Fort Belknap Child Care Program

Fort Belknap Indian Community
656 Agency Main Street
Harlem, MT 59526

Phone: (406) 353-8493
(406) 353-8488
(406) 353-8486
Fax: (406) 353-4564

PROVIDER APPLICATION CHECKLIST & DOCUMENTATION NEEDED:

__ New Application Form *(must be completed in full - signed, dated & notarized.)*
__ Certificate of Indian Blood
__ W-9 Tax ID Form *(Please submit two copies)*
__ Release of Information *(must be completed in full - signed & dated)*
__ Yourself __ Your Spouse __ Any household member(s) 18 or older.
__ Statement of Health Form
__ Yourself __ Your Spouse __ Any household member(s) 18 or older.
__ Immunization Records *(MMR-Measles, Mumps, Rubella, TD-Tetanus Diphtheria)*
__ Yourself __ Your Spouse __ Any household member(s) 18 or older.
__ T.B.-Tuberculosis Skin Test *(For Anyone Providing Direct Care to Children.)*
__ First Aid Certification *(For Anyone Providing Direct Care to Children.)*
__ Infant, Child, and Adult CPR *(For Anyone Providing Direct Care to Children.)*
__ Background Check Investigation packet *(Bring back to Child Care Office to get signed by director, then take to personnel.)*
__ Copy of valid Montana Driver's License or valid Photo I.D.

*PLEASE NOTE: Failure to complete any portion of this checklist may result in denial of application.

Official Use Only

Name: _____

___ Approved **Date of Approval** _____

___ Denied **Recertification Date** _____

Reason for Action: _____

_____

Child Care Manager: _____ **Date:** _____

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APPLICATION FOR REGISTRATION CERTIFICATE

INFANT, FAMILY OR GROUP DAY CARE HOME

Provider Name: _____ Phone Number: _____

Provider Address: _____

(Street/P.O. Box) (City) (State) (Zip Code)

Social Security Number: _____ Tribal Affiliation: _____

Email: _____ Enrollment Number: _____

Facility Name: _____

Facility Address: _____

(Street/P.O. Box) (City) (State) (Zip Code)

Mailing Address: _____

(Street/P.O. Box) (City) (State) (Zip Code)

Type of registration applying for: (Please check one box)

[ ] Family (Family homes allow a maximum of 6 children)
[ ] Group (Group homes allow a maximum of 12 children)
[ ] Center (Classrooms have ratios set in place: 4;1, 4;1, 8;1, 10;1)

Please specify if you wish to take less than the maximum allowable number of children as specified above. ***(yes/no)*** _____

Number of own children, under the age of 12, that will be cared for at the facility: _____

Hours of operation (days and hours): _____

ORIENTATION: (One will be scheduled if you have not taken one)

[ ] I have taken Provider Orientation _____

[ ] New Provider Orientation _____

Start Date: / / (Please see effective date policy)

I would like my registration to be effective: _____

REGISTRATION EFFECTIVE DATE POLICY

We will not give you a registration start date prior to the date we receive your application. Your registration date will not be approved until FULL completion of checklist and forms.

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1. EDUCATION AND EXPERIENCE

High School Diploma/GED? **( ) Yes** **( ) No**

College Degree(s)? **( ) Yes** **( ) No**

Describe any experience and/or training you have had in the care and supervision of children. Please provide: dates, locations, and names of any individuals, organizations or agencies which you have worked for: _____

_____

2. PRIOR REGISTRATION/LICENSES

Are you registered or licensed to care for children in Fort Belknap, Montana, or any other reservation or state? **( ) Yes** **( ) No**

If yes, when were you registered or licensed? _____

Location: _____

What Kind of registration do you have? (daycare, foster care, etc.)

_____

Have you ever been denied a license or registration to care for children? **( ) Yes** **( ) No**

If yes; when, where, and why was the application denied or the registration or licensed restricted, suspended or revoked? _____

_____

3. CHILD ABUSE and NEGLECT

Have you ever had a child removed from your home? **( ) Yes** **( ) No**

Have you, or any individuals living in your home, ever been investigated for possible abuse and/or neglect of a child by any Tribal or State child and/or law agency? **( ) Yes** **( ) No**

If yes, please indicate child's name: _____

What is your relationship to the child? _____

When did this incident happen? (Date): _____

4. CRIMINAL CHARGES/CONVICTIONS

Applicants and providers must meet certain requirements such as being free of criminal charges and convictions within the service period. As the agency responsible for child care registration/licensing, the Fort Belknap Child Care Program must ensure the safety of children in a child care setting. In complying with this; each provider, caregiver, and adult(s) residing in the home must complete a "*Release of Information Form*", to be notarized and submitted alongside this application, in addition to the applicant completing the following questions. <u>These questions apply to all individuals residing in the home.</u>

a. Have you, or any individuals residing in the home, lived in another state within the last five years? **( ) Yes ( ) No**

If yes, please list the state(s) resided in the last five years and the dates:

_____

_____

b. Have you, or any individuals residing in your home, been convicted of, pleaded guilty to, or currently charged with a crime classified as an offense against any person or family?

