



Osage Nation
Child Care & Development Services

239 W. 12th St.
Pawhuska, OK 74056



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CHILD CARE RELATIVE PROVIDER APPLICATION

To process your application, **all required documents must be submitted with the application** to the Child Care Department in person, by mail, or via email. Once the application is complete, all documentation has been received, and background information is completed and approved, the Licensing and Compliance Specialists will schedule a licensing visit and will make a determination to approve/deny your application. Applicants must complete required child care trainings **before** becoming a licensed Relative Provider. All information on this Application must be truthful and correct.

Required documents to be submitted:

- ☐ Completed Child Care Relative Provider Application
- ☐ Completed W-9
- ☐ Completed Electronic Funds Transfer (EFT) Form
- ☐ Signed Provider Agreement
- ☐ Copy of Social Security Card
- ☐ Copy of Current Oklahoma Driver's License or State Issued ID
- ☐ Copy of Home Insurance verification (In accordance with Section 4045.3 of Title 10 of the Oklahoma Statutes). If home insurance is not maintained, the state Insurance Exception Notice must be completed (the last document in this package.)
- ☐ Copy of CDIB/Membership Card (if applicable)
- ☐ Copy of CPR/First Aid Certification Cards (If you do not have one, you have 60 days from the date of approval to obtain one. CPR/First Aid Training is provided for providers through Osage Nation, but it is your responsibility to consult with the Compliance Officer and schedule this training)
- ☐ Copy of Vehicle Insurance (if children are transported)
- ☐ If transportation is not provided, an emergency transportation plan will need to be submitted (see pg. 3)
- ☐ Completed Criminal Background Consent for each resident residing in the home where children are being cared for (18 years and older) (see pg.4)



SECTION 1: CAREGIVER INFORMATION

First Name:		Last Name:	
Physical Address:			
City:		Zip:	County:
Mailing Address (if different):			
City:		Zip:	
Phone Number:			
Email:			

SECTION 2: HOUSEHOLD INFORMATION

NAME AND AGES OF ALL RESIDENTS RESIDING IN THE HOME WHERE CHILDREN ARE BEING CARED FOR:

NAME	AGE
1.	
2.	
3.	
4.	
5.	

SECTION 3: CHILD(REN) INFORMATION

Name of the family you would be providing child care for:	
Is this family on Osage Nation Child Care subsidy? Yes No	
If not, the family must be approved before you can submit the application.	
Name of child(ren) providing care for:	Age
Your relation to the child(ren)?	



SECTION 4: TRANSPORTATION

Will the provider be responsible for transporting the child(ren): Yes No

Drivers Name:

License #:

Drivers Name:

License #:

EMERGENCY TRANSPORTATION PLAN

If no transportation is provided, describe the Emergency Transportation Plan here.

Provider Signature

Date

CRIMINAL BACKGROUND CONSENT

CRIMINAL BACKGROUND INFORMATION MUST BE OBTAINED ON EVERY ADULT PRESENT IN THE HOME WHERE CHILDREN ARE BEING CARED FOR.

ALL COMPREHENSIVE BACKGROUND CHECKS WILL BE CONDUCTED AS REQUIRED BY 45 CFR 98.43 AND 45 CFR 98.38(d) (3).

Last Name: _____ First Name: _____ MI: _____

List all Aliases (including maiden name): _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Phone Number: _____ Email: _____

DOB: _____ Race: _____ Sex: ☐ M ☐ F Height: _____ Weight: _____

Place of Birth (state): _____ Hair Color: _____ Eye Color: _____

Social Security Number: _____

Driver's License Number: _____ State Issued: _____

Are you required to register under the Sex Offenders Registration Act or Mary Rippy Violent Offenders Registration Act?

☐ Yes ☐ No Initials: _____

Do you have any pending charges? Have you ever entered a plea of guilty or nolo contendere (no contest) or been convicted of any criminal activity involving gross irresponsibility or disregard for the safety of others, violence against an individual, sexual misconduct, child abuse or neglect, animal cruelty, or possession, sale or distribution of illegal drugs or convicted of a crime?

☐ Yes ☐ No Initials: _____

If yes, please explain

Have you lived outside the USA or the state of Oklahoma in the past five years? ☐ Yes ☐ No

State: _____ From _____ to _____

State: _____ From _____ to _____

State: _____ From _____ to _____

I, (print name) _____, hereby grant full consent to the Osage Nation Child Care Department to obtain a background check through the OSBI's Criminal History Information Request Portal (CHIRP) to become a licensed relative provider with the Osage Nation Child Care Department.

