CHILDCARE PROVIDER APPLICATION

Please turn in a completed application and required documentation listed below:

- Complete and review application before submitting
- Background checks for anyone in the household 16 years old and over. An individual cannot be an approved provider if they refuse a background check, make materially false statements in connection with the background check, or are registered or required to be a registered on the State of Alaska or National Sex Offender Registry. Providers also cannot be approved if they have been convicted of a **felony** consisting of murder, child abuse or neglect crimes against children, spousal abuse, crimes involving rape or sexual assault, kidnapping, arson, physical assault or battery.
- ASNA can review and approve or deny if an individual has a drug related offense committed during the preceding 5 years; a violent misdemeanor committed as an adult against a child, including the following crimes – child abuse, child endangerment, or sexual assault; or a misdemeanor involving child pornography (98.43(c)(1))
- Fire inspection -within 30 days of approval. Please contact your local fire department to request an inspection
- CPR/First Aid -within 30 days of approval
- Verification of Tuberculosis Test (TB) - cannot be more than one (1) year old - within 30 days of approval
- Copy of Driver's license or Identification Card
- If day care center please provide business license/Copy of Alaska License

Eligibility Criteria for Child Care:

By statute, all eligible children must be under the age of 13 and reside with family whose income does not exceed 85% of the Grantee Median Income (GMI) for a family of the same size and whose parent(s) are working or attending a job training or educational program or who receive or need to receive protective services. Arctic Slope Native Association Child Care Assistance Program is now following the State Income Median.

ALL PROVIDERS WHO PARTICIPATE IN THE CHILD CARE ASSISTANCE PROGRAM MUST BE APPROVED ARCTIC SLOPE NATIVE ASSOCIATION CHILD CARE ASSISTANCE PROGRAM OR HAVE A LICENSE ISSUED BY THE STATE OF ALASKA

Applicant Last Name First Name DOB

Child Care Facility Name

Mailing Address City State Zip Code

Physical Address City State Zip Code

Home Phone Number Work Phone Number Cell Phone Number

E-Mail Address

List all household members: If you need more space, please list others on separate sheet of paper.

Name DOB Relationship to Provider

Name DOB Relationship to Provider

Name DOB Relationship to Provider

Name DOB Relationship to Provider

TRIBAL CHILD CARE PROVIDER CARE INFORMATION AND RESPONSIBILITIES:

THIS SECTION MUST BE COMPLETED IN ORDER TO BE CONSIDERED AND TO IDENTIFY THE TYPE OF CARE AND SERVICES PROVIDED FOR CHILD CARE FACILITY

Number of Children you would be able to care for: ☐

Please indicate the ages that you would like to care for:

- ☐ 0-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-12

Are you interested in providing services for a child with special needs?

- ☐ YES
- ☐ NO

Have you received any training for caring for special needs children?

- ☐ YES
- ☐ NO

If yes, please explain the type of training that you acquired and attach copy of certificates.

_____

_____

_____

Provider:

Make Check Payable to: _____

Name of Parent: _____

Type of Facility (check one)

- ☐ Center based (licensed Provider, non-residential setting)
- ☐ Group Home (2 or more providers, private residence setting)
- ☐ In-Home (individual provider in child's own home) ☐ Relative ☐ Non-Relative
- ☐ In-Home (individual provider in providers home) ☐ Relative ☐ Non-Relative

Type of Provider (check one)

- ☐ Open Provider - Open to watch children under Child Care Assistance
- ☐ Closed Provider - Do not give my information to anyone else

