

CONFEDERATED TRIBES OF COOS, LOWER UMPQUA & SIUSLAW INDIANS
FAMILY SERVICES
CHILD CARE ASSISTANCE PROGRAM
1245 Fulton Avenue, Coos Bay, Oregon 97420
PARENT APPLICATION

Applicant Name: _____ Spouse Name: _____

Address: _____

Phone: _____ Message phone: _____

The Child Care Assistance Program is provided through a grant from the Federal Government entitled the Child Care Development Fund (CCDF). In order to be eligible for assistance, parents/ guardian must be working full time, enrolled in an education program full time or a combination of working or attending school. This program is also income based and all applicants will be required to submit income verification.

Employment and/or Training of Parent/Guardian/Legal Foster Parent of Tribal Children

A) Working/Employed full-time (150 or more hours per month)
_____ applicant _____ spouse _____ household member over the age of 18

Working/Employed part time (60 or more hours per month)
_____ applicant _____ spouse _____ household member over the age of 18

Applicant: Employer: _____ Phone: _____

Address: _____

Usual Hours/Days of Work: _____

Spouse: Employer: _____ Phone: _____

Address: _____

Usual Hours/Days of Work: _____

Household member: Employer: _____ Phone: _____

Address: _____

Usual Hours/Days of Work: _____

B) Student Enrolled 12 credits or more per quarter _____ applicant _____ spouse

Enrolled/Active in part-time Education _____ applicant _____ spouse

Name and Location of Education Program: _____

Days/Time for classes: _____

(Attach proof of enrollment and class schedule)

C) Training

Active in On-the-Job Training full-time _____ applicant _____ spouse

Active in part-time training _____ applicant _____ spouse

Days/Time for Training: _____

(Attach proof of training program)

Parent/Guardian of children needing Child Care for children 0-12 years, or under age 18

for special needs children including children in foster care.

A) Confederated Tribes of Coos, Lower Umpqua & Siuslaw children in my home needing child care:

	<u>Childs Name</u>	<u>Age</u>	<u>Birthdate</u>	<u>Enrollment Number</u>
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			
6.	_____			

Income Eligibility Requirements

A) My monthly income is \$_____ for a family of_____.

(Pay stubs of all employed members of household, or other documentation, must be provided)

B) I am income eligible _____ Yes _____ No

I am eligible based on need to provide
child care for at-risk or special needs child _____ Yes _____ No

I am eligible due to care of foster children _____ Yes _____ No

Type Of Child Care Requested

____ Center Based _____ Family Child Care Home _____ Group Home

Names of Preferred Providers: _____

Dates Child Care Requested

Start ____/____/____

End by ____/____/____

Parent/Guardian Initials:

_____ If required to, based on income, I agree to pay the registered provider a monthly co-payment as listed on the sliding fee scale, according to Tribal pay rates.

_____ I recognize that I must advise the preferred provider of my choice to bill hours only when I am transporting or active in approved work, training, education programs or documented job searching.

_____ I recognize that a provider cannot be paid or authorized to provide child care unless I have a currently approved application that includes an approved Criminal Background Check and fingerprints for the child care provider, and enrolled in the State of Oregon Child Care Registry. I further recognize that unless the provider of my choice completes the registration process prior to starting child care, no payment will be made. Payment will only be made in accordance with the program requirements and timelines.

_____ I recognize that as a parent/guardian that I have the right to have access to my child(ren) at any and all times while in the care of the provider and that I have the right to have access to the premises/facilities when the provider is providing child care.

_____ I agree to work with my provider and to notify them in writing of what to do in the case of an emergency and where and who in our family to contact in such an emergency.

_____ I agree to communicate and coordinate all issues regarding the safety and health of my children with my child care provider.

_____ I recognize that should my child participate in activities/ field trips with my child care provider I agree to hold the child care provider and the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians, it's employees and agents harmless from and against any and all claims, and liabilities arising from any act or failure to act by the care provider, or CTCLUSI, which action or failure to act results in injury, illness, or death, to my child/children, unless such injury was directly caused by the reckless or intentional acts of the caregiver or any employee of CTLCUSI.

_____ I have received a copy of the Child Care Assistance Program guidelines and participation policies and by signing below I certify that I understand and agree to its contents. I give permission for Family Services to investigate any information given by me on this application for service. I affirm under penalty of perjury that the Child Care application is complete and correct to the best of my knowledge and belief.

_____ By signing this form I certify that I, as a parent/ guardian I will give the following items to the child care provider of my child/ children in care:

1. Two (2) emergency names and phone numbers
2. A permission slip for emergency transport to a health care facility.
3. A permission slip for emergency medical treatment.
4. The names of the hospital and physician(s) of the parent's choice.
5. A list of the child's immunizations OR a letter exempting them due to:
 - a. Objection to immunization on religious grounds AND/OR
 - b. A medical condition requires that immunization not be given
6. A list of any special health care needs-including allergies

_____ By signing this application I agree that any violations of my application or child care assistance program policies or guidelines will result in:

A: FIRST OFFENSE – Suspension from the program for 1 month

B: SECOND OFFENSE – Suspension from the program for a period of not less than 3 months, or more than 6 months

C: Any further violations will be grounds for termination from the program.

Parent's signature

Date

Child Care Parent Participation Agreement

1. I will receive child care assistance only during the hours that I am working, training or attending school.
2. I will provide my Child Care Provider with my daytime telephone number as well as other emergency contact phone numbers.
3. In the event that my child is ill and does not receive child care, I will note the information on the attendance record.
4. I will never sign a blank attendance form.
5. I understand and will inform my Child Care Provider that if I request additional child care services, I will pay for any additional services.
6. I will notify Family Services in writing within seven (7) days of any changes on my application. This will include, but is not limited to, changes in my address, telephone, income or number of people residing in my home.
7. I will notify Family services for approval of a change of provider before my child is in care with a new provider. I understand that before any Child Care Assistance Program payments can be made, the provider must complete a provider application, which must be approved (including a criminal background check and fingerprinting). Any hours billed prior to program approval will not be paid for by the child care program. A letter from the previous provider stating there are not monies owed by the parent must also be provided.
8. I will submit all income that is received in my household.
9. I understand that my child care assistance file must be considered active in order for assistance to be paid.
10. I understand that if my file is inactive, I am financially responsible for my child care services and that Family Services will not provide any back pay.
11. I understand that the co-payment amount is the dollar amount that I must pay to the child care provider each month according to my monthly income.
12. I understand that all financial obligations to my child's care provider must be paid in full on a monthly basis and I am not allowed to charge my monthly co-payment.
13. I understand that if any fraud is committed, I will re-pay the amount in question to Family Services and will be ineligible to participate in the Child Care Assistance Program for a period of one year.
14. I understand that I will be required to complete an updated application annually.

By signing the parent application I certify that I understand and agree to the contents of the participation agreement section of this information packet. I give permission for Family Services to investigate any information given by me on this application for service. I affirm under penalty of perjury that the child care application is complete and correct to the best of my knowledge and belief.

Parent's signature

Date

Family Services Staff signature

Date

OFFICE USE ONLY		
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_____ Approved

_____ Not Approved

_____ Wait List