the Chickasaw Nation

Bill Anoatubby
Governor

Department of Community Services / Education Division
Child Care Assistance Program
Post Office Box 1548 / 300 Rosedale Road / Ada, OK 74820 / (580) 421-7711 / Fax: (580) 436-0128

CHILD CARE APPLICATION

The application must be complete with the documentation listed below:

- ☐ Child's CDIB
- ☐ Child's immunization record under age six
- ☐ Household income (check copy - last 30 days)
- ☐ Class schedule (if attending college or training)
- ☐ Parents identification
- ☐ Doctor's report (if a member of the household is disabled)
- ☐ Child's Social Security card
- ☐ Each dependent's state birth certificate
- ☐ Utility bill (gas, electric, water - not older than 30 days)
- ☐ Rental/lease agreement
- ☐ Custodial documentation
- ☐ Social Security, or any additional income

Applicant information:

Child's name: _____
First Middle Last Suffix

Mailing address: _____
Street City County State ZIP

Physical address: _____
☐ same as mailing Street City County State ZIP

Gender: ☐ Male ☐ Female Age: _____ Birth date: _____ Social Security no.: _____

Home phone no.: (____) _____ Cell phone no.: (____) _____

Work phone no.: (____) _____ Ext: _____ Email address: _____

Is the child a First American? ☐ Yes ☐ No Does the applicant have a CDIB? ☐ Yes ☐ No

List tribe and degree: _____

Emergency contact (other than parent/legal guardians):

Name: _____
First Middle Last Suffix

Address: _____
Street City State ZIP

Phone no.: (____) _____

Schedules:

Mother/legal guardian's schedule:

____ Work ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
Time _____ to _____

____ School ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
Time _____ to _____

____ Other ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
Time _____ to _____

Father/legal guardian's schedule:

____ Work ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
Time _____ to _____

____ School ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
Time _____ to _____

____ Other ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
Time _____ to _____

Additional information:

Do you receive TANF benefits? ☐ Yes ☐ No

Does your child have a special need? ☐ Yes ☐ No If yes, please list needs: _____

Assets: Own a home? ☐ Yes ☐ No Value: $ _____ Own a vehicle? ☐ Yes ☐ No Value: $ _____

Accounts: Checking? ☐ Yes ☐ No Value: $ _____ Business? ☐ Yes ☐ No Value: $ _____

Savings? ☐ Yes ☐ No Value: $ _____

Family Status: (Please check what best describes your situation)

☐ Single, head of household, never been married ☐ Divorced ☐ Separated ☐ Married ☐ Widowed

☐ Common law

HOUSEHOLD INFORMATION (List all members in the home)			
Family member name (first, middle, last, suffix)	**Birth date**	**Relationship to the applicant**	**Social Security no.**

HOUSEHOLD INCOME (List all income and provide verification of all income)		
Family member(s) receiving income: (to include employment, SSI, disability)	**Employer name and telephone number**	**Hire date Gross income and how often you are paid**
	_____ (____) _____	Date: _____ $ _____ ☐ Weekly ☐ Bi-weekly ☐ Bi-monthly ☐ Monthly
	_____ (____) _____	Date: _____ $ _____ ☐ Weekly ☐ Bi-weekly ☐ Bi-monthly ☐ Monthly
	_____ (____) _____	Date: _____ $ _____ ☐ Weekly ☐ Bi-weekly ☐ Bi-monthly ☐ Monthly
	_____ (____) _____	Date: _____ $ _____ ☐ Weekly ☐ Bi-weekly ☐ Bi-monthly ☐ Monthly

Eligibility determination is based upon a completed and signed application with the required documentation. BEING FOUND ELIGIBLE DOES NOT GUARANTEE THAT AN INDIVIDUAL WILL RECEIVE SERVICES. Placement is dependent upon the availability of funds.
I certify the information I have submitted is true and correct to the best of my knowledge. I accept the information is subject to verification, and falsification is grounds for immediate termination and may subject me to prosecution under the law. I allow the release of information for verification and reporting purposes.

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of parent/legal guardian Date

Form no. 04963 CS-EDU Rev. 8/2021

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Provider Registration and Agreement

Type: ☐ New ☐ Renewal

☐ Licensed center ☐ Licensed home ☐ Unlicensed relative

☐ One star ☐ One star plus ☐ Two star ☐ Three Star

Date: _____ Start date: _____

Child's name: _____
First Middle Last Suffix

Name of provider: _____
First Middle Last Suffix

Mailing address: _____
Street City County State ZIP

Physical address: _____
☐ same as mailing Street City County State ZIP

EIN/SSN: _____ or _____ Birth date: _____ Phone no.: (____) _____

Email address: _____

Finding directions:
_____
_____

Are you First American? ☐ Yes ☐ No Tribal affiliation: _____ Degree: _____

If you are an unlicensed relative, what is your relationship to the child: _____

****Licensed centers and homes, please send a copy of your current state license or permit, DHS monitoring report, and star certificate****

What is your licensed capacity? _____ What hours and days do you operate? _____

List maximum daily rates for the children for whom you provide care:

Full-time	0 - 12 months	$_____	Part-time	0 - 12 months	$_____
	13 - 24 months	$_____		13 - 24 months	$_____
	25 - 48 months	$_____		25 - 48 months	$_____
	49 - 72 months	$_____		49 - 72 months	$_____
	73+ months	$_____		73+ months	$_____

Is this the amount that you charge everyone? ☐ Yes ☐ No
If no, please explain: _____
_____

The provider agrees the above information is correct to the best of their knowledge.

_____ _____
Child care provider/owner Date

Each person or organization that received payment from the Chickasaw Nation must complete this form and return it to:
The Chickasaw Nation
Child Care Assistance Program
Post Office Box 1548 / 300 Rosedale Road
Ada, Oklahoma 74820

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