WYOMING MILITARY ASSISTANCE TRUST FUND

APPLICATION FOR DEPENDENT CARE ASSISTANCE

NOTE: Approved assistance requests can take 30-60 days for funds to be disbursed. Completed forms with all supporting documents must be submitted to State Family Programs Office or Airman and Family Readiness Program Manager within 90 days of duty.

Guardsman Name: _____ _____ _____
Last **First** **MI**

Address below will be used to mail reimbursement payment.

Mailing Address: _____ _____ _____ _____
Street and number Apt. City State Zip Code

Contact Phone Number:_____**SSN:** _____

Rank / Pay Grade:_____**Army/Air:**_____**Unit:** _____

Dates of Drill:_____**Drill Status:**_____(RSD, RD, UTA, MUTA, etc.)

Proof of military status *MUST* be attached? Yes _____ **No** _____

Care Provider Name:_____**Phone Number:** _____

Invoice for expenses *MUST* be attached? Yes_____**No** _____

Number of days care was provided:_____**Total cost of care:** _____

Dependents for whom reimbursement is requested:

Name	Date of Birth	DEERS Registered?	Cost of care

NOTE: Any dependent 12 years and older must have a medically documented need for dependent care in order to be considered for reimbursement under this program. Such documentation should be attached to this application.

Applicant's Certification

I,_____, understand that providing false information is subject to penalties under state and federal code or the Uniformed Code of Military Justice, as applicable. I further attest that the information provided in this application is complete, true, and correct.

I understand that requests are not permitted for care provided by a parent / guardian of the dependent.

I understand that any fraudulent requests will result in forfeited grant support in the future.

I understand that reimbursement through the grant is capped by current Market Rates from the Wyoming Department of Family Services.

I understand that if my request is approved, it may take up to 60 days to receive reimbursement.

Signature of applicant: _____ Date: _____

Unit Certification

Member's name: _____

Dates of Duty: _____ Date Application Received by Unit: _____

Dependent Name	Date of Birth	Age	DEERS Registered?

Printed Name of Unit Representative: _____

Position Title: _____

Signature:_____Date: _____

Family Support Certification

Date Application Received by Family Support: _____

Application Complete: Yes_____No_____ If no, Date Returned to Unit: _____

Printed Name of Family Support Representative: _____

Signature: _____

WYMD State Office Action

Date Complete Application Received: _____ Approved _____ Not Approved _____

Justification for Disapproval:

_____

_____

Assistance Amount:_____Date of Payment: _____

Signature: _____

DEPENDENT CARE RECEIPT

Receipt Date: _____

_____
(Provider Name)

_____
(Provider Address)

_____
(Provider Telephone Number)

Provider Signature: _____

Child Care Services Provided for:

_____
(Guardsman Name)

_____
(Guardsman Address)

_____
(Guardsman Telephone Number)

Date of Payment Made to Provider: _____

Date of Care	Name of Dependent	Age of Dependent	Cost of Care
		Total	