



Kiowa Tribe Child Care Program



Child Care Assistance Application

Thank you for choosing the Kiowa Tribe to assist you in meeting your early care and education needs! Complete this application fully and have copies of all necessary documentation attached before it can be reviewed and to be considered as a complete application.

Eligibility is based on income guidelines, that parents must be working, going to school or in training; have an OKDHS Denial letter; the parent or child must be Kiowa CDIB eligible; the child(ren) must be under 13 years of age; and live within the Southwestern portion of Oklahoma in one of the 22 counties served.

Kiowa Child Care program staff have thirty (30) days from the date of the receipt of the application to issue an eligibility determination letter. You will be notified along with your provider, by phone and by mail.

Any **changes in your household** (Change of employers, address, divorce or separation, or someone moving into your household) **must be reported to our office immediately.**

***The following documents are required to be submitted at the same time as the application.
Incomplete applications will not be accepted and will be returned to the applicant.***

- ___ Denial Letter for child care services from Oklahoma DHS in your county.
- ___ Copies of Kiowa Tribal Enrollment Verification and/or CDIB for parents and children.
- ___ Copy of Child and Parent Social Security Card.
- ___ Copy of Child's State Birth Certificate (or hospital verification) for whom assistance is requested for.
- ___ Copy of Child's current Immunization Record.
- ___ Income Verification (included in this packet) for each working parent to be completed by employers and two recent check stubs.
- ___ A Self-Employment form is included in this application, if applicable.
- ___ Copies of other income to the household such as TANF, SSI/Disability, VA, child support, etc.
- ___ Current Utility bill with your name and address (Gas, electric, water, telephone, cable).
- ___ Copy of school enrollment, class schedule or training schedule if attending school.

You will receive recertification papers annually one year from your approval date, so it is imperative that we always have your correct address and contact information. The recertification papers are dated and need them be completed and submitted in our office to prevent termination from the program. **If we do not receive them by the due date, you will be terminated from the program and will have to reapply for assistance.**

Please visit the following websites for a list of licensed child care providers in your area:

www.oklahomachildcare.org, www.gpcrr.org, or <http://childcarefind.okdhs.org/childcarefind>

Stop by the office, call us at (580) 654-6372, email childcare@kiowatribe.org or visit www.kiowatribe.org/child-care/ for more information or questions.

806 Wynan Ct. Anadarko, OK 73005
PH: 580-654-6372 FAX: 405-648-7078
childcare@kiowatribe.org

Updated 3-1-18



Kiowa Tribe Child Care Program



PART I - Applying Parent/Guardian Information

Home Mailing Address: _____

Mother: (**circle one**) Biological Mother – Step Mother – Legal Guardian – Other (Explain)

Name: _____ Cell: _____
First Middle Maiden Last

Marital Status: (**circle one**) Single Married Divorced Separated Never Married

E-mail address: _____ Date of Birth: _____ SS#: _____

Mother's Employer: _____ Work phone: _____

Mother attending school/training: ___Yes ___No If yes, name of School/training: _____

Circle One: High School College Classroom Training GED Other: _____

Father: (**circle one**) Biological Father – Step Father – Legal Guardian – Other (Explain)

Name: _____ Cell: _____
First Middle Last

Marital Status: (**circle one**) Single Married Divorced Separated Never Married

E-mail address: _____ Date of Birth: _____ SS#: _____

Father's Employer: _____ Work phone: _____

Father attending school/training: ___Yes ___No If yes, name of School/training: _____

Circle One: High School College Classroom Training GED Other: _____

PART II – Medical Emergency

PLEASE LIST TWO EMERGENCY CONTACTS OTHER THAN YOURSELF OR YOUR PROVIDER:

Name: _____

Name: _____

Address: _____
City State Zip Code

Address: _____
City State Zip Code

Phone: _____

Phone: _____

Allergies: _____

Medication needed? ___Yes ___No

Family Clinic/Hospital: _____

Phone: _____ Address: _____

Child's Primary Physician: _____

Contact number: _____

Child's Insurance: ___Sooner Care ___Private

___Tri-Care ___IHS Other: _____

Date of most recent well-child visit: _____

Date of most recent Dental visit: _____

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PART III - Family and Benefits