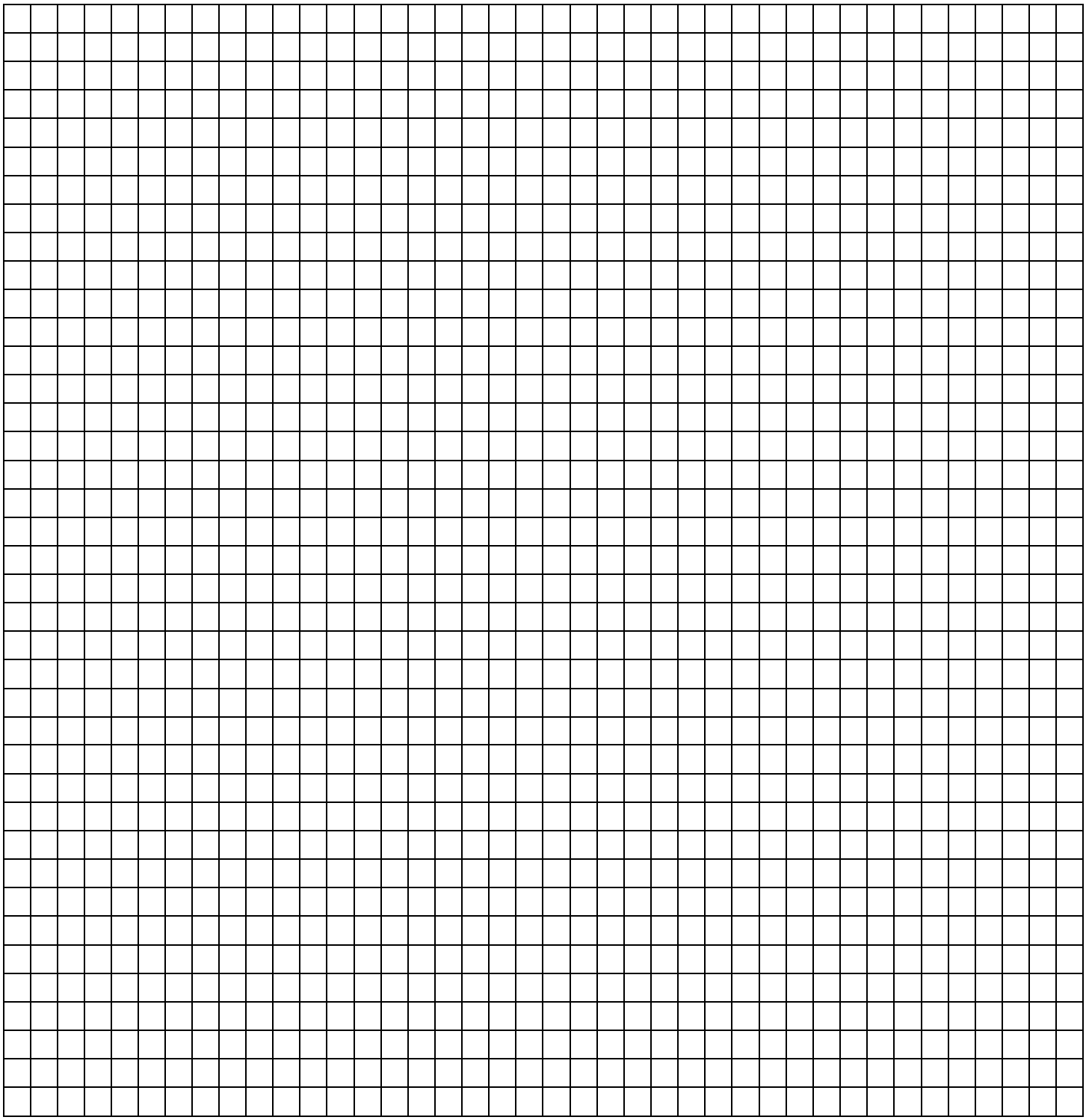
FLOOR PLAN OF HOME

Date:

In space provided, please draw a diagram of your home/facility. Draw a floor plan sketch and label each room, ie. "Kitchen." Indicate positions of all doors and windows. Also, show and label the location on the outside of the home where your family will gather if there is an emergency.

Facility Name: _____

Physical Address: _____



PROVIDER ACKNOWLEDGEMENT FORM

Please carefully review and initial each requirement certifying this document to be true and correct to the best of your knowledge.

