Comanche Nation Child Care Program

Application Checklist

The following documents are required to be submitted at the same time as the application. Incomplete applications will not be accepted and will be returned to the applicant.

_____ Denial letter for child care services from DHS

_____ Copies of Certificate of Indian Blood (CDIB) card(s) and/or certified letter(s) and/or certified pending enrollment letter(s) for each applicant (child/ren)

_____ Copy of parents and/or guardians Driver license, State ID, or CDIB

_____ Copy of Birth certificate(s) for each applicant

_____ Copy of Social Security Card(s) for each applicant

_____ Copy of Immunization Records for each applicant

_____ Proof of Residence (Utility Bill, Lease Agreement, Ect.)

_____ Copies of the past month's income to include pay stubs, child support, alimony, SSI/Disability, or any other income received

_____ Copy of School and/or training schedule

_____ Copy of the day care provider license

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Comanche Nation Child Care Program

Primary Adult: _____

Mailing Address: _____

City, State, Zip _____

Home/Cell Number: _____ Work Number: _____

Employer: _____Employer Number: _____

Days & hours worked: _____

Education and/or Job Training: _____Contact Number: _____

Days & Hours Attended: _____

Secondary Adult:

_____

Mailing Address: _____

City, State, Zip _____

Home/Cell Number: _____ Work Number: _____

Employer: _____Employer Number: _____

Days & hours worked: _____

Education and/or Job Training: _____Contact Number: _____

Days & Hours Attended: _____

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Household Info:

How many in household?_____

List ALL persons residing in home:

Name	DOB	Relationship	S/M/D/Separated	Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Why are you seeking Child Care Assistance at this time? Please Describe:

_____

_____

_____

_____

Have you been on the CCDF program before? Y or N If Yes, when? _____

Are you currently receiving assistance through DHS? Y or N If Yes, Describe.

_____

Do you receive any other assistance from tribal or state agencies? Y or N If Yes, Describe.

_____

Education & Job Training Info:

Is anyone in the household attending school and/or job training? Y or N

If yes, what type of program? ____ 4yr College ____ 2yr College ____ Vo-tech ____ W.I.A. ____ Other

____ Full time ____ Part time ____ Temporary

Please describe other: _____

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Children Needing Child Care:

1st Child's Name:_____D.O.B____/____/____Age_____

Tribal Affiliation: _____ Enrollment #:_____ Social Security #:_____

2nd Child's Name:_____D.O.B____/____/____Age_____

Tribal Affiliation: _____ Enrollment #:_____ Social Security #:_____

3rd Child's Name:_____D.O.B____/____/____Age_____

Tribal Affiliation: _____ Enrollment #:_____ Social Security #:_____

Day Care Center, before & after school care, or extended day info:

Facility name Address City, State, Zip Code

Days & Times childcare is needed for: (list children names)

1._____ 2._____ 3._____

Sun: _____ Mon:_____ Tues: _____Wed: _____Thurs: _____Fri: _____Sat: _____

2nd Child Care Facility (If Applicable)

Facility name Address City, State, Zip Code

Days & Times childcare is needed for: (list children names)

1._____ 2._____ 3._____

Sun: _____ Mon:_____ Tues: _____Wed:_____Thurs: _____Fri: _____Sat:_____

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Comanche Nation Child Care Program