Children Requiring Child Care Services:

Complete Name	DOB (MM/DD/YY)	Age	SS#	Grade (Infant, PreK-8)	Sooner Care ID #	IHS Yes or No


Family Composition

(List all persons currently living in your household, except the children named above)

Family Member Name	DOB (MM/DD/YY)	Age	Tribe	Tribal Enrollment #	Relationship to the Applicant

Have you been on the CCDF Program before? Yes or No If yes, when? _____

Yes	No	Type of Other Income	Amount	Amt by Week or Month	Date Payment Began	Date Payment Ended	Still Receiving?
		A TANF Case #					
		B SNAP/Food Stamps					
		C WIC (Women, Infants & Children)					
		D Social Security					
		E SSI (Supplemental Security)					
		F Child Support Amount					
		G Worker's Compensation					
		H Unemployment Benefits					
		I Foster care or adoption subsidy					
		J Other Assistance (college work study, rent, stipends, taxable retirements, bonuses, etc.)					

I certify that the above information is complete, true and correct: 

Parent Signature

Date

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PART IV- Child Care Center/Child Care Home/ or Relative Information

Your choice of Daycare Facility: _____

Contact Person at Facility: _____

Mailing Address: _____

City State Zip Code

Phone Number: _____ Fax Number: _____

County: _____

Is this person licensed? Yes No Is this person a relative of the child? Yes No

If this person is a relative, how are they related to the child? _____

Days & Time: When is Childcare needed: (provide information for each child needing services)

Name of child: _____ Time (Beginning to end): _____

Days of Child Care: Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____

Days & Time: When is Childcare needed: (provide information for each child needing services)

Name of child: _____ Time (Beginning to end): _____

Days of Child Care: Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____

Days & Time: When is Childcare needed: (provide information for each child needing services)

Name of child: _____ Time (Beginning to end): _____



Days of Child Care: Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____

PART V – Parent Acknowledgement

Eligibility determination is based upon a completed and signed application with the required verification documents. **BEING FOUND ELIGIBLE DOES NOT GUARANTEE THAT AN INDIVIDUAL WILL RECEIVE SERVICES.** I certify that the information I have submitted is true to the best of my knowledge and realize it is subject to verification and that **falsification of facts is grounds for immediate termination and may subject me to prosecution under law.** I allow the release of information for verification and reporting purposes.

Any changes in employment, income, residence, household size, or class schedule should be reported to the Child Care Assistance office in writing within thirty days of the change.

If you do not inform the Child Care Assistance office of the change, your child’s day care assistance could be terminated and the parent/guardian could be responsible for payment to the child’s day care.

 _____
 _____

Signature of the Parent/Guardian

Date



Kiowa Tribe Child Care Program



PART VI - Parent Agreement-Page 1

1. I will receive child care assistance only during the time that I am working, in training or attending class/lab. Time spent running errands, shopping, doctor appointments, etc., will not be covered by child care assistance.
2. I will provide my child care provider with my current day time phone number as well as other emergency contact information.
3. If my child is ill and does not receive services, I will note that on the attendance record.
4. I will never sign a blank attendance form, or sign-in sheet and will not allow my provider to claim days when my child is not at the daycare.
5. I understand that all childcare time sheets must be signed and agreed upon by both provider and parent. Unsigned time sheet will not be processed for payment to provider.
6. I will notify the Kiowa Child Care Program (KCCP) of any changes from the information provided on my original application. This will include, but is not limited to, changes in my address, telephone number and income. I understand that I have seven (7) days to report changes or my child(ren) could be terminated from the program.
7. If I change caregivers/providers, I will notify the KCCP within seven (7) days before the change is made with proper documentation signed by the original provider showing no co-payment owed.
8. I will submit documentation for all income that is received in my household.
9. I understand that my child(ren)'s file must be complete and considered active in order for assistance to be paid.
10. I understand that my child is not approved for the Child Care Assistance program until I receive the "Approved Child Care Application Notification" signed by the Kiowa CCDF Director.
11. I understand that if my child(ren)'s file becomes inactive, I am financially responsible for my child care services and that the KCCP will not back pay.
12. I understand that the co-payment amount is the dollar amount I must pay per eligible child to the caregiver/provider at the beginning of each month and not to become delinquent.
13. I understand that if any fraud is substantiated, I will repay the amount of money in question to the KCCP or as ordered by the court and will not be able to participate in the child care program for a period of one (1) year. Defrauding a Federal Grant Program is subject to Federal prosecution and potential jail time.
14. I understand that I will be required to complete a new application if I am terminated and wish to participate again.
15. I understand that I will need to recertify in one (1) year to continue my assistance.

