

CHILD CARE ASSISTANCE

BASIC ELIGIBILITY CONDITIONS

- The child MUST be either **ENROLLED IN** or **ELIGIBLE** for enrollment in a Federally Recognized Tribe

REQUIRED DOCUMENTS

- Copy of child(ren) tribal card/certificate
- Copy of child(ren) birth certificate
- Copy of child(ren) immunization record (must be no more than 1 year old)
- Last 30 day pay-stubs (**Not required for Foster Care families or families from vulnerable populations**)
- Copy of parent(s) Identification Card or Driver's License
- Copy of current rent/lease/mortgage agreement and/or receipts (**Not required for Foster Care families or families from vulnerable populations**)
- Copy of current Utility bill (**Not required for Foster Care families or families from vulnerable populations**)

Family Application Process

Program Purpose- Arctic Slope Native Association provides this child care assistance to clients who are engaged in eligible activities and to families with children in protective services or from vulnerable populations.

DETERMINATION PROCESS- Once the application is completed and ALL required documents are provided or updated our staff will process the application then notify you via e-mail with a letter whether you have been approved or denied.

- If the client falls within the income guidelines, the client is eligible to receive child care subsidy. The determination will indicate the amount of co-pay that the client will pay. In some cases, ASNA can make a determination to waive the co-pay.
- If the client does not fall within the income guidelines the client is over-income and cannot receive childcare subsidy. The determination will indicate the amount of overage with the income guideline.
- Arctic Slope Native Association is required to give priority to children in vulnerable populations- children with special needs, children experiencing homelessness, or in protective services. (658E(c)(3)(B); 98.46(a)).
 - This priority of CCDF assistance is "*not limited to eligibility determination (e.g., prioritize for enrollment, serve without placing vulnerable populations on waiting lists, waive co-payments, pay higher rates for access to higher quality care, use grants or contracts to reserve slots for priority populations).*"

CHILD CARE CLIENT ASSISTANCE APPLICATION

APPLICATION MUST BE FULLY COMPLETED AND SIGNED IN ORDER TO BE PROCESSED

Applicant's Name:

DOB _____

Name M. Last

Mailing and
Physical Address:

City State Zip

Email Address

Cell/Phone #

Please indicate household type:

- Single parent
- Both parent

LIST ALL MEMBERS OF HOUSEHOLD. "if you reside with others please do not include them"
PLEASE INDICATE WHICH CHILDREN NEED CHILD CARE SERVICES BY PLACING AN ASTERISK (*) NEXT TO
THE CHILDREN NAME

*	NAME	RELATION TO HEAD OF HOUSE	SEX	DATE OF BIRTH	TRIBE	PLEASE CHECK MARK IF DISABLED

Please initial

_____ I certify that my family listed on this application is not receiving or applying for any other childcare services with any other entity.

PLEASE ATTACH 30 DAY PAYSTUB'S

LABOR FORCE STATUS (PLEASE CHECK MARK ONE)

Are you currently employed?

- YES
- NO

If yes, please indicate the type of Employment

- SELF EMPLOYMENT
- EMPLOYER

Are you:

- PERMANENT
- TEMPORARY
- FULL-TIME
- PART-TIME

Wage Per Hour: \$ _____ **Are your paydays** Weekly Bi-weekly

Is your spouse or significant other currently employed?

- YES
- NO

If yes, please indicate the type of employment:

- SELF EMPLOYMENT
- EMPLOYMENT

Is he/her employment:

- PERMANENT
- TEMPORARY
- FULL-TIME
- PART-TIME

Wage Per Hour: \$ _____ **Are your paydays** Weekly Bi-weekly

EDUCATION and/or TRAINING STATUS

Are you currently enrolled into college or trainings?

- YES
- NO

If yes, please indicate the if you are

- Full time student (12 credits or more)
- Half time student (11 credits or less)
- Attending short-term training (examples: 1st Aid/CPR, 40 hour Hazwoper, CDL)

Please indicate if you or your spouse/significant other does not exceed assets over \$1,000,000.00

- Yes
- No

EMERGENCY CHILD CARE RECORD

(FOR USE BY CHILD CARE PROVIDER)

Name of Child _____

DOB: _____

Name of Child _____

DOB: _____

Name of Child _____

DOB: _____

Name of Child _____

DOB: _____

Name of Child _____

DOB: _____

Who has legal custody of children? _____

Relationship _____

Persons authorized to take children listed above from childcare:

1. _____

2. _____

3. _____

4. _____

How to reach parent(s) or legal guardians:

Mother: _____

Father: _____

Phone/cell: _____

Phone/cell: _____

Guardian: _____

Guardian _____

Phone/Cell: _____

Phone/cell: _____

PHYSICIAN/Name/Address/Phone _____

Name, Address and phone number(s) of person(s) who can assume responsibility for the child if parent(s) cannot be reached

during an emergency _____

Allergies (including drugs) _____

Signature of parent or legal guardian

Date

CONSENT FOR EMERGENCY MEDICAL OR SURGICAL CARE

This authorizes _____, consent to have the hospital personal provide medical or surgical care for the children list above in the event that I cannot be contacted immediately. It is understood that a conscientious effort will be made to locate me or my child's other parent or legal guardian BEFORE any action will be taken. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care.