PARENT AGREEMENT

SIGN AND RETURN TO OUR OFFICE

1. **I** understand that our services with the Comanche Nation Child Care Program will be for a 24 month service period.
2. **I** will receive childcare assistance only during the time that I/we are physically working, training or attending class/lab.
3. **I** will provide my childcare provider with a daytime telephone number as well as emergency contact information.
4. In the event that my child is ill and does not receive services, I/we will note that information on the attendance record.
5. **I** will never sign a blank statement form. If the time sheet I/we sign is inaccurate the following month of service payment will either be increased or decreased to make payment current.
6. **I** understand and will inform my childcare provider that if I/we request additional childcare services, I/we will pay for the additional services.
7. **I** will notify the childcare program verbally within **seven (7)** days in the event of information changes such as address, telephone number, persons living in residence, and employment/income status.
8. If **I** decide to change providers, I/we will notify the childcare the childcare office **seven (7)** days before the change is made with the proper documentation signed by the original provider showing no co-payment owed.
9. **I** will submit **ALL INCOME** that is received in my household.
10. **I/We** understand that my child's application must be completed in order to receive child care assistance.
11. **I** understand that if my child's file is under suspension, I/we will be totally responsible for payment to the childcare provider.
12. **I** understand that all financial obligations to my childcare provider must be paid in full on a monthly basis and I/we are not allowed to charge my monthly co-payment.
13. **I** understand that Comanche Nation Child Care Program will pay a maximum rate per day or rate according to my child's age, and I/we will be responsible for the remaining cost.
14. **I** understand that co-payment is a dollar amount that I/we must pay to the childcare provider each month for my family share. My/Our co-payment is $_____per month.
15. **I** understand that if any fraud is committed, I/we will repay the amount of money in question to the childcare program and be unable to participate in the program **FOR A PERIOD OF ONE YEAR.** If monies are not repaid, I/We will be subject to prosecution.

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16. **I** understand that I/we will be required to submit an updated application bi-annually.
17. **I** understand that to receive Special Needs and Foster Care Priority, I/We must submit a doctor's statement and/or legal documents verifying that my child needs this type of care.
18. **I** understand that all childcare time sheets must be signed and agreed upon by both provider and parent. Unsigned time sheet will not be processed for payment to provider.
19. **I** understand that all phone calls regarding childcare cases must be from applicant. No information will be shared with relatives or providers. If I/we have a complaint about child care staff or providers, I/we will make this in writing and submit to the Human Service Manager.
20. **I** understand that all calls concerning childcare payments should be directed to the childcare office, not the Chairman, Tribal Administrator, or the Executive Administration assistance's office. Phone calls directing childcare staff to allow certain persons to pick checks will not be tolerated or allowed.

I authorize the Comanche Nation Child care Staff permission to make any investigation to verify any answer I/we have given. I/we are certifying that I/we understand and agree to the contents of the "Parent Agreement". I/We affirm under penalty of perjury that the childcare application is complete and correct to the best of my knowledge and belief. I/We also understand that providing false information may result in termination of these benefits.

By signing below, **I/We** agree to the following rules and regulations of the Comanche Nation Child Care Program.

_____ _____

Applicant Parent/Guardian **Date**

INDIVIDUAL ACKNOWLEDGEMENT

State of _____, County of _____. Before me the undersigned, a Notary Public, in and for the said County and State, on this ___ day of _____, 20__, personally appeared _____, she/he Subscribed and Sworn the above Parent Agreement.

My commission expires on the __ day of _____ 20__.

_____

Notary Public

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Comanche Nation Child Care Program

EMERGENCY CONTACTS

Client Information:

Child's Name: _____

Physical Address: _____

Home Phone #: _____Work #: _____

Cell #: _____

Emergency Contact #1

Name & Relationship: _____

Physical Address: _____

Home #: _____Best Contact #: _____

Emergency Contact #2

Name & Relationship: _____

Physical Address: _____

Home #: _____Best Contact #: _____

Emergency Contact #3

Name & Relationship: _____

Physical Address: _____

Home #: _____Best Contact #: _____

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CONSENT TO RELEASE INFORMATION

Date:_____

To Whom It May Concern:

Please send a copy of my records to the:

Comanche Nation of Oklahoma
Child Care Program
P.O. Box 908
Lawton Ok 73501

This information to be used to determine eligibility for child care services for the following:

_____
Print Name

_____
Sign Name

_____
Address

_____
City, State, & Zip Code

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Comanche Nation Child Care Program

CHILD SUPPORT CONSULTATION FORM

To whom it may concern:

_____ has met with the Comanche Nation Child Support Program on this _____day of _____20__.

_____has been counseled on his/her options provided by this office.

_____
Parent Signature Date

_____
Child Support Caseworker Date

_____
Reviewed by Childcare Tech & Date

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Comanche Nation Child Care Program

CHILD SUPPORT AFFIDAVIT

Date: _____

To whom it may concern:

I, _____ do not receive child support payment for the following children:

_____
_____
_____
_____
_____
From the children's father and/or mother.

_____
Signature Date

Subscribed and Sworn by me this ___ day of _____ 20__.
My commission number_____ expires the ____day of _____20__.