_____ I understand that a representative from the Arctic Slope Native Association may call my home and may contact other people in order to verify my eligibility for childcare provider. I also understand that any information I give may be verified by cross matching information with other agencies.

_____ I understand upon approval of this application I will be required to attend ASNA Child Care Orientation.

_____ I understand I will be required to attend/participate in required training regarding Health and Safety Standards as Child Care Provider.

_____ I understand a representative of Arctic Slope Native Association will be conducting at least one Child Care Home Inspection annually.

_____ I understand that it is against the law to make false statements.

_____ I certify I have checked the information on the application carefully and that it is an accurate statement of facts to the best of my knowledge.

_____ I certify that this is the only application submitted from or on the behalf of myself.

If you have any question or concerns regarding your Child Care Provider Application please contact the ASNA Child Care Staff.

_____	_____	_____
Print Name	Signature	Date

STATE OF ALASKA
DEPARTMENT OF PUBLIC SAFETY
REQUEST FOR CRIMINAL JUSTICE INFORMATION
From the Alaska Criminal History Record Repository

Original forms must be submitted to:

Criminal Records and Identification Bureau
5700 E. Tudor Road, Anchorage, AK 99507
Telephone: (907) 269-5767 Fax: (907) 269-5091 (RSAs only)
Include fee: $20 single copy, $5 each additional copy
Check or money order must be made payable to 'State of Alaska'

Type of information being requested **(from other than the record subject): (Choose ONE)**

☑ 1. Criminal Justice Information available to **ANY PERSON for ANY PURPOSE**
- This report includes current/open criminal charges and charges that resulted in conviction, excluding sealed records.

☐ 2. Criminal Justice Information available to an **INTERESTED PERSON**
- This report includes all criminal charges and dispositions, excluding sealed records

2.A. If you checked item 2, the requester must provide the following information:
I request this report for the purpose of determining whether to grant the record subject supervisory or disciplinary power over (check all that apply):
☐ Minor(s)
☐ Dependent adult(s)
Title or brief description of the position under consideration: _____

☐ 3. Criminal Justice Information needed for another purpose authorized by federal or state law.
Client Number: _____
If you check this box, you **must** provide the client number assigned by the DPS Records and Identification Bureau.
To obtain a client number, you must provide the applicable state or federal statute to this office for review and approval prior to submitting this request.

*A check or money order payable to the State of Alaska in the amount of $20 **must** accompany this request. Additional copies, if requested at the time of this request, may be obtained for an additional $5 per copy. State agencies with a Reimbursable Services Agreement (RSA) in place may fax the appropriate forms. All other requests must be submitted via U.S. Postal Service or in person.*

Subject Name: _____

Maiden/Alias name(s): _____

Mailing Address: _____

City/State/Zip: _____

Alaska Drivers License #: _____

Date of Birth: _____

Sex: ☐-Male ☐Female Soc Sec No. _____

Telephone: _____ Msg: _____

To be completed by the record subject: *"I authorize the release of my criminal justice information record, (described above) to the named requester."*

Signature of subject: _____

Date Signed: _____

Requester Name: _____

Title: _____

Business/Agency: ARCTIC SLOPE NATIVE ASSOCIATION SOCIAL SERVICE DEPT

Mailing Address: PO BOX 1232

City/State/Zip: BARROW, ALASKA 99723

Date of Birth: _____ Telephone: _____

Sex: ☐ -Male ☐ - Female Soc Sec No. _____

The requested record will be mailed to the above named individual at the listed address. If you would like the record faxed, check the box below:

☒ Fax Number: 907-852-2761

Signature of requester: _____

Date Signed: _____

Unsworn Falsification Statement (Your request will not be processed if you do not sign this statement.)
I certify under penalty of unsworn falsification (AS 11.56.210) that the information I am supplying on and with this form is true and correct.