Signature of parent or legal guardian _____

Date: _____

NOTICE OF CLIENTS RIGHTS ACKNOWLEDGE FORM

If your application is approved, you will have complete and total authority to select the type of child care you prefer and any specific child care provider as long as the child care provider you identify meets the Tribal certification criteria, and are willing to enter into agreement with the Arctic Slope Native Association Child Care Program to serve as a Provider.

- I/We certify that I have checked the information on the application very carefully and that it is true and complete statement of facts to the best of my knowledge and belief
- I/We understand that it is against the law to make false statement and that I/we am/are subject to prosecution if I/we do.
- I/We understand that a representative for the Arctic Slope Native Association may call my home and may contact other people in order to verify my eligibility for the childcare assistance. I/we also understand that any information I/we give may be verify by cross matching information with other agencies.
- I/We authorize the Arctic Slope Native Association Social Services Department to communicate with my childcare program.
- I/We certify that this is the only application submitted from or on the behalf of my household for any Child Care Services.
- I/We understand Arctic Slope Native Association is not liable for my choice in childcare provider. Also if my child should be injured or harmed while under the care of child care provider, that I/we will pursue the child care provider and **not** Arctic Slope Native Association.

Signature of Parent or legal guardian

Date

Signature of Parent or legal guardian

Date

CLIENT AGREEMENT FORM

1. I/We understand that program funds are for use when the parent(s) are engaged in eligible activities. I/We will notify Arctic Slope Native Association Social Service Department **within five days** following a change, which might affect my eligibility. Changes include employment or training status, number of children in family, and income.
2. I/We will secure a provider who will accept my child on attendance or scheduled enrollment basis, and will have a valid authorization agreement before childcare cost are incurred under the program.
3. I/We will give the provider at least **fourteen (14) days'** notice of my intent to terminate childcare services except in the case of sudden program ineligibility, being fired, laid off, increase in wages, etc.
4. I/We will renew our authorization agreement early enough to provide continued care. Authorization agreement cannot be backdated. Any childcare received outside of the effective dates is my responsibility.
5. I/We will sign the provider's **two-week, one-week billing or monthly** statement at the end of the billing period to verify that care was billed only for the times of eligible activity.
6. I/We will pay for authorized childcare costs not paid on my behalf of the program. I/We are responsible for paying the provider for any cost above the maximum authorized subsidy.
7. I/We will pay for childcare if I/we refuse an alternating provider during an unscheduled facility closure.
8. I/We may use more than one provider, however, any costs incurred exceeding the authorized amount or the monthly maximum subsidy is my responsibility.
9. I/We have the right to appeal in writing to Arctic Slope Native Association on decisions made by the local administrator regarding my program eligibility, co-payment of state subsidy, or times for which care is authorized.
10. I/We understand that if I/we do not comply with these responsibilities under this childcare assistance program agreement my authorization for provided childcare assistance will be terminated. I/We also understand that it is fraud to misrepresent facts in order to receive program benefits, including misrepresentation regarding income status, living arrangements, or work status. I/We further understand that any fraud may result in removal from the program and I/We will have to repay any wrongfully used funds.

Signature of parent or legal guardian

Date

Signature of parent or legal guardian

Date

PAYMENT AGREEMENT FORM

This is an agreement between, _____ and _____
(Client) (Provider)

The client named above has been approved into the Arctic Slope Native Association Child Care Assistance Program on _____ and will expire _____. The above named client is responsible for a co-payment in the amount of _____ per month and Arctic Slope Native Association Child Care Assistance Program will subsidize the approved remaining child care cost.

If, _____ owes a co-payment amount to _____ it is the Client's
(client) (provider)
responsibility to pay that portion directly to the provider.

I, as a provider understand that program funds are for use when the parent(s) are engaged in eligible activities.

I, as a provider will complete or overlook my timesheet at the end of billing period or at the end of the month to verify that care was billed ONLY for the times of eligible activity with parent(s).

I, as a provider understand that it is a fraud to misrepresent facts in order to receive funding, including misrepresentation regarding where childcare is taken place.

I, as a provider understand that payments can take up to twenty-one (21) business days for a check/direct deposit to be made.

Childcare timesheet has to be turned in either by fax/email/ in-person to the Arctic Slope Native Association Child Care Assistance Program.

In signing this document we are in agreement and full understanding of the payment process and responsibilities.

Client's signature

Date

Provider's signature

Date

ASNA Social Service Staff

Date