



Kiowa Tribe

Indian Child Welfare

Promoting Safe and Stable Families or Title IV-B(1)

P. 580-654-2349 F. 405-247-4921

CHECKLIST

- Please notify worker if services have been provided through either of the Programs.
- Provide **CDIBs of all Kiowa enrolled children** in the home.
(Ages: Birth to 17 years. 18 years if still in school.)
- Provide a signed **Letter of Request**. Must include what the request is for and go into detail of why you are unable to take care of it.
- Physical Examination of one enrolled Kiowa child *(6 years to 17 years)* **OR** Shot Record of the youngest enrolled Kiowa Child *(5 years and under)*.
- If applying for utility assistance, a copy of the bill must be submitted
- If applying for rent, the following must be provided:
 - a. *Landlord's Name, Address, and Phone Number*
 - b. *Address of Rental*
 - c. *Statement of how much the rent or deposit is.*
 - d. *W-9 Form filled out and signed by the Landlord.*
- Complete Application



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Children's information

Name	Age	Tribe & Roll #	SSN	Gender

Address _____

Family information

Marital Status	
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Mother

Name		Tribe		SSN	
Address		Home Phone		Work Phone	

Father

Name		Tribe		SSN	
Address		Home Phone		Work Phone	

Guardian

Name		Tribe		SSN	
Address		Home Phone		Work Phone	

Other household members <i>(Over 18 years old)</i>	Age / DOB	Sex	SSN	Tribe	Relationship

Has child had a <i>(Check all that apply)</i>	Physical	Hearing Test	Psychological Evaluation
	Education IEP	Dental Checkup	Medical Checkup

Has child been diagnosed as having a disability?	Yes	No
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If so, what was the child diagnosed with? <i>(check all that apply)</i>	Mental Retardation	Visual or Hearing Impaired
	Emotionally Disturbed	Physical Disability
	Other medically diagnosed condition requiring special care Please explain:	

Financial Status

Are you currently employed?	Yes	No
If yes, where are you employed and how long have you been employed here?		
Please list the monthly income of all household members		
Wages, Salaries, and Support		
Social Security		
SSI or Disability		
TANF/Food Stamps		

Reason for request

CHILD HEALTH RECORD: PHYSICAL EXAMINATION/ASSESSMENT

Child's Name		Gender		DOB	
Address			Phone		
City		State		Zip	

Parent/Guardian Signature

Screening Tests

(When recording results, enter at a minimum "N" for normal, "S" for suspect, or "A" for atypical/abnormal)

Present Age	Date		Results	
Height <i>(No shoes, to nearest 1/8th in.)</i>	Date		Results	
Weight <i>(Light clothing to nearest ¼ lb.)</i>	Date		Results	
Blood Pressure	Date		Results	
Hematocrit or Hemoglobin	Date		Results	
Hearing <i>(Type or Test)</i>	Date		Results	
Vision <i>(Type or Test)</i>	Date		Results	
Acuity, R/L	Date		Results	
Rescreening	Date		Results	
Strabismus	Date		Results	
Comments				
TB	Date		Results	
Sickle Cell	Date		Results	
Lead	Date		Results	
Ova & Parasites	Date		Results	
Urinalysis	Date		Results	
Other:	Date		Results	

PHYSICAL EXAMINATION/ASSESSMENT

General Appearance	
Posture, Gait	
Speech	
Head	
Skin	
Eyes	
External Aspects	
Optic Fundiscopic	
Cover Test	
Ears	
External & Canals	
Typanic Membrane	
Nose, Mouth, Pharynx	
Teeth	
Heart	
Lungs	
Abdomen (Includes hernia)	
Genitalia	
Bones, Joints, Muscles	
Neurological/Social	
Gross Motor	
Fine Motor	
Communication Skills	
Cognitive	
Self-Help Skills	
Social Skills	
Glands (Lymphatic/Thyroid)	
Muscular Coordination	
Other:	

General statement on child's physical status

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Findings, treatments, and recommendations

Abnormal Findings/Diagnosis	
Treatment Plan	
Recommended Follow-up or Results <i>(Initial and date when complete)</i>	

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**To be signed by a doctor*

Signature & Title *Date*

Address

State *Zip Code*

Phone Number