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:

- ❐ Child's CDIB Card
- ❐ Child's Immunization Record
- ❐ Income (Check copy - last 30 days)
- ❐ Class Schedule (If attending college or training)
- ❐ Doctor's Report (If a member of the household is disabled)
- ❐ Child's Social Security Card
- ❐ Each Child's State Birth Certificate
- ❐ Utility Bill (Gas, electric, water - no older than 30 days)
- ❐ Custodial/Child Support Documentation (Must have if single, separated, divorced or guardian)
- ❐ Social Security, Child Support or Any Additional Income

APPLICANT INFORMATION

1. Child's name	2. Sex	3. Age	4. Birth date	5. Social Security number
			/ /	- -

6. Address

Address: ____________________

City & zip code: ____________________

E-mail: ____________ County: ________

7. Telephone number (work or school)

Work: (_____) _____-______ Ext. ______

Home: (_____) _____-______

Cell: (_____) _____-______

8. Certificate of Degree of Indian Blood (CDIB)

(a) Is child an American Indian? ☐ Yes ☐ No

(b) Does applicant have his/her CDIB? ☐ Yes ☐ No

(c) List tribe and degree:

____

9. Emergency contact (other than parents/guardians)

In case of emergency, notify:

Name: ____________________

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.

(b) **Mother's or guardian's schedule**

____ Work ☐ S ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S
Time ______ to ______

____ School ☐ S ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S
Time ______ to ______

____ Other ☐ S ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S
Time ______ to ______

(c) **Father's or guardian's schedule**

_____ Work ☐ S ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S
Time ______ to ______

_____ School ☐ S ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S
Time ______ to ______

_____ Other ☐ S ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S
Time ______ to ______

ADDITONAL INFORMATION

Do you receive TANF benefits? ☐ Yes ☐ No

Does your child have a special need? ☐ Yes ☐ No If yes, please list needs:

FAMILY STATUS
(Please check what best describes your situation)

☐ (a) Single, head of household, never been married
☐ (b) Divorced
☐ (c) Separated
☐ (d) Married
☐ (e) Widowed
☐ (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
	________________ ( )	$________ ☐ wkly ☐ bi-wkly ☐ bi-monthly ☐ monthly
	________________ ( )	$________ ☐ wkly ☐ bi-wkly ☐ bi-monthly ☐ monthly
	________________ ( )	$________ ☐ wkly ☐ bi-wkly ☐ bi-monthly ☐ monthly
	________________ ( )	$________ ☐ wkly ☐ bi-wkly ☐ bi-monthly ☐ 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 ☐ Renewal

☐ Licensed Center
☐ Licensed Home
☐ Unlicensed Relative

☐ One Star
☐ One Star Plus
☐ 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			Part-time		
	0-12 months	$____________		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**