



The Chickasaw Nation Child Care Assistance Program

P.O. Box 1548 / 300 Rosedale Rd. / Ada, OK 74820

(580) 421-7711 / (580) 436-0128 Fax

CHILD CARE ASSISTANCE APPLICATION

The application must be complete with the documentation listed below:

- | | |
|---|--|
| <input type="checkbox"/> Child's CDIB Card | <input type="checkbox"/> Child's Social Security Card |
| <input type="checkbox"/> Child's Immunization Record | <input type="checkbox"/> Each Dependent's State Birth Certificate |
| <input type="checkbox"/> Household income (Check copy - last 30 days) | <input type="checkbox"/> Utility Bill (Gas, electric, water - no older than 30 days) |
| <input type="checkbox"/> Class Schedule (If attending college or training) | <input type="checkbox"/> Custodial/Child Support Documentation
(Must have if single, separated, divorced or guardian) |
| <input type="checkbox"/> Doctor's Report (If a member of the household is disabled) | <input type="checkbox"/> Social Security, Child Support or Any Additional Income |

APPLICANT INFORMATION				
1. Child's name	2. Sex	3. Age	4. Birth date	5. Social Security number
			/ /	- -
6. Address			7. Telephone number (work or school)	
Address: _____			Work: (____) _____ - _____ Ext. _____	
City & ZIP: _____			Home: (____) _____ - _____	
E-mail: _____ County: _____			Cell: (____) _____ - _____	
8. Certificate of Degree of Indian Blood (CDIB)			9. Emergency contact (other than parents/guardians)	
(a) Is child an American Indian? <input type="checkbox"/> Yes <input type="checkbox"/> No			In case of emergency, notify:	
(b) Does applicant have his/her CDIB? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name: _____	
(c) List tribe and degree: _____			Address: _____	
			Telephone: (____) _____ - _____	
10. SCHEDULES (Work and school)				
a. Mother's or guardian's schedule		b. Father's or guardian's schedule		
___ Work <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> F <input type="checkbox"/> S	Time _____ to _____	___ Work <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> F <input type="checkbox"/> S	Time _____ to _____	
___ School <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> F <input type="checkbox"/> S	Time _____ to _____	___ School <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> F <input type="checkbox"/> S	Time _____ to _____	
___ Other <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> F <input type="checkbox"/> S	Time _____ to _____	___ Other <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> F <input type="checkbox"/> S	Time _____ to _____	
ADDITIONAL INFORMATION				
Do you receive TANF benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Does your child have a special need? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list needs:				

FAMILY STATUS
(Please check what best describes your situation)

- | | |
|--|---|
| <input type="checkbox"/> (a) Single, head of household, never been married | <input type="checkbox"/> (d) Married |
| <input type="checkbox"/> (b) Divorced | <input type="checkbox"/> (e) Widowed |
| <input type="checkbox"/> (c) Separated | <input type="checkbox"/> (f) Common law |

HOUSEHOLD INFORMATION
(List all members in the home)

11. Family member (First and last name)	Birth date	Relationship to the applicant	Social Security number
	/ /	Applicant	- -
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -
	/ /		- -

HOUSEHOLD INCOME
(List all income and provide verification of all income)

12. Member(s) receiving income: (to include employment, child support, work study, SSI, TANF, Disability)	Name & telephone number of employer / hire date	Gross income and how often you are paid
	_____ ()	\$ _____ <input type="checkbox"/> wkly <input type="checkbox"/> bi-wkly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
	_____ ()	\$ _____ <input type="checkbox"/> wkly <input type="checkbox"/> bi-wkly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
	_____ ()	\$ _____ <input type="checkbox"/> wkly <input type="checkbox"/> bi-wkly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly
	_____ ()	\$ _____ <input type="checkbox"/> wkly <input type="checkbox"/> bi-wkly <input type="checkbox"/> bi-monthly <input type="checkbox"/> 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 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 law. I allow the release of information for verification and reporting purposes.

Signature of parent/guardian

Date

Signature of parent/guardian

Date



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PROVIDER REGISTRATION & AGREEMENT FORM

CHILD'S NAME: _____ Date: _____

Each person or organization that receives payment from the Chickasaw Nation must complete this form and return to:

The Chickasaw Nation
Child Care Assistance Program
P.O. Box 1548 / 300 Rosedale Rd.
Ada, OK 74820

Type: New Licensed Center One Star
 Renewal Licensed Home One Star Plus
 Unlicensed Relative Two Star
 Three Star

Name of provider: _____ EIN/SSN: ____-____-____ or ____-____-____

Address: _____ Birth date: _____

City & ZIP: _____ E-mail address: _____

County: _____ Telephone: (____) _____ - _____

Finding directions: _____

Are you a Native American? No Yes, Tribal affiliation: _____ Degree: _____

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

***** Licensed centers & 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 his/her knowledge.

Staff use only:
Provider Information will be filed in a central location.

Child care provider/owner Date