Record Subject's Signature **Date**

STATE OF ALASKA
DEPARTMENT OF PUBLIC SAFETY
REQUEST FOR CRIMINAL JUSTICE INFORMATION
From the Alaska Criminal History Record Repository

Original forms must be submitted to:

Criminal Records and Identification Bureau
5700 E. Tudor Road, Anchorage, AK 99507
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Date of Birth: _____

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Signature of subject: _____

Date Signed: _____

Requester Name: _____

Title: _____

Business/Agency: ARCTIC SLOPE NATIVE ASSOCIATION SOCIAL SERVICE DEPT

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Date Signed: _____

Unsworn Falsification Statement (Your request will not be processed if you do not sign this statement.)
I certify under penalty of unsworn falsification (AS 11.56.210) that the information I am supplying on and with this form is true and correct.

Record Subject's Signature **Date**

AUTHORIZATION FOR RELASE OF INFORMATION FOR CHILD CARE PROVIDER

I, _____, hereby authorize the Native of Barrow Social Service Department to release the following:

- Information pertaining to any **open or previous** child abuse and or / neglect investigation in which I have been identified as the alleged perpetrator, and
- Dates of any substantiated reports of harm in which I have been identified as the perpetrator of child abuse and or/ neglect, and
- Date of any negative licensing action.

_____

First Name Middle Name Last Name

_____

Date of Birth Social Security Number

_____ _____

Signature Date

Complete a separate form for each child care provider and household member's age of 16 and older. The application provides only one (1) Authorizations for Release of Information forms. You may need to make extra copies.

SPACE BELOW THIS LINE WILL BE FILLED OUT BY THE NATIVE VILLAGE OF BARROW SOCIAL SERVICE DEPARTMENT

Is the applicant identified as the alleged perpetrator in a substantiated report of harm or as a perpetrator in an open or prior child abuse or neglect case?

YES ☐
NO ☐

Dates of any substantiated reports of harm, perpetrator and child abuse.

_____

_____

_____ _____

Social Services Signature Date

AUTHORIZATION FOR RELASE OF INFORMATION FOR CHILD CARE PROVIDER

I, _____, hereby authorize the Native Village of Barrow Workforce Department to release the following:

- Information pertaining to any **open or previous** child abuse and or / neglect investigation in which I have been identified as the alleged perpetrator, and
- Dates of any substantiated reports of harm in which I have been identified as the perpetrator of child abuse and or/ neglect, and
- Date of any negative licensing action.

_____

First Name Middle Name Last Name

_____

Date of Birth Social Security Number

_____ _____

Signature Date

Complete a separate form for each child care provider and household member's age of 16 and older. The application provides only one (1) Authorizations for Release of Information forms. You may need to make extra copies.

SPACE BELOW THIS LINE WILL BE FILLED OUT BY THE NATIVE VILLAGE OF BARROW WORKFORECE DEPARTMENT

Has the applicant ever been licensed?
YES ☐
NO ☐

Were there any negative licensing action?
YES ☐
NO ☐

Dates of any substantiated reports of harm, perpetrator and child abuse.

_____

_____

_____ _____

Workforce Signature Date

Alaska Department of Health and Social Services
Office of Children's Services

CLEARANCE FORM

CONFIDENTIAL

Worker_____
Field Office or
Private Agency

Instructions: Complete a separate form for ***EACH*** foster care applicant, unlicensed relative caregiver, adoptive applicant or guardian, household member age 16 years and older, and adult with direct access to children in the home.

Last Name	First Name	Middle Name	Household Name	
Aliases, Maiden Name, Previous Married Name(s)		Social Security #	☐ Male ☐ Female	
Date of Birth	Place of Birth: City	State	Country	
Driver License Number	State of Issuance	Home Phone Number	Alternate Phone Number	
Physical Address		City	State	Zip
Mailing Address		City	State	Zip

Residency: Alaska _____Yrs _____Mo's Physically here _____Yrs _____ Mo's

Please list your previous residence for the last ten (10) years. Attach additional page(s) if necessary.