( ) Yes ( ) No

If yes, give details, including name of person, date, place and nature of the conviction and disposition:

_____

_____

c. Have you, or any individuals living in the home ever been named as a perpetrator in a substantiated report of child or adult abuse or neglect (or exploitation of an adult)?

( ) Yes ( ) No

d. Have you, or any individuals living in the home been convicted of a crime involving child or elder abuse or neglect; including sexual abuse, physical assault or any other act of violence?

( ) Yes ( ) No

If yes, please explain: _____

_____

_____

5. HEALTH

Applicants and providers must meet certain personal health requirements. As the agency responsible for child care registration/licensing, the Fort Belknap Child Care Program must ensure that the health of all providers and family members is adequate to meet the demands of the care being provided. In complying with this each provider, caregiver, and adult(s) residing in the home must complete a "Statement of Health Form", to be submitted with this application.

a. Please indicate state of health: *(Please circle one)*

Poor **Average** **Fair** **Excellent**

6. ACKNOWLEDGEMENT

RELEASE STATEMENT

In accordance with the Fort Belknap Child Care Program, I hereby request the issuance of an Infant, Family, or Group Day Care Home Certificate of Registration on the basis of my affirmation of the following statements:

a) I have received a copy of the Regulations for Family/Group Day Care Homes and Infant Care.
b) I certify, to the best of my knowledge and belief that, I will be in compliance with the regulations for Family/Group Day Care Homes and Infant Care, while children are in my care.
c) I understand that I cannot care for more children at any one time than are indicated by the Registration Certificate. This number includes my own children under the age of 6 years.
d) I will immediately report any conviction or pending charges; for sex offenses, offenses involving children, or drug convictions within my service period.
e) I understand that any complaints about my registered day care home may be investigated by a representative of the Department, without prior notification.
f) I understand that my registered day care home may be visited, and I will allow worker entry.
g) If I move to another address or stop providing care to children, I must notify the Fort Belknap Child Care Licensing Program.
h) I understand that the name and address of my registered day care home will appear on a list which is maintained by the Fort Belknap Child Care Program Services.
i) I will provide the department with the names, addresses, phone numbers, and parents' names of each child in my care whenever requested by the department.
j) Per Inter-Agency Agreement, I authorize the Fort Belknap Child Care Program to release and exchange information to the state of Montana DPHHS, or its agents of general participation information; including, but not limited to, progress reports, enrollment, attendance and eligibility.
k) I understand that I must allow unlimited access of children to parents.

To the best of my knowledge and belief, all information I have given to the Department of Public Health and Human Services and/or its authorized agents this form is true and correct. I will supply true and correct information requested during all subsequent contacts.

_____ _____/_____/_____

Signature **Date**

TO BE COMPLETED BY A NOTARY PUBLIC

Taken, sworn, and subscribed before me, this _____ day of _____, 20_____

_____

(Notary of the Public for the State of Montana)

Residing at _____

My Commission Expires _____

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DAY CARE LOCATION:

Is the day care located in your residence? **( ) Yes ( ) No**

If Yes, please complete both the ***Household member*** table and the ***Caregivers*** table

If No, you only need to complete the Caregivers table.

**If you are renting, please verify with your landlord to provide day care on the rental property.*

HOUSEHOLD MEMBERS

**In the space provided below, please include the name and birthdates of all individuals currently residing in the home where day care will be provided. (Please include yourself, if you reside there)*

Name:	Date of Birth	School (if applicable):	Relationship:

Caregivers

Please list the names, addresses, and phone numbers of all individuals responsible for the direct care and supervision of children in your facility.

Name:	Mailing Address (Street/P.O. Box, City, State, Zip)	Phone Number:

a. **Each person living in the home and all caregivers are required to complete a "*Release of Information Form*"**
    a. If a household member or a caregiver has lived outside of Montana within the last five years, that person will need to obtain an out of state background check.
b. **Each person over 18 living in the home and all caregivers** are required to complete a **"*Statement of Health Form*".**
c. **Each person over 18 living in the home and all caregivers, including volunteers,** are required to supply **copies of their immunizations** to the Child Care Licensing Program. Immunizations required are:
    - MMR, if born after 1-1-57.
    - MMR or a Rubella titer test is required for those born prior to 1-1-57.
    - Tetanus/Diphtheria (required every 10 years).
d. Tuberculosis (TB Skin Test) is required for CAREGIVERS ONLY. This includes volunteers. (Must be current within the year prior to registration.)
e. All caregivers must hold a current course completion card in Infant, Child, and Adult CPR (regardless of the ages that are in care) and Standard First Aid.

The above forms are to be completed by each person over 18 living in the house and all caregivers.

FORT BELKNAP CHILD CARE PROGRAM
STATEMENT OF HEALTH FORM

_____ _____

(Print Name) (Phone Number)

_____

(Street/P.O. Box) (City) (State) (Zip)

_____ _____

(Social Security Number) (Birthdate)

I am: ( ) Provider of Child Care ( ) Spouse ( ) Other Adult Living in the Home

Applicants and household members must meet certain health requirements. As the agency responsible for approving Fort Belknap Care payment numbers, the Fort Belknap Child Care program must ensure that the health of each provider is adequate to meet the demands of the care being provided.

