

**QUAPAW TRIBE CHILD CARE DEVELOPMENT FUND (CCDF)
APPLICATION FOR CHILD CARE ASSISTANCE**

The documentation must be delivered to the CCDF office by mail or hand. **FAXED APPLICATIONS WILL NOT BE ACCEPTED.** The following documentation is required to determine eligibility for child care assistance.

1. Yes No APPLICATION
2. Yes No CERTIFICATE DEGREE OF INDIAN BLOOD (CDIB) CARD
3. Yes No PROOF OF INCOME FOR ALL HOUSEHOLD MEMBERS (Must have 3 most recent check stubs.)
4. Yes No PROOF OF ADDRESS (Utility bill, must have physical address not P.O. Box. If your address is not in your name, you must fill out a physical address form and return it with your application. Must reside within 100 mile radius of Quapaw, OK.)
5. Yes No COPY OF IMMUNIZATION RECORDS (must be up to date)
6. Yes No COPY OF CHILDREN'S BIRTH CERTIFICATES
7. Yes No BILLING STATEMENT FOR ALL COLLEGE FEES FROM BUSINESS OFFICE (if attending school)(must include total fees for books, tuitions, etc., and it must include any pell grant or subsidies received)
8. Yes No COPY OF STATE LICENSE FROM CHILD CARE FACILITY
9. Yes No STUDENT ENROLLMENT CARD/LETTER OF ACCEPTANCE FROM SCHOOL OR TRAINING FACILITY (if attending)
10. Yes No CLASS SCHEDULE (if attending school)
11. Yes No EMPLOYMENT VERIFICATION FORMS FOR ALL WORKING HOUSEHOLD MEMBERS
12. Yes No FOOD STAMP VERIFICATION (letter stating how much and when received.)
13. Yes No OTHER _____

I understand that I must have all the above documentation delivered to the QTCCDF office and have a completed application before I will be considered for assistance. I also have read the above terminology and understand that I must be attending work, a job training program, and/or school, or pre-approved job search while my child is receiving CCDF subsidies. I also understand if I falsify information or fail to submit information required for eligibility, I will be suspended or terminated and will be required to reimburse the program.

SIGNATURE OF APPLICANT

DATE

APPLICATION FOR CHILD CARE SERVICES

Applicants Name:		County:	Date:	
Mailing Address:		City:	State:	Zip:
Physical Address:		City:	State:	Zip:
List your Tribal Affiliation:	Phone #:	Other #:		

1. LIST ALL PERSONS LIVING IN HOUSEHOLD

Child Care Needed	Name	Sex F/M	CDIB Card or Tribal Enrollment Card	Date of Birth	Marital Status M/S	Relation to client	Special Needs
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no				<input type="checkbox"/> yes <input type="checkbox"/> no

2. Special Needs. If your child has special needs please describe: _____

3. Need for child care. Please check the block that best describes your situation:
 Work School Training Protective/Preventive TANF Work Other _____

4. Screening for Expedited Child Care.
 Are you in danger of losing a job or cannot start a new job because you do not have the money to pay toward the cost of child care? yes no

5. Name of Child Care Facility: (if you have not chosen a facility just leave blank)	
Facility Name:	Director's Name:
Address:	
Phone Number:	Center or Home:

FOR OFFICE USE ONLY:			
Date application received in the office:		<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> NOT ELIGIBLE
Monthly Co-Pay: \$		Approval Date:	
Net Monthly Income:\$	Deductions:\$	Adjusted Monthly Income: \$	
REASON FOR DENIAL:			

6. MOTHER OR LEGAL GUARDIAN:	
Place of Employment:	Phone#:
Place of Job Training:	
Place of School: (currently attending)	

7. FATHER OR LEGAL GUARDIAN:	
Place of Employment:	Phone#:
Place of Job Training:	
Place of School: (currently attending):	

8. Please list parent(s) or guardian(s) job and/or school/training schedule:							
NAME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
EXAMPLE: Jane Doe	8:00 – 4:30	8:00 – 4:30	8:00 – 4:30	8:00 – 4:30	8:00 – 4:30	Off	Off