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Updated 3-1-18

PART VI - Parent Agreement -Page 2

- 16. I understand that to receive Special Needs and Foster Care Priority, I must submit a doctor’s statement and/or legal documents verifying that my child needs this type of care.
- 17. I understand that all phone calls regarding childcare cases must be from me as the parents and as the applicant. No information will be shared with relatives or providers. If I have a complaint about child care staff or providers, I will submit this in writing to the CCDF Program Director.
- 18. I understand that all calls concerning childcare payments should be directed to the Kiowa CCDF Director, not the Chairman or Tribal Administrator.

I authorize the Kiowa CCDF Director permission to make any investigation to verify any answer I have given. I am certifying that I understand and agree to the contents of the “Parent Agreement”. I affirm under penalty of perjury that the childcare application is complete and correct to the best of my knowledge and belief. I also understand that providing false information may result in termination of these benefits.

By signing below, I agree to the rules and regulations of the Kiowa Child Care Program.

 <input data-bbox="126 869 846 930" type="text"/>	 <input data-bbox="889 869 1180 930" type="text"/>	_____
<i>Parent Signature</i>	<i>Date</i>	<i>County</i>

Name of Child(ren):



Kiowa Tribe Child Care Program



Affidavit of Separation

Please Circle True (T) or False (F) for each statement:

* I am not divorced, but am separated from my spouse at this time.....T or F

* I was never married to the father/mother of the child/ren for which I am asking assistance and **WE ARE NOT LIVING TOGETHER AT THIS TIME**.....T or F

* He/she does not reside with me and does not contribute financially to the household income of household expenses in any way, other than child support or any other financial assistance as I have shown on the Child Support Statement.....T or F

I, _____, hereby certify that I am separated and estranged from my spouse/father/mother of my children, effective _____.

I further certify that if I reconcile with my spouse/father/mother of my children, I will report this within 7 days to the Kiowa Child Care Office (to be in compliance with the rules and regulations of the child care assistance program). At that time, our household must recertify to see if we qualify for future services.

I am aware that failure to report such changes can be construed as suspected fraud and charges can be filed if it occurs or is discovered.

(Signature of parent/guardian)

Date

SUBSCRIBED and SWORN to before me on this _____ day of _____, 20_____.

NOTARY PUBLIC

My Commission Expires: _____

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INCOME VERIFICATION FORM

(Form must be completed by employer and submit with 2 recent paycheck stubs)

Parent/Guardian Name: _____ **Date:** _____

The Kiowa Tribe Child Care Assistance Program and Child Care Development Fund is required to verify the employment and the income of applicants in order to establish eligibility. The person identified above has informed us that he/she is employed by your firm. The Child Care Assistance Program would appreciate your cooperation in supplying the following information concerning the above person. This information will be kept in strict confidence.

A. This portion to be completed by Parent/Guardian

I authorize the release of information from _____, to the Kiowa Child Care Assistance Program regarding my employment; therefore, releasing my employer from liability regarding this information.



Parent/Guardian Signature

Social Security Number



Date

B. This portion is to be completed by employer:

Employed from _____, _____ to _____, _____	YES	NO
Occupation: _____ Employment is: Permanent	____	____
	Temporary	____
	Seasonal	____

(Select only one form of pay)

Current rate of Gross pay is \$ _____ per hour.
 Current rate of Gross pay is \$ _____ per week.
 Current rate of Gross pay is \$ _____ per month.
 Current rate of Gross pay is \$ _____ every other week

Show actual hours of the week worked: (example: 9:00AM to 5:00 PM Mon-Fri)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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Date: _____ Name of Firm: _____

Address: _____

Employer's Phone: _____ Employer's FAX: _____

Completed by:



Employer Signature



Date

Print Name

Title



Kiowa Tribe Child Care Program



Self-Employment Verification

Parent/Guardian Name:

The Kiowa Child Care Assistance Program requires self-employed individuals **to submit Schedule C, Profit or Loss from Business tax forms and this completed Self-Employment Verification form.** New businesses are required to submit this Self-Employment form and an Income Projection from a tax accountant.

