, firefighters, and emergency medical technicians.

INSTRUCTIONS: Complete the form and submit it to your employer for signature and submission. The Authorized Designee can either be management or someone from the HR Department. The form must be signed by the Authorized Designee and emailed to childcare.subsidy@dhr.alabama.gov. Approval of your case will be emailed to the e-mail address provided on the form. Child care will be provided for children in your household from ages birth through 12 years of age.

PLEASE NOTE: The child care provider selected must be a licensed facility. The facility must register with the local child care management agency in order to receive funding and prior to enrollment of your child(ren). For assistance locating a provider, please visit https://apps.dhr.alabama.gov/daycare/daycare_search and search the statewide daycare directory.

Use of Time and Attendance System (TAS) Card: You will receive a TAS card to swipe attendance of your child at the child care facility within 10 days of case approval. Your provider will receive a point-of-service device to use with your card. Instructions on how to use the card is included with the card. You must swipe your child in and out each day in order for the provider to receive payment. Do not leave your card with the provider or any employee of the provider.