9. PLEASE LIST ALL INCOME SOURCES IN YOUR HOUSEHOLD: (Please provide documentation for any income received.)	
SOURCE OF INCOME	MONTHLY NET AMOUNT
a. What is the total of your household's net monthly WAGE or SALARY? (please provide copies of 3 check stubs & employment verification form)	\$
b. What is the total of your household's SELF EMPLOYMENT wages? (please provide copy of most recent Income Tax Return)	\$
c. Does anyone in your household receive SOCIAL SECURITY BENEFITS? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
d. Does anyone in your household receive WORKERS' COMP? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
e. Does anyone in your household receive ALIMONY? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
f. Does anyone in your household receive FOOD STAMPS? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
g. Does anyone in your household receive UNEMPLOYMENT COMPENSATION? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
h. Does anyone in your household receive TANF/SSP/SSI? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
i. Does anyone in your household receive PENSIONS AND ANNUITIES? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
j. Does anyone in your household receive DIVIDENDS, INTEREST, ROYALTIES? If yes, how much? (please provide documentation for any income received)	<input type="checkbox"/> YES <input type="checkbox"/> NO \$
k. Please list any OTHER source(s) of income received in the household: How much? (please provide documentation for any income received)	\$

10. Are you currently receiving Child Care Subsidies from any other program? Yes or No
If yes, please state who you receive subsidies from: _____

11. Have you ever received Child Care Subsidies from any other program? Yes or No
If yes please state when you received the subsidies and what program you received them from:
When: _____ Program: _____

CLIENT CHILD CARE RESPONSIBILITIES AND SERVICE PLAN AGREEMENT

I agree to:

- Use the child care services **only for the days and hours as specified below and only for the reason/need listed on this form.** Include travel time needed. Check the days care is needed:

	From	To	Child	Reason/Need
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S				
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S				
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S				
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S				
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S				
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S				

- Be responsible for payment for any expense incurred by my failure to notify the QTCCDF program or the facility as noted above;
- Pay charges for care provided in excess of the QTCCDF approved child care plan;
- Notify QTCCDF immediately of any **CHANGES** in the following:
 - household income from any source, such as change in pay, or change in employer;
 - household members (child in or out of the home, adult in or out of the home);
 - address and/or phone number;
 - work/school/training schedule;
 - change of Provider/facility
 - if the participant is no longer in need of child care services
- **NEVER** sign a blank certificate claim form;
- Be responsible to promptly pay or make arrangements to pay the facility any co-payment;
- Provide immunization records and health information regarding my child(ren) unless objected based on religious grounds.

I understand that:

- The earliest date child care benefits will be paid is the day I bring all required verification to the QTCCDF Office (unless authorized by the QTCCDF Office)
- I must choose a child care provider who is licensed by the OKDHS; and
- If I choose a child care center provider, this center must be at one plus; two, or three star status.

I agree to and understand the Client Responsibilities and Service Plan and to provide the QTCCDF office all information necessary to verify any statements made in this application and hereby give permission to QTCCDF to obtain such verification. I affirm under penalty of perjury that this application is complete and correct to the best of my knowledge and belief. I understand and agree that if any statement is false and results in my receiving benefits for which I am not eligible, I am subject to suspension and/or prosecution for fraud. Disciplinary action is to be determined on a case-by-case basis.

GUIDELINES MAY BE AMENDED TO THE BEST INTEREST OF THE QTCCDF PROGRAM AT ANY TIME.

By signing this form I agree and understand the guidelines of the QTCCDF Program.

APPLICANT'S SIGNATURE

DATE

FOR OFFICE USE ONLY:	DOCUMENTATION
CDIB:	<input type="checkbox"/> yes <input type="checkbox"/> no
CHECK STUBS:	<input type="checkbox"/> yes <input type="checkbox"/> no
EMPLOYMENT VERIFICATION FORMS:	<input type="checkbox"/> yes <input type="checkbox"/> no
PROOF OF ADDRESS:	<input type="checkbox"/> yes <input type="checkbox"/> no
IMMUNIZATION RECORDS:	<input type="checkbox"/> yes <input type="checkbox"/> no
BIRTH CERTIFICATES:	<input type="checkbox"/> yes <input type="checkbox"/> no
PROOF ATTENDING SCHOOL:	<input type="checkbox"/> yes <input type="checkbox"/> no
COPY CHILD CARE FACILITY LICENSE:	<input type="checkbox"/> yes <input type="checkbox"/> no

PROOF OF ADDRESS

Please use this form if you do not have a **UTILITY BILL** that is in your name. This form will be used solely for the purpose of the QTCCDF Program.