_____
Notary Signature

_____
Reviewed by Childcare Tech & Date

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Comanche Nation Child Care Program

LIABILITY RELEASE FORM

Date: _____

I, _____, understand that the Comanche Nation Child Care Program, the Comanche Nation of Oklahoma and all its entities are not liable for any accidents, Injuries, or Mishaps that may happen to my child, while he/she is in the care of _____, to be inclusive of transportation and the dispersal of medications. All efforts are made by the Comanche Nation Child Care Program to provide a safe and healthy environment for my child. I understand that by placing my child in _____ for childcare also releases this facility from liability due to Accidents, Injuries, or Mishaps. However, this does not release the provider from being liable for any child abuse.

_____ _____
Primary Adult Signature Secondary Adult Signature

_____ _____
Date Date

INDIVIDUAL ACKNOWLEDGEMENT
Subscribed and Sworn by me this ___ day of _____ 20____.
My commission number:
_____ expires the _____day of _____ 20___.

_____
Notary Signature

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PARENT'S WAIVER OF ADDITIONAL INSURANCE

Children's Name: _____

I_____ hereby waive my right for my provider,

_____, to obtain additional homeowner's and vehicle insurance. I realize that by waiving my right for my provider to obtain additional coverage, I will not hold the Comanche Nation Child Care Program, the Comanche Nation of Oklahoma and all of its entities liable for any Accidents, Injuries, or Mishaps that may happen while my child (ren) are in the care of my provider. By signing this document, I herby release the Comanche Nation Child Care Program, the Comanche Nation of Oklahoma, and all its entities from all liability for loss or injury in association with the care of my child (ren). However, this does not release the provider of liability due to child abuse.

_____ _____
Primary Adult Signature Date

_____ _____
Secondary Adult Signature Date

INDIVIDUAL ACKNOWLEDGEMENT
Subscribed and Sworn by me this ___ day of _____ 20___.
My commission number:
_____ expires the ____ day of 20_____.

_____
Notary Signature

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Comanche Nation Child Care Program

Provider's Registration

Name of Facility:

Contact Person at Facility:

Telephone #: _____ FAX #:_____
Physical
Address: _____City: _____
ST: _____ Zip Code: _____

Finding Directions:
_____
_____
_____

Type of Child Care Services (please check one):

Day Care Center: _____ Provider's Home: _____
Before & After Care Program: _____ Extended Day Program:_____

License number: _____
Maximum Number of Children: _____
Issued Date: _____

I hereby consent to any authorized representative of the Comanche Nation to obtain information from any and all records that may be needed to determine my eligibility as a Child Care Provider for the Comanche Nation Child Care Program. I will attach a copy of my Child Care License with this Provider Registration form.

Provider Signature:_____ Date:_____

Childcare Program Staff: _____Date: _____

Revised 10/12/2011

Client name & date:

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Revised 08/18/2016

Comanche Nation Child Care Program

PROVIDER'S WAIVER OF ADDITIONAL INSURANCE

Children's Name: _____

I, _____ as the provider for
_____
_____
_____

(list children names) hereby waive my right to obtain additional homeowner's and vehicle insurance. I realize that by waiving my right as a provider to obtain additional coverage, I will not hold the Comanche Nation Child Care Program, the Comanche Nation of Oklahoma and all of its entities liable for any Accidents, Injuries, or Mishaps that may happen while the child(ren) of the afore mentioned parent (s) are in my care. By signing this document, I herby release the Comanche Nation Child Care Program, the Comanche Nation of Oklahoma, and all its entities form all liability for loss or injury in association with my services as a child care provider. However, this does not release me of liability due to child abuse.

_____ _____
Signature of Provider Date

INDIVIDUAL ACKNOWLEDGEMENT
Subscribed and Sworn by me this ___ day of _____ 20___.
My commission number:
_____ expires the ____ day of 20_____.

_____
Notary Signature

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Comanche Nation Child Care Program

DAYCARE PROVIDER AGREEMENT

PROVIDER'S AGREEMENT
PART ONE

THIS AGREEMENT: entered into an effective the _____day of _____ 20__, by and between the Comanche Nation Child Care Program, P.O. Box 908, Lawton, OK 73502, hereinafter referred to as "Program", and _____ as an (check one) ,Licensed In-Home Daycare_____, or Licensed Daycare _____ which is located at: _____, hereinafter referred to as "Provider" in this agreements set forth herein, it is mutually agrees as follows:

PART TWO

THIS AGREEMENT is too effective for twenty-four (24) months and may not be extended or renewed under the discretion of the Program.

