FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Relative Caregiver Simplified Application

The Relative Caregiver Simplified Application can only be used to apply for CASH and Medicaid for a child who was placed with you by the Florida Juvenile Courts. If you live outside of the SunCoast Region, wish to apply for other types of benefits or have yourself included in the assistance, you must apply using the regular ACCESS Florida application. Please visit our website at www.myflorida.com/accessflorida for additional information on how to apply.

Family Safety/Community Based Contracted Provider: _____ Date of Actual Placement: _____

Adjudication Date: _____ Home Study: _____ Court Approved Placement:_____

Counselor's Name: _____ Unit #_____ Phone #: (____)_____ Signature: _____

Note: Please complete the application in its entirety. Provide copies of Court Order(s) placing the child(ren) with the caregiver to be used for upfront child support cooperation, this will be used instead of physically sending the client to Child Support Enforcement. If court order is not yet available, your signature above indicates that you will provide the order as soon as it becomes available to be used in conjunction with the absent parent information provided below (SunCoast Region Only). Attach immunization documentation or complete the immunization section below.

Please provide the CAREGIVER's name and information along with all children placed with the caregiver.

Caregiver's Name:	Phone Number: ( )	Date of Birth:	Sex:	Social Security #

Address:	City:	State:	Zip Code:

Please provide information for all RELATIVE CHILDREN residing in your home: (Note: Do NOT list your own children)

Part A	Name	Date of Birth	Sex M-F	Race	Social Security #	US Citizen or Alien #	Relationship to You	Placed by FL Court (Y or N)	In school (Y or N)	School Name	Date to Graduate?
Child 1											
Child 2											
Child 3											

Please review the information for the child or children listed above, your signature will certify that you are the parent, guardian, or representative of the child(ren) listed above and also certify under penalty of perjury that the child(ren) listed above are who you claim them to be:

Signature _____

Are there any children in Part A above not related to the caregiver but are half sibling to any of the children who are placed by the Florida Juvenile Court? Please provide their information below:

Part B	Child's Name	Half sibling to which child above?	Child's Name	Half sibling to which child above?

Part C. Parent of the child(ren) in Part A and/or B above	Parent Name	Date of Birth	Sex	Race	Social Security #	Last known living address	Is AP child's legal parent? (Yes or No)	Last known employer & address

Immunization: Please list all the children under age 5 below and provide medical documentation showing shots are current, date the next shot(s) due and signed by medical provider. At initial application only, the immunization verification requirement is met with an approved home study.

Part D	Child's Name	Medical Provider's Name	Medical Provider's Address and Phone Number	Immunizations current (Y or N)	Date immunization is due	Date of Dr. appointment
1						
2						
3						

Do any of the children listed above have income? No ☐ Yes ☐ If yes, please provide the information below, verification of all income is required before case is approved. If the parent is paying child support directly to the caregiver, please provide verification from the absent parent as to the amount given and the frequency of payment.

Name of child with income	$ Amount	Type of income (child support, foster care payments, Social Security, SSI, etc.)	Frequency: Weekly, bi-weekly etc.	Source of income (Name and address of provider)

Do any of the children listed above have assets or insurance? No ☐ Yes ☐ If yes, please provide the information below.

Name of child	Type of asset (bank acct. trust fund, life/medical insurance, etc.)	Asset Value	Jointly Owned (Y or N)	Available (Yes or No)	Location of Asset (Name and Address of Bank or Company)	Account # or Insurance ID#

Shelter: Please indicate how much of the benefits received will be used towards the child's shelter cost: ☐ $0 ☐ $.01-$50 ☐ $50.01 or more.

Note: The child(ren) must be obligated to a shelter amount, the obligated amount will determine the amount of Temporary Cash Assistance received for the child.

Signature of Caregiver: _____ Date: _____

NOTE: Relative Caregiver payment is a 2 step process.
Step 1: CASH assistance with required verification.
Step 2: Conversion to relative caregiver payment which requires a CBC provider completes packet which includes, relative custody order, order of adjudication, home study and completed communication form.

In accordance with federal law and our policy, the Department of Children and Families is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion, political belief or marital status.