From (MM/YY)	To (MM/YY)	City	State	Country

Have you been previously licensed to care for children or adults?
NO ☐ YES ☐ If yes, indicate city, state and type of care and dates of licensure:

Have you ever had a license to care for children or adults revoked or denied in Alaska or any other state?
NO ☐ YES ☐ If yes, attach an explanation

Have you or any household members at any time ever been investigated for child abuse or neglect?
NO ☐ YES ☐ If yes, attach an explanation.

Do you have a physical, health, mental health or behavioral problem that might pose a risk to the health, safety, or well-being of children? If you have a question regarding a problem, discuss it with your licensing worker.
NO ☐ YES ☐ If yes, attach an explanation.

Do you have a domestic violence problem or an alcohol or other substance abuse problem that might pose a risk to the health, safety or well-being of children?
NO ☐ YES ☐ If yes, attach an explanation.

Have you been convicted of a crime or charged with a criminal offense?
NO ☐ YES ☐ If yes, attach an explanation.

I authorize the department representative to review criminal justice(CJ), including, where applicable, juvenile criminal history, protective service, and licensing records and to share this information (except federal CJ records) with the applicant/licensee and if applicable, between the department and agency responsible for evaluating the facility. I agree and understand that I will be placed on the APSIN flag system. I certify that the contents of this form and information provided with it are true, accurate, and complete.

_____ _____
Household Member Signature Date

06-9437 (Rev. 9/18) LIC ADOP CPS Page 1 of 2 Authority: AS 47.05.310, AS 47.32
42 U.S.C. 671(a)(20)

Alaska Department of Health and Social Services
Office of Children's Services

CLEARANCE FORM

CONFIDENTIAL

Worker_____
Field Office or
Private Agency

Instructions: Complete a separate form for ***EACH*** foster care applicant, unlicensed relative caregiver, adoptive applicant or guardian, household member age 16 years and older, and adult with direct access to children in the home.

Last Name	First Name	Middle Name	Household Name	
Aliases, Maiden Name, Previous Married Name(s)		Social Security #	☐ Male ☐ Female	
Date of Birth	Place of Birth: City	State	Country	
Driver License Number	State of Issuance	Home Phone Number	Alternate Phone Number	
Physical Address		City	State	Zip
Mailing Address		City	State	Zip

Residency: Alaska _____Yrs _____Mo's Physically here _____Yrs _____Mo's

Please list your previous residence for the last ten (10) years. Attach additional page(s) if necessary.

From (MM/YY)	To (MM/YY)	City	State	Country

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NO ☐ YES ☐ If yes, indicate city, state and type of care and dates of licensure:

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NO ☐ YES ☐ If yes, attach an explanation.

Have you been convicted of a crime or charged with a criminal offense?
NO ☐ YES ☐ If yes, attach an explanation.

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_____ _____
Household Member Signature Date

06-9437 (Rev. 9/18) LIC ADOP CPS Page 1 of 2 Authority: AS 47.05.310, AS 47.32
42 U.S.C. 671(a)(20)

Form **W-4V**

(Rev. February 2018)

Department of the Treasury
Internal Revenue Service

Voluntary Withholding Request

(For unemployment compensation and certain Federal Government and other payments.)

▸ **Go to *www.irs.gov/FormW4V* for the latest information.**

Instructions

Purpose of Form

If you receive any government payment shown below, you may use Form W-4V to ask the payer to withhold federal income tax.

- Unemployment compensation (including Railroad Unemployment Insurance Act (RUIA) payments).
- Social security benefits.
- Social security equivalent Tier 1 railroad retirement benefits.
- Commodity Credit Corporation loans.
- Certain crop disaster payments under the Agricultural Act of 1949 or under Title II of the Disaster Assistance Act of 1988.
- Dividends and other distributions from Alaska Native Corporations to its shareholders.

