



Osage Nation Community Outreach Department

239 W. 12th Street
Pawhuska, Oklahoma 74056
(918) 287-5363-phone
(918) 287-5220-fax

CHILD CARE ASSISTANCE APPLICATION

Dear Applicant:

The Osage Nation Child Care Program provides assistance to families with children between the ages of 0-12 who need child care in order to work or attend school. Applications will not be reviewed until all required documentation has been received by the Child Care Program. Completed applications will be processed within thirty (30) days of receipt. Please provide the following information along with your application:

- Copy of CDIB or tribal membership cards for the children and/or parent(s)
- Copy of court records verifying custody of each applicant (if applicable)
- Copy of birth certificate for each child in the household requiring services
- Proof of residence (utility bill or rent receipt with current address)
- Proof of income (most recent pay stub) for each adult in the household or written statement from employer (on employer letterhead)
- Work schedule verification form or a copy of school schedule for each adult in the household
- Copy of Social Security Cards for each member of the household

Should you have any questions or concerns regarding this application or the Child Care Program, please feel free to call us between the hours of 8:00 a.m. to 4:30 p.m., Monday through Friday. We look forward to serving you.

Clair Wood
Director of Community Outreach & CCDF

PARENT INFORMATION

Last Name:		First Name:		MI:	Date:
Street Address:			City:	State:	Zip:
Mailing Address:			City:	State:	Zip:
Email:		Cell Phone:	Work Phone:	Date of Birth:	
Social Security No.:		Tribal Affiliation:		CDIB or other verification: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

SPOUSE/PARTNER INFORMATION

Last Name:		First Name:		MI:	Date:
Email:		Cell Phone:	Work Phone:	Date of Birth:	
Social Security No.:		Tribal Affiliation:		CDIB or other verification: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer:					

Is your household currently receiving child care assistance through DHS?

Yes No

Is your household currently receiving assistance through State or Tribal TANF?

Yes No

Are you or your partner currently attending school or training?

Yes No

Name of school: _____

School Address: _____

County: _____

Applicant

Travel time to work/school: _____

Mileage to work/school: _____

Spouse

Travel time to work/school: _____

Mileage to work/school: _____

HOUSEHOLD INFORMATION		
Name of Household Member	Relationship	Gross Monthly Income
	Self	

Please only list information for children requiring child care assistance.

CHILD (applicant) INFORMATION			
Last Name:	First Name:	MI:	Date of Birth:
Tribal Affiliation:	CDIB or other verification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security No.:	
Custody Status (if applicable): <input type="checkbox"/> Guardianship <input type="checkbox"/> Foster child	Age of Child:		

CHILD (applicant) INFORMATION			
Last Name:	First Name:	MI:	Date of Birth:
Tribal Affiliation:	CDIB or other verification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security No.:	
Custody Status (if applicable): <input type="checkbox"/> Guardianship <input type="checkbox"/> Foster child	Age of Child:		

CHILD (applicant) INFORMATION			
Last Name:	First Name:	MI:	Date of Birth:
Tribal Affiliation:	CDIB or other verification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security No.:	
Custody Status (if applicable): <input type="checkbox"/> Guardianship <input type="checkbox"/> Foster child	Age of Child:		

CHILD CARE PROVIDER INFORMATION	
Provider Requested:	
Type of Facility: <input type="checkbox"/> Child Care Center <input type="checkbox"/> Child Care Home <input type="checkbox"/> Family Provider <input type="checkbox"/> In Home	
Alternate Provider Requested:	
Type of Facility: <input type="checkbox"/> Child Care Center <input type="checkbox"/> Child Care Home <input type="checkbox"/> Family Provider <input type="checkbox"/> In Home	

WORK SCHEDULE VERIFICATION

EMPLOYEE NAME: _____

Dear Employer:

Please complete the work schedule below for the days the client/employee named above works for your company & their current rate of pay.

EMPLOYMENT VERIFICATION	
Company Name:	
Company Address:	
Company Phone Number:	

WORK SCHEDULE VERIFICATION							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week#1							
Week#2							
Week#3							
Week#4							

1. RATE OF PAY: \$_____ PER: HOUR WEEK ANNUAL

2. HOW OFTEN DOES THE CLIENT RECEIVE A PAYCHECK?

WEEKLY BI-WEEKLY MONTHLY YEARLY

Printed Name

Signature

Date

CHILD CARE APPLICANT AGREEMENT

By applying for assistance through the Osage Nation Child Care Program, I expressly agree to the following terms and conditions:

- 1) I understand I am responsible for any monthly co-payment and for any additional charges not covered by the Osage Nation Child Care Assistance Program.
- 2) I am responsible for the care of my child/children when I am not attending work or school.
- 3) If I work or attend school more than 300 hours per month, I am responsible for and will pay the costs of childcare in excess of 300 hours.
- 4) I will notify both Osage Nation Child Care Assistance Program and the Provider, within a minimum of ten (10) days of: 1) any change in facility or caretaker 2) the participant is no longer in need of assistance, otherwise you are still required to pay the full monthly "family" co-pay for that month that we weren't notified that your child did not attend. Each additional child in care adds 1.25% onto your total monthly co-pay amount.
- 5) I must notify Osage Nation Child Care Assistance Program of any change in the amount of my family's income or the size of my family. I further agree to make this notification within fifteen (15) days of the change.
- 6) I am required to re-pay to the Osage Nation Child Care Assistance Program any benefits paid out on my behalf that are determined to be an overpayment of benefits because of my failure to report correct information in a timely manner.
- 7) I understand that I am responsible for reviewing my child/children's attendance at day care and signing the attendance record maintained by the facility at the end of each month's care. I understand that my failure to review my child/children's attendance and sign the attendance record form may result in the Osage Nation Child Care Assistance Program terminating payment to the facility and/or the facility discontinuing care of my child(ren).
- 8) I understand that I must work at least twenty (20) hours per week and/or attend class equivalent to twelve (12) hours per semester, in college, or twenty (20) hours a week for High School or Vo-Tech.
- 9) I understand that I will be required to complete a recertification twice a year. If I do not complete and submit the forms by the deadline I may not be eligible for coverage.
- 10) The undersigned hereby expressly recognizes that the benefit sought or presently receiving by the undersigned from the Osage Nation government, to wit: Child Care Assistance is a privilege and a benefit to the undersigned and not a property interest or matter of right. The undersigned further stipulates to be bound by all Osage Nation laws, codes, regulations, policies and procedures governing such benefits, privileges and activities. The undersigned further expressly waives all further rights to contest the jurisdiction of the Osage Nation Tribal Court over any such matters, disputes, actions or decisions of any branch of the Osage Nation government.
- 11) The information contained within this Agreement and any supporting documentation attached is a protected record under the Osage Nation Open Records Act. The Osage Nation will not disclose any record containing protected information without the written consent of

the applicant unless the information is being used to perform the duties of an Osage Nation employee. The applicant's information may be released to other Osage Nation Departments/Programs with which the applicant is receiving or requesting services and to the Office of the Osage Nation Attorney General for an investigation to detect or eliminate fraud.

12) I agree to provide the Osage Nation Child Care Assistance Program with all information necessary to verify the information provided in this application.

I affirm under penalty that the information given in this application is complete and the information is correct to the best of my ability and knowledge. I understand and agree that if any statement is false, and results in my receiving benefits for which I am not eligible; this case will be turned over to the Osage Nation Attorney General for legal action. I further agree and acknowledge that I have read and understand this agreement, and sign it on my own free will.

Applicant Signature

Date