NAME OF APPLICANT(s):			
PHYSICAL ADDRESS:			
CITY:	STATE:	ZIP:	
MAILING ADDRESS:			
CITY:	STATE:	ZIP:	

By signing this form I declare that the information above is true and I understand that any false information is grounds for termination from the QTCCDF Program. Please sign below and have notarized.

APPLICANT'S SIGNATURE

Imprint

Seal Here

Notary Public

My Commission Expires: _____

State of: _____

County of: _____

Date: _____

1001. STATEMENT OR ENTRIES GENERALLY

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or documents knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years or both.

June 25, 1948, c. 645, 62, Stat. 749

EMPLOYMENT VERIFICATION FORM

(This form should be completed by the Manager or Owner of the Company)

1. Verification of employment for: _____
(Name of Employee)

2. Company/Employer Name: _____

3. Company/Employer Address: _____

4. Manager/Supervisor Name & Title: _____

5. Date of Employment: _____

6. Rate of Pay: _____

7. Pay Schedule: _____ (weekly, bi-weekly, other)

8. Work Schedule:

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours:							

9. Number of Hours Employee Works/Week _____

10. Is the employee paid cash only? Please circle: Yes or No

11. Does the employee receive a pay check? Please circle: Yes or No
Date of first pay check: _____

12. Circle the category the employee is considered: Full Time or Part Time

13. Circle the category the employee is considered: Temporary or Permanent

14. Employer's Phone Number: _____

Manager/Supervisor Signature: _____ Date: _____

This form is for the Quapaw Tribe Child Care Development Fund (CCDF) Program, which will be used to determine the client's eligibility for child care services.

CCDF PROGRAM GUIDELINES

ELIGIBILITY CRITERIA

**NOTE– the QTCCDF will determine Eligibility within a 10-day period if all criteria have been submitted.*

1. The applicant must complete an application and submit all information required before eligibility can be determined. The following information must be submitted:
 - a. Original application (faxes not accepted)
 - b. Child(s) birth certificate (if birth certificate has not been received the applicant will have approximately 60 days to get certificate)
 - c. Updated immunization records (if records are not updated the applicant has one week to begin the process of having them updated)
 - d. Proof of address
 - e. CDIB Card from parent of the child or child. (Applicant has 90 days to submit child's CDIB Card)
 - f. If attending school: college transcripts, student enrollment card/letter of acceptance, and class schedule
 - g. Proof of income: grants or loans for school, copies of three most current check stubs from all household members, employment verification form provided by QTCCDF.
 - h. Copy of State License from child care facility your child attends.
2. The applicant is responsible for choosing a State Licensed child care facility.
3. The QTCCDF program will only pay for child care services while the applicant(s) are attending work, school, or job training. Thirty days of job search is allowable on a case-by-case basis.
4. A child must be under the age of thirteen to receive child care subsidies unless child has special needs.
5. The applicant is required to submit any household member changes immediately.
6. The applicant is required to submit any income changes immediately.
7. The applicant is required to submit any address or phone number changes immediately.
8. **Applicants will be required to Re-Certify every six months.**
9. Applicants are responsible for paying any overtime charges required by their chosen Child Care Provider.
10. Job search may be approved for a maximum of 30 consecutive days when a recipient who has received QTCCDF subsidies for at least 30 days loses employment or successfully completes a formal education or training program.
11. Time for sleep may be approved for applicant(s) who work the graveyard shift. Graveyard shift is considered to be from 11 p.m. to 7 a.m.

