



# 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 Child's State Birth Certificate  |
| <input type="checkbox"/> 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<br>(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				
<b>1. Child's name</b>	<b>2. Sex</b>	<b>3. Age</b>	<b>4. Birth date</b>	<b>5. Social Security number</b>
			/ /	- -
<b>6. Address</b>			<b>7. Telephone number (work or school)</b>	
Address: _____			Work: (____) _____ - _____ Ext. _____	
City & zip code: _____			Home: (____) _____ - _____	
E-mail: _____ County: _____			Cell: (____) _____ - _____	
<b>8. Certificate of Degree of Indian Blood (CDIB)</b>			<b>9. Emergency contact (other than parents/guardians)</b>	
(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: (____) _____ - _____	

### SCHEDULES (Work and school)

**10. If your child attends public school, please complete section (a):**

(a) School attending: \_\_\_\_\_ City: \_\_\_\_\_

Days:  Su    M    T    W    R    F    Sa      Time \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

<p><b>(b) Mother's or guardian's schedule</b></p> <p>___ 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</p> <p>                  Time _____ to _____</p> <p>___ 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</p> <p>                  Time _____ to _____</p> <p>___ 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</p> <p>                  Time _____ to _____</p>	<p><b>(c) Father's or guardian's schedule</b></p> <p>___ 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</p> <p>                  Time _____ to _____</p> <p>___ 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</p> <p>                  Time _____ to _____</p> <p>___ 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</p> <p>                  Time _____ to _____</p>
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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	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 code: \_\_\_\_\_ 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