Signed: _____ Date: _____



Osage Nation
Child Care & Development Services



Osage Nation Child Care Relative Provider Agreement

Please read this agreement carefully to ensure you understand each provision.

This agreement ("Agreement") is between Osage Nation Child Care & Development Services (from now on known as "ONCCDS") and


Provider Name

Purpose and Performance of the Agreement

This Agreement aims to establish eligibility for Provider participation with ONCCDS and to set forth Tribal and Provider responsibilities and assurances. The Provider must comply with Tribal regulations. If any statute or regulation is enacted or promulgated requiring changes in this Agreement, both parties will consider this Agreement to be automatically amended to comply with the newly enacted statute or regulation as of the effective date of the statute or regulation. The Tribe shall notify the Provider in writing within thirty (30) days of receiving any necessary changes or amendments to this Agreement.

Provider understands and agrees to the following: (please initial each item)

- ____ I understand that ONCCDS licensing staff has access to the entire private residence of the caregiver.
- ____ I agree to allow the Osage Nation Child Care Department to conduct a background check to ensure the safety of the child(ren) and meet the Federal, State, and Tribal regulations pertaining to child care programs.
- ____ I understand I must comply with random/unannounced home visits to ensure a safe place for the child(ren) in my care. A minimum of one (1) home visit per year.
- ____ I understand I must complete First Aid and Cardiopulmonary Resuscitation (CPR) Training within 60 days of approval and maintain current certification during the approval period.
- ____ If a severe violation affects the child's (ren's) welfare, the ONCCDS may be required to report the situation to the Osage Nation Social Services Department and/or the Oklahoma Department of Human Services (depending on the jurisdiction). Depending on the disposition of the possible investigation, disciplinary action will be determined accordingly.
- ____ I agree to maintain adequate safety precautions and health practices to ensure the well-being of the child(ren) and follow minimum health and safety guidelines set by the ONCCDS.
- ____ Failure of the applicant to report others living in the home at the time of application or at any other time after becoming a provider for the ONCCDS will result in termination.

- 
- ☐ I understand my provider license and the provider agreement will be a yearly agreement. I will have to recertify before my license expires. This process must be completed before subsidy payments are authorized by the ONCCDS.
- ☐ I agree to have a phone in case of an emergency.
- ☐ I agree to maintain a current driver's license or state-issued ID.
- ☐ I understand BEFORE I can be a Relative Provider, I must complete the Oklahoma Department of Human Services Child Care Orientation video.
- ☐ I understand BEFORE I can be a Relative Provider, I must complete Safe Sleep Practices Training. **(Only if caring for infants)**
- ☐ I agree to abide by the ONCCDS Timesheet Policy.
- ☐ Timesheets must be submitted monthly; multiple submitted months will not be paid. Parents will not be held financially liable for claims not submitted correctly and on time for payments by the provider.
- ☐ Falsifying attendance documents and/or receiving services and/or payments by misrepresenting or withholding pertinent information will result in termination. Provider acknowledges that filing a fraudulent claim for services submitted to the ONCCDS is a felony punishment and will be turned over to the Osage Nation Attorney General.
- ☐ I will notify ONCCDS of any anticipated change of address.
- ☐ Provider must follow the guidelines of the approval letter. Provider understands that starting a child before receiving an approval letter will be the parent's responsibility for payment of days attended without ONCCDS's approval.
- ☐ The Provider or someone on his/her behalf will not threaten violence, harm, or any similar inappropriate conduct against ONCCDS staff. Any such behavior may result in the termination of this Agreement.
- ☐ I understand the ONCCDS requires each childcare assistance applicant to recertify every twelve (12) months. Recertification notices are sent to each client via mail. I acknowledge that the individual whose children I am caring for will be responsible for any payments due if the recertification process is not completed.
- ☐ I understand and agree I am responsible for collecting the due co-pay from the parent. The co-pay will be paid directly to the provider and is not the responsibility of the ONCCDS.
- ☐ I understand as a child care provider, I am not an employee of the Osage Nation; I am an independent contractor and will be responsible for all applicable State and Federal Income Tax and obligations related to payments received from the Osage Nation under the terms of this agreement as a child care provider. I also understand I am not entitled to coverage under the Osage Nation where insurance (medical or liability), Social Security, workman's compensation, retirement, or unemployment benefits are concerned.
- ☐ The information in 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 document containing protected information without the applicant's written consent 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 or 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.