This form verifies that I have been self-employed since, _____ and I contribute \$_____ to the household per month. My actual work hours are:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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What is the nature of your business? _____

I will notify the Kiowa Child Care Assistance Program of any changes in my employment **within seven (7) days of change.**

If the Kiowa Child Care Assistance Program determines that you have falsified any information submitted in this document you will be responsible for repaying the Kiowa Child Care Assistance Program for any overpayments.

(Signature of parent/guardian)

Date

If no tax return has been filed, we will use your estimate or minimum wage to calculate your income (whichever is greater).



Kiowa Tribe Child Care Program



Release of Information

(Complete this form for each child for whom assistance is being requested)

Child's Name:	Child's Birth Date:
Parent/Guardian Name:	
Mailing Address:	Contact Phone:

The Kiowa Tribe Child Care Program uses information from the Health & Developmental History and Child Health & Developmental Screening to identify any possible problems that might interfere with your child's health, growth, development or learning. Under Oklahoma law, health and screening information and results are classified as confidential and tribal, state, and federal privacy laws apply. This information cannot be released or discussed with anyone without your consent. If you refuse to release this information, it will not affect your child's eligibility for medical assistance or any other health, education, or social service program.

Information may be used for the following purpose:

1. To obtain follow-up services for your child after the screening.
2. To arrange for further evaluation or assessment of your child's health, growth, development, or learning.
3. To fulfill the requirements for your child's entrance into public school.
4. To evaluate screening programs by the Kiowa Tribe Child Care Program and partner entities. Your child's name will not be identified in any evaluation results.

Your signature indicates that you have read, understand, and agree that the information can be used as stated above.


Consent to Release Information

I hereby authorize release of my child's health, developmental, educational, and screening information to the following program/service provider for the purposes of evaluation, assessment, diagnoses, follow-up, and or programming.

Authorized Recipient:
Program/Service Provider Name:
Recipient Address:
Recipient Phone:
Recipient Fax:



(Signature of parent/guardian)



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Informed Consent

Name of Child(ren): _____

The Kiowa Child Care Program (KCCP) would like you to participate in our program’s Family Engagement, Parent-Teacher Conferences, Evaluations, etc. Your participation is important to the program and will help to increase Parent Involvement and assess the effectiveness of the program. There will be evaluations, questionnaires mailed to you or short interviews at events.

We will keep all your answers confidential. Your name will never be included in any reports and none of your answers will be linked to you in any way. The information that you provide will be combined with information from everyone else participating in these evaluations, questionnaires, or interviews. Data collected may be on Family Bonding, Children’s Behaviors, Discipline, Language and Culture, etc.

Some other data collected may include questions regarding child abuse, drug abuse, or suicidal behaviors. The KCCP has a legal obligation to report disclosed information that raises suspicion of child abuse, drug abuse, or suicidal behaviors to the appropriate authorities. In these rare cases, confidentiality may be broken according to the law.

Your choice to participate in these evaluations is voluntarily. Even if you agree to participate now, you may stop participating at any time or not answer any questions.

Please Check one: Agree to Participate Decline to Participate

 _____

(Signature of parent/guardian)


 _____

Date


Media Release and Consent for Use of Image *(Please check one of the consents)*

_____ I hereby give my permission for myself, my family, and/or my children(ren)’s picture, video, or various forms of media (newspaper, fliers, and brochures) to be utilized for the purpose of advertising, public relations, program publications, child observations, teaching, curriculum development, language/culture promotion, etc.

_____ I hereby DO NOT give my permission for myself, my family, and/or my children(ren)’s picture, video, or various forms of media (newspaper, fliers, and brochures) to be utilized for the purpose of advertising, public relations, program publications, child observations, teaching, curriculum development, language/culture promotion, etc.

 _____

(Signature of parent/guardian)

 _____

Date

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