CERTIFICATE CLAIM FORMS:

1. It is the applicant(s) responsibility to view the certificates at the end of the month to confirm that the Child Care Provider is only claiming days that the child was in their care.
2. It is the applicant(s) responsibility to sign the certificates at the end of the month. Original signatures will only be accepted.
3. If the applicant(s) leaves a Child Care Provider with an unpaid balance, the QTCCDF will not make any payments to a new Provider until the balance is paid.
4. If a certificate has not been signed by the client, future QTCCDF subsidies may be forfeited.
5. If the Provider requires payment for the child even when the child is absent from day care it is the parent's responsibility to pay for those days that the child is not in care.
6. If a co-pay exceeds the amount of the day care fee for the month then the applicant is responsible for paying the day care fee and not the co-pay.

INCOME VERIFICATION

1. The QTCCDF will calculate your co-payment when adequate income verification has been received.
2. The QTCCDF calculates your co-pay using the net sum on your most recent paycheck stub. Check stubs with no names or social security numbers will be required to attach letterhead from employer or copy of the actual check.
3. SELF-EMPLOYED persons must submit most recent Income Tax Forms, Income Statement Verification (supplied by QTCCDF program), and if possible proof of business (license, Employer Identification Number).
4. Applicants who are starting a new job must have employment verification letter that is supplied by the QTCCDF. When the first full pay check stub is received the applicant is required to submit a copy of the check stub to the QTCCDF. If check stub is not submitted the applicant will be dropped from the program.
5. If a applicant is working odd jobs the applicant must gather receipts from the person working for along with job description, hours worked, rate of pay, and the signature and phone number of each person that has been worked for. They must also submit an Income Verification Statement supplied by the QTCCDF. **Applicant must turn in information to the Child Care Office weekly.**

ELIGIBLE CHILD CARE PROVIDER

1. It is the parental right of the applicant to make an informed choice and to monitor the quality of child care provided by a State Licensed Child Care Provider. It is the applicant's responsibility to determine the appropriateness of their chosen Child Care Provider.
2. The Provider must remain state licensed and follow QTCCDF guidelines while receiving QTCCDF subsidies. If the provider does not remain licensed payments will be denied and become the responsibility of the parent.
3. The parent may take their child to another Child Care Provider at any time as long as the Provider is State Licensed. The Child Care Office must be notified in writing and a copy of the license must be sent to the Child Care Office immediately or payment may be delayed.
4. The provider is not an employee of the Quapaw Tribe. They are considered an independent vendor. No taxes are withheld from their payments. They are not eligible for unemployment, social security, workman's compensation, or medical insurance. The provider will be requested to complete a W-9 Form to verify Taxpayer Identification Number (TIN). They will receive a 1099 from if received more than \$600 in a year from the program. They will not receive a W-2 Form.
5. Child Care Providers are required to notify the program if they are not attending work, school, or training program. The Child Care Providers cannot claim days that the parents are not working, attending school, or a training program.
6. Children must be supervised at all times.
7. The Provider must remain in complete compliance with State Licensing Regulations.
8. The Provider cannot receive more than one source of subsidies for the same child without the prior approval of the QTCCDF. Parents are required to inform the child care office if they are receiving other subsidies than from the QTCCDF.

*NOTE- IT IS THE APPLICANTS RESPONSIBILITY TO HAVE ALL CRITERIA SUBMITTED. INFORMATION BETWEEN THE QTCCDF AND APPLICANT IS CONFIDENTIAL AND WILL NOT BE DISCUSSED WITH PROVIDER. WHEN APPLICANT IS DETERMINED ELIGIBLE FOR SERVICES THE QTCCDF WILL CALL OR SEND LETTER OF APPROVAL TO THE PROVIDER, BUT WILL NOT DISCUSS INFORMATION WITH PROVIDER.

PENALTIES FOR FRAUD

1. **30 DAY SUSPENSION AND MUST REIMBURSE QTCCDF PROGRAM.**
2. **60 DAY SUSPENSION AND MUST REIMBURSE QTCCDF PROGRAM.**
3. **INDEFINITE TERMINATION AND MUST REIMBURSE QTCCDF PROGRAM.**
4. **PENALTY BY LAW.**