____ I, hereby, expressly recognize that the benefit sought or presently enjoyed by the undersigned for the Osage Nation Government, to wit, participating as a licensed child care provider with the Osage Nation, is a privilege and a benefit to the undersigned and not a property interest or matter of right. In consideration of, and as a condition precedent to, the grant, issuance of continued enjoyment of this privilege and benefit, regardless of whether the undersigned is a natural or artificial person or entity, and further, regardless of whether is an Indian or non-Indian blood, descent or legal character, the undersigned hereby agrees with jurisdiction over all matters and disputes arising out of exercise of such a benefit shall vest in Osage Nation Tribal Court over any such issues, disputes, actions or decisions of any branch of the Osage Nation Government.

____ I agree it is the provider's responsibility to follow these requirements and abide by any and all terms of this agreement.

Provider Signature

Date

Osage Nation Child Care & Development Services Licensing

Date

**Request for Taxpayer
Identification Number and Certification**

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	
	<input type="checkbox"/> Exempt payee	
	Address (number, street, and apt. or suite no.) City, state, and ZIP code List account number(s) here (optional)	Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number								
				-				
Employer identification number								
				-				

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.



Authorization for Electronic Funds Transfer (EFT) / Direct Deposit Form

Form Submission Instructions

Important Information Regarding EFT/Direct Deposit.

(Please read before signing the Authorization Agreement form.)

- Participants who wish to have their checks deposited directly into their bank account must complete an Authorization Agreement for EFT/Direct Deposit Form.
- Once you agree to the EFT/Direct Deposit process, all transactions will be in this format until we receive your written request to cancel the process.
- Notice of EFT/Direct Deposits will be sent via email if chosen.



Authorization for Electronic Funds Transfer (EFT) / Direct Deposit Form

Vendor

First Name, MI: _____

Last Name: _____

Email Address: _____

Account Information

Please check one of the following:

- ☐ **Add.** Deposit funds to the account shown.
- ☐ **Change.** Change my financial institution and/or account number.
- ☐ **Cancel.** Stop my participation in the direct deposit program.

Type of account. Please check one of the following:

- ☐ **Checking** (default if none selected)
- ☐ **Savings**

Type of account. Please check one of the following:

- ☐ **Business**
- ☐ **Personal**

Name of Financial Institution: _____

Bank Routing # (ABA#): _____

Account #: _____

Account Holder Name: _____

Account Holder Signature: _____

I hereby authorize Osage Nation Treasury Department to initiate deposits to the bank account indicated below. This agreement authorizes the Osage Nation Treasury Department to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future. This agreement authorizes the financial institution holding the account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable federal and tribal laws. This authorization will be in effect until the Osage Nation Treasury Department receives a written termination notice from myself and has a reasonable opportunity to act on it. I understand the Osage Nation Treasury Department will not provide written statements advising me of deposits. Osage Nation may assign its rights and obligations under this agreement to Osage Nation's designated fee-for-service contractor. Osage Nation may change its designated contractor at Osage Nation's discretion. I acknowledge that I have read, and I understand, this entire agreement. If my financial institution information changes, I agree to submit to Osage Nation an updated EFT Authorization Agreement.

Vendor Signature: _____

Date: _____

Attach Voided Check Below

- *Providing a voided check is optional but will eliminate any errors in payee information.*

Please tape your voided check here

(Do not send deposit slips)

1071 Grandview Lane Pawhuska, OK 74056
| Phone (918) 287-5343 |
FAX (918) 287 5251
<https://www.osagenation-nsn.gov/>



Insurance Exception Notification

When insurance coverage is **NOT** maintained, state law requires this form is:

- Completed; and
- Posted at the main entrance of the facility in a conspicuous location where parents and the public enter the facility.

Program Information

Program name		K8	
		License number	
Program street address		City	State ZIP code
Phone		Owner	

This program:

- does NOT maintain liability insurance coverage of at least \$200,000 for each occurrence of negligence, which would cover injury to a child due to negligence that occurs while the child is in the care of the child care program.
- reports self-insurance in accordance with state law.

I agree to contact the Oklahoma Department of Human Services, Child Care Services Licensing when liability insurance coverage changes.

Owner signature	Date
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