ELIGIBLE START DATE: _____ END DATE:_____

X_____

PART THREE

IT IS AGREED AND UNDERSTOOD that daycare services are provided to the following child(ren):

_____ _____

_____ _____

_____ _____

IT IS FURTHER AGREED that said services will be provided at the following location:

_____

IT IS FURTHER UNDERSTOOD AND AGREED that no services authorized under this contract will be subcontracted by provider to any other person or entity without prior written approval by the Program.

X_____

PART FOUR

IT IS AGREED AND UNDERSTOOD that the Program will pay for services rendered by Provider pursuant to this agreement only (a) in accordance with written authorized from the Program for each client served and (b) upon receipt from Provider, and verification of monthly timesheet by the Program. In addition, the Provider agrees to provide unlimited access to the facility by the parent/guardian during normal hours of operation in order that the child maybe observed in the care setting may be assessed.

X_____

IT IS AGREED AND UNDERSTOOD by Provider that changes to the Program for authorized services will not exceed the Program maximum payment rates schedules of the Comanche Nation Child Care Program.

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X_____

IT IS FURTHER AGREED AND UNDERSTOOD by Provider that in the event of an overpayment by the Program to a Provider, the Program at its discretion may (1) demand immediate reimbursement by Provider (2) withhold the full amount of overpayment from any and all funds in possession of said Program the due or to become due and owing to Provider (3) accept a mutually agreeable written re-payment plan of (4) seek collection by ligation.
X_____

PART FIVE

IT IS AGREED AND UNDERSTOOD that the Program will determine eligibility for all authorized clients' services.
X_____

IT IS FURTHER AGREES that the Provider will not include on any list for billing, invoice or monthly claim any person or persons without prior certificate of eligibility by the Program.
X_____
IT IS FURTHER AGREED AND UNDERSTOOD that any recipient of service will have the right to a fair hearing in cases of denial or termination of services described herein.
X_____

PART SIX

IT IS AGREED AND UNDERSTOOD that Provider must meet and maintain all Tribal, State and Federal standards applicable to the authorized services being provided pursuant to this Agreement and Provider hereby acknowledges full awareness of such standards. Provider shall, prior to renewal or approval of this agreement, disclose to the Program the name of any person who has an ownership or controls an interest in or is an agent or managing employee of Provider and who has been convicted of criminal offense related to such person's involvement in any program under Title XVIII, XIX or XX of any Social Security Act since inspection of these Program.
X_____

PART SEVEN

PROVIDER AGREES to develop and maintain written records sufficient to document proper fiscal and program management of Providers' responsibilities under this Agreement. All records shall be retained for a period of three (3) hours Provider further agrees to utilize a uniform method of record keeping.
X_____

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PROVIDER FURTHER AGREES AND UNDERSTANDS that all such business records shall be made available and accessible to the Program at any time with or without notice, for the Program use in inspecting, monitoring, evaluating, and audition, Provider's compliance with the terms of this agreement.
X_____

PART EIGHT

IT IS AGREED that any Provider who resides, or has principal place of business in Indian Country, as defined in 18 USC 151, will be subject to the C.F.R. Court of Indian Offenses or the Comanche Nation Court as the court of competent jurisdiction.
X_____

PART NINE

IT IS AGREED AND UNDERSTOOD that this Agreement may be canceled at any time by mutual consent of the parties hereto, by either party, without cause by giving a thirty (30) day written notice of intent to cancel to the other party; or by another party with cause by giving a ten (10) day written notice of intend to cancel the other party. The term "with cause" is hereby defined as failure to meet the terms and conditions, of the Agreement as set forth herein or incorporated herein, as through fully set out, by reference thereto.
X_____

PART TEN

FOR the faithful performance of the terms of this Agreement, the parties hereto in their respective capacities as stated affix their signature below.

PROVIDER:
BY:_____
Authorized Representative Date

Subscribed and Sworn by me this ___ day of _____ 20__.
My commission number_____ . Expires the ____day of _____20__.
_____
Notary Signature

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