STATEMENT OF UNDERSTANDING:

I understand that information that I provide with this application, interview, or when requesting other benefits, including computer information matches with other agencies, is subject to verification by DCF and other Federal and State agencies including Public Assistance Fraud. I understand and agree to the following: DCF, Public Assistance Fraud (PAF), and authorized Federal Agencies may verify the information I give on this form, interview, or when requesting other benefits. Information may be obtained from my past or present employers. My signature authorizes release of such information to DCF and/or PAF. As a condition of participation in Medicaid, I consent to review and release of all medical records deemed necessary by Medicaid under its auditing and investigatory powers. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from the program for knowingly providing incorrect or false information or hiding information. I have read my Rights and Responsibilities. I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits. I hereby acknowledge receipt of the Florida DCF CFOP 60-17, Chapter 1, Attachment 2, Management and Protection of Personal Health Information Policy.

NOTICE OF PENALTIES – Temporary Cash Assistance:

If you intentionally give false information or hide information to receive or continue to receive Temporary Cash Assistance and are convicted by a state or federal court or by an administrative disqualification hearing, or sign a hearing waiver, you may be disqualified for 12 months for the first violation, 24 months for the second violation and permanently for the third violation. If you are found guilty of a drug-trafficking felony, or fleeing to avoid prosecution, custody or confinement, after conviction for a crime or an attempt to commit a crime which is a felony, or are in violation of probation or parole imposed under a federal or state law, you are ineligible for Temporary Cash Assistance. If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive Temporary Cash Assistance in more than one state at the same time, you will be ineligible to participate in the Temporary Cash Assistance program for a period of 10 years.

HHS NON-DISCRIMINATION STATEMENT:

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

For TDD or TTY services, please call 1-800-955-8771.

Note: If you have access to a computer, please visit our website at www. www.myflorida.com/accessflorida to apply for additional assistance or to report changes in your household. All changes MUST be reported within 10 days of the known change. Failures to report a change could result in receipt of benefits to which you are not entitled, which could result in the necessity to establish overpayment.

RELATIVE CAREGIVER PROGRAM
REQUEST FOR ELIGIBILITY CONSIDERATION

Please read the program requirements and program options listed herein. Your signature below indicates that you are requesting consideration for Relative Caregiver program eligibility and understand the requirements and options of the Relative Caregiver Program.

Relative Caregiver Program Requirements

- I must be taking care of children who are related to me.
- There must be a Florida court order by a judge finding that the children were abandoned, abused or neglected. The child(ren) who I am applying for has been placed in my custody by a Florida juvenile court judge.
- I understand that the Department's office of Family Safety will do a home study to be sure that the children in my custody are safe from abuse or neglect. If there are problems in my home, the Department may be court ordered by a judge to supervise them or even remove them from my home.
- I must file a Request for Assistance with the Department of Children and Families Economic Self-Sufficiency office, have an interview and provide all the requested documentation that the Department needs to decide if I meet the requirements for Temporary Cash Assistance. If it is hard for me to get the requested documentation, I understand that I can ask my caseworker to help me.
- If I receive Temporary Cash Assistance, I cannot also receive Relative Caregiver benefits in the same month. If I meet technical and financial requirements, I can ask to receive Temporary Cash Assistance while the request for Relative Caregiver eligibility is being processed. If I am eligible for Temporary Cash Assistance, I will not receive the increased Relative Caregiver benefit until the first month after the Department stops my Temporary Cash Assistance.
- I understand that the Relative Caregiver payment is to cover the cost of the child's basic needs such as food, clothing, shelter, school supplies, and personal items like toiletries, entertainment, etc.

Relative Caregiver Program Options. I would like to be considered for the following:

Please select only one:

☐ Temporary Cash Assistance (TCA) and Medicaid while my Relative Caregiver (RCG) application is being processed. I understand that once my RCG application is approved, I will receive the increased child's benefit effective the month after the TCA payment is closed.

☐ Relative Caregiver (RCG) assistance and Medicaid for the eligible child(ren) only.

☐ Temporary Cash Assistance (TCA) and Medicaid for the eligible child(ren) only.

☐ Temporary Cash Assistance and/or Medicaid including my own needs and the needs of my own children.

☐ Relative Caregiver (RCG) assistance for the eligible child(ren) and Temporary Cash Assistance (TCA) for other qualified individuals in my home.

☐ Medicaid for the related child(ren) only.

☐ I do not wish anyone residing in my household to be considered for Relative Caregiver assistance, Temporary Cash Assistance, or Medicaid at this time.

ASK AN ELIGIBILITY SPECIALIST FOR HELP IF YOU NEED MORE INFORMATION ABOUT YOUR OPTIONS

☐ I have been given a copy of the relative caregiver program brochure.

Print Name	Signature	Date
Address	City / Zip Code	Phone #