☐ CCDF ☐ Enrichment

For office use only	Date Received:
	Date Reviewed:

Comanche Nation Child Care Program Application Checklist

For Child Care Staff Only

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.

Date:	Initials:	Type of Documentation Requested:
		Proof of Residence Utility Bill (Water, Gas, Internet or Electric) or Rent/Lease Agreement
		Copy of parents and/or guardians Identification (Driver license, State ID, or CDIB with photo
		Copy of Certificate of Indian Blood (CDIB) or Certified pending enrollment letter(s) for each child with Parent's CDIB • If pending enrollment-submit the child's CDIB once enrolled
		Copy of child(ren) Birth certificate(s)
		Copy of child(ren) Social Security Card(s)
		Copy of child(ren) Immunization Records
		Proof of Income/Training/Schooling (income includes recent pay stubs (30 days worth), child support, alimony, SSI/Disability, or any other income documents) • If newly employed we need a letter from your employer stating how many hours you work and your pay rate • If in training/school we need copy of school schedule (each period/semester)

Comanche Nation Child Care Program

Section I - Primary Adult			
Last Name:	**First Name:**	**Middle IN:**	**Preferred Name:**
Date of Birth:	**Gender:**		**CDIB #**
Physical Address:			
City, State, Zip code		**Mailing Address: (If different from Physical Address)**	
Home Phone:	**Work Phone:**	**Ext.**	**Cell Phone:**
Email Address:			
Name of Employer / School			
Address of Employer / School:			

Section II - Secondary Adult (Responsible Party)			
Last Name:	First Name:	Middle IN:	Preferred Name:
Date of Birth:	Gender:		CDIB #
Physical Address:			
City, State, Zip code		Mailing Address: (If different from Physical Address)	
Home Phone:	Work Phone:	Ext.	Cell Phone:
Email Address:			
Name of Employer / School			
Address of Employer / School:			

FAMILY INFORMATION

Family Size (number of persons) _____

	Name	DOB	Income	Relationship	Single/Married (over18)
1.					
2.					
3.					
4.					
5.					
6.					
7.					

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

_____

_____

_____

Have you been on any tribal Childcare Programs before? Yes or No If Yes, when and which tribe? _____

_____

_____

Are you currently receiving assistance from tribal or state agencies including DHS? Yes or No If Yes, Describe.

_____

_____

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 #:_____

4th Child's Name:_____D.O.B____/____/____Age_____

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

5th Child's Name:_____D.O.B____/____/____Age_____

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

CHILD CARE CENTER INFORMATION:

Facility Name: _____

Telephone number: _____

Address: _____

City, State, Zip code: _____

Email: _____

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

1._____ 2._____ 3._____ 4._____ 5._____

Mon:_____ Tues: _____Wed:_____ Thurs: _____Fri: _____

CONSENT TO RELEASE INFORMATION

To Whom It May Concern:

Please send a copy of my records and my child's records to the following agency, this information is being used to determine eligibility for child care services:

Comanche Nation of Oklahoma
Child Care Program
P.O. Box 908
Lawton, Oklahoma 73502

Child's Information:

	Name:	DOB:
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	

Print Name: _____

Sign Name: _____

EMERGENCY CONTACTS:

Contact #1:			
Last Name:	**First Name:**	**Middle IN:**	**Preferred Name:**
Physical Address:			
City, State, Zip code		**Relationship to Child**	
Home Phone:	**Work Phone:**	**Ext.**	**Cell Phone:**
Email Address:			

Contact #2:			
Last Name:	**First Name:**	**Middle IN:**	**Preferred Name:**
Physical Address:			
City, State, Zip code		**Relationship to Child**	
Home Phone:	**Work Phone:**	**Ext.**	**Cell Phone:**
Email Address:			

READ CAREFULLY BEFORE SIGNING:

1. I will abide by the rules and regulations of program (CCDF and CCA/FEP) and I will pay all co-pays and additional fees on time & in full to the provider.
2. I understand I must notify the program office of any changes in household including add/subtract family members, pay rate, work status, address/phone, email address, # of children, work/class schedules within **seven (7) days**. If I must discontinue during this period full payment to the provider will be solely my responsibility.
3. I understand if I am "terminated" from the program (CCFD and CCA/FEP) for any unfavorable reason, I will be put on a suspension period and my application will be evaluated before further assistance will be provided. Also any costs that are incurred during this period will be solely my responsibility.
4. By accepting my application for the program (CCFD and CCA/FEP) and meeting all eligibility requirements upon approval, the program (CCFD and CCA/FEP) agrees to furnish financial assistance for child care services limited to maximum allowances under the program (CCFD and CCA/FEP) guidelines.
5. This financial assistance will be granted during my approval period (36 months max on CCFD) as long as I observe the rules mentioned above and maintain renewal/re-certification guidelines and all procedures.
6. I understand that to receive Special Needs and/or Foster Care Priority, I must submit a doctor's statement and/or legal documents verifying that my child needs this type of care.

7. I understand that all child care time sheets must be signed and agreed upon by both the child care provider and parent. *Unsigned time sheets will not be processed for payment due to the provider*.
8. I will never sign a blank statement form. If the time sheet I sign is inaccurate, I understand the following month of service payment will either be increased or decreased to make payment current.
9. If I decide to change providers, I will notify the program office seven (7) days prior to changes and that all balances owed to previous provider have been settled.
10. I understand that if any fraud is committed, I must repay the amount in question to the Comanche Nation Child Care Program and will be unable to participate in the program until the repayment is made.
11. I understand that all phone calls regarding child care cases must be from applicant, no information will be shared with relatives or providers. If I have a complaint about child care staff or providers, I will make this complaint in writing to the program director.
12. A Parental complaint form is located on our website at Child Care | Comanche Nation
13. If notification is received from your provider that your child (ren) have not been in attendance for more than one calendar month you risk being removed from the program.

By my signature, I fully understand the terms under which I have applied for assistance with the program (CCFD and CCA/FEP). I authorize the Comanche Nation Child Care Staff permission to make any investigation to verify any answers I have given. I affirm under penalty of perjury that the child care application is complete and correct to the best of my knowledge and belief. I also understand that providing false information may result in termination of these benefits. I certify that my family assets are not in excess of 1,000,000 (million) dollars.

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

_____ _____

APPLICANT'S SIGNATURE DATE

_____ _____

Signature of Subsidy Program Office Staff DATE

CHILD SUPPORT CONSULT & AFFIDAVIT

To whom it may concern:

I, _____ do not receive child support payments for below listed children AND have been counseled on my options regarding the filing for child support by supporting state/tribal agencies:

	Name:	DOB:
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	

_____ _____

Signature Date

INDIVIDUAL ACKNOWLEDGEMENT

Subscribed and Sworn by me this _____ day of _____ 20_____.

My commission number: _____ expires the _____ day of _____ 20_____.

_____

Notary Signature

_____ _____

Signature of Subsidy Program Office Staff Date