Consult your payer if you're uncertain whether your payment is eligible for voluntary withholding.

You aren't required to have federal income tax withheld from these payments. Your request is voluntary.

Note. Payers may develop their own form for you to request federal income tax withholding. If a payer gives you its own form instead of Form W-4V, use that form.

Why Should I Request Withholding?

You may find that having federal income tax withheld from the listed payments is more convenient than making quarterly estimated tax payments. However, if you have other income that isn't subject to withholding, consider making estimated tax payments. For more details, see Form 1040-ES, Estimated Tax for Individuals.

How Much Can I Have Withheld?

For unemployment compensation, the payer is permitted to withhold 10% from each payment. No other percentage or amount is allowed.

For any other government payment listed above, you may choose to have the payer withhold federal income tax of 7%, 10%, 12%, or 22% from each payment, but no other percentage or amount.

What Do I Need To Do?

Complete lines 1 through 4; check one box on line 5, 6, or 7; sign Form W-4V; and **give it to the payer, not to the IRS.**

Note. For withholding on social security benefits, give or send the completed Form W-4V to your local Social Security Administration office.

Line 3. If your address is outside the United States or the U.S. possessions, enter on line 3 the city, province or state, and name of the country. Follow the country's practice for entering the postal code. Don't abbreviate the country name.

Line 4. Enter the claim or identification number you use with your payer. For withholding from social security benefits, the claim number is the social security number under which a claim is filed or benefits are paid (for example, 123-45-6789A or 123-45-6789B6). The letter or letter/number combination suffix that follows the claim number identifies the type of benefit (for example, a wage earner, a spouse, or a widow(er)). The claim number may or may not be your own social security number. If you are unsure about what number to use, contact the Social Security Administration at 1-800-772-1213 (toll-free). For other government payments, consult your payer for the correct claim or identification number format.

Line 5. If you want federal income tax withheld from your unemployment compensation, check the box on line 5. The payer will withhold 10% from each payment.

Line 6. If you receive any of the payments listed on line 6, check the box to indicate the percentage (7%, 10%, 12%, or 22%) you want withheld from each payment.

Line 7. See *How Do I Stop Withholding?* below.

Sign this form. Form W-4V is not considered valid unless you sign it.

When Will My Withholding Start?

Ask your payer exactly when income tax withholding will begin. The federal income tax withholding you choose on this form will remain in effect until you change or stop it or the payments stop.

How Do I Change Withholding?

If you are getting a payment other than unemployment compensation and want to change your withholding rate, complete a new Form W-4V. **Give the new form to the payer.**

How Do I Stop Withholding?

If you want to stop withholding, complete a new Form W-4V. After completing lines 1 through 4, check the box on line 7, and sign and date the form; then **give the new form to the payer.**

Separate here

Form **W-4V**

(Rev. February 2018)

Department of the Treasury
Internal Revenue Service

Voluntary Withholding Request

(For unemployment compensation and certain Federal Government and other payments.)

▸ **Give this form to your payer. Do not send it to the IRS.**

OMB No. 1545-0074

1	Your first name and middle initial	Last name		**2** Your social security number	
3	Home address (number and street or rural route)	City or town	State	ZIP code	
4	Claim or identification number (if any) you use with your payer				

5 ☐ I want federal income tax withheld from my unemployment compensation at a rate of 10% of each payment.

6 I want federal income tax withheld from (a) my social security benefits, (b) my social security equivalent Tier 1 railroad retirement benefits, (c) my Commodity Credit Corporation loans, (d) certain crop disaster payments under the Agricultural Act of 1949 or under Title II of the Disaster Assistance Act of 1988, or (e) dividends and other distributions from Alaska Native Corporations to its shareholders, at the rate of (check one):

7% ☐ **10%** ☐ **12%** ☐ **22%** ☐

7 ☐ I want you to stop withholding federal income tax from my payment(s).

Your signature ▸ **Date** ▸