Please answer the following questions by entering an "X" in the appropriate box for each question.

The Fort Belknap Child Care Manager overseeing the child care provider materials packet and the Child Care Manager who approves the payment number will review this form. In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your response. The answer "yes" does not mean you will automatically be denied. Your explanation or, if necessary, your physician's or other appropriate professional's statement will be taken into consideration. The purpose of the questions is to help decide if you have health problems that may affect your ability to safely provide care. If an evaluation or statement is needed, the Child Care Supervisor will send the required information to the applicant.

1. During the past 3 years, have you had any disabling chronic conditions, or physical, mental, or emotional illness requiring care from a physician, psychologist, or other medical professional?

   *If "Yes" please describe. Include a description of any vision or hearing problem and any limitations on mobility. Include treatment and current status. (You may use additional paper if needed.) **( ) Yes ( ) No**

2. Do you suffer from any physical or mental health limitations, which might affect your ability to provide child care? **( ) Yes ( ) No**

*If "Yes", please explain. (You may use additional paper if needed.)

3. Are you currently diagnosed, receiving therapy or medication for a mental health problem which might affect your ability to provide care? **( ) Yes ( ) No**

*If "Yes", please explain. (You may use additional paper if needed.)

4. Have you received counseling or treatment related to chemical dependency for drugs and/or alcohol within the past 3 years? **( ) Yes ( ) No**

*If "Yes", please explain. (You may use additional paper if needed.)

5. Have you ever been addicted to drugs and/or alcohol or been treated for drug and/or alcohol abuse within the past 3 years? **( ) Yes ( ) No**

*If "Yes", please include the name of the tester, date, type of test administered, and the results. (Please attach documentation.)

*If "No", please arrange to be tested and supply the information indicated above. If, for medical reasons, you cannot be tested, please indicate.

*In either circumstance, please supply medical documentation.

CHILD CARE CONFIDENTIALITY AGREEMENT

AGREEMENT, made this ___ day of _____, 20 __ by and between the Fort Belknap Child Care Program, hereinafter referred to as "Program" and _____,

Here in after referred to as the "Employee".

In consideration of the employment or continuance of employment (as the case may be) of the Employee of the Program, it is hereby agreed as follows:

1. CONFIDENTIAL INFORMATION: During the period of employment, the Program may disclose information relating to the business recognized by the Employee, to be the property of the Program and the Employee agrees to hold such information in trust and solely for the Program's benefit and not to disclose such information to others, either during or after employment, without the written consent of the program.
2. SUBSEQUENT EMPLOYMENT AND TERMINATION OF EMPLOYMENT: This agreement shall continue in any subsequent employment of the employee by the program, and extends to the Program's successors or assignees.
   Upon leaving the Program's employment, the Employee shall not take with them, without first obtaining the written consent of the program any documents, whether an original or reproduction, or any tangible evidence of confidential information or data belonging to or under control of the Program.
3. FORMER OBLIGATIONS: The employee will strictly adhere to any obligations which he or she may have to former employers as the use of disclosure of confidential information is concerned.

PLEASE READ, SIGN, AND DATE:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate, and complete, to the best of my knowledge. I fully understand that any misstatement on my part in completing this health statement is grounds for denial of my application, or revocation of my license, should one be issued to me on the basis of the statements I have made herein. I understand this information is confidential and is used only be the Fort Belknap Child Care Program. I hereby consent to the use of this information for such purposes.

Signature: _____ Date: _____

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Release of Information

I, _____, authorize the release of information requested by the Child Care Program to share, exchange, give and receive any information required about my Client/Provider Application and the contents therein; in an effort to serve both myself and my family (as declared on my application). In addition, I authorize the following program/agencies to release information to the Child Care Program. These programs include but are not limited to: The Department of Commerce, Department of Law, Department of Public Safety, Department of Labor, Department of Military & Veterans Affairs, Department of Revenue, The Bureau of Citizenship & Immigration Services, Fort Belknap Housing Authority, Tribal Personnel, Child Support Program, Aaniiih Nakoda College, Credit Program, Tribal Finance, Commodity Program, Head Start/Early Head Start, Tribal Health, Vocational and Technical Institutions, Adult Basic Education, Bureau of Indian Affairs, Social Security Administration, Local Governments, Public Assistance Programs, Financial Institutions, Landlords, Any & All Employers, School Authorities , Clerk & Recorder and County Treasurer, 477 Employment & Training, Fort Belknap Enrollment, Earned/Unearned Income, or any other source.
Other: _____

I understand that:

- Any and all information by the above named programs/agencies will remain confidential and be used for professional purposes only.
- No information will be released without prior knowledge.
- This consent may be canceled, in writing, at any time.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

Print Name:	Signature:
Address:	Phone Number:
Social Security Number:	Date (MM/DD/YYYY):