Cowlitz Indian Child Care and Development Program Application

Form to be completed by the Parent/Guardian

Assigned #

☐ New ☐ Re-Qual. ☐ Update

If change in center, please indicate start date

Parent/Guardian:	County:	Date:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
Parent/Guardian Email:		Phone #:	
Preferred method of contact: ☐ Email ☐ Phone ☐ Text			
Emergency Contact:	Relationship to child:	Phone #:	

Name (full name of **all** children in household)	Date of Birth	List Child Care Provider & Location Confirm Days, Pick Up and Drop Off Hours	Type of Care: Childcare	Type of Care: Before & After	Other Types: Holiday/ Closure	Other Types: 1 on 1
			☐	☐	☐	☐
[redacted]		S M T W T F S Drop off Pick Up ☐☐☐☐☐☐☐ AM PM	Hours Needed	Alternative ☐	Non-Trad. ☐	Over Time ☐
			☐	☐	☐	☐
[redacted]		S M T W T F S Drop off Pick Up ☐☐☐☐☐☐☐ AM PM	Type of Hours Needed	Alternative ☐	Non-Trad. ☐	Over Time ☐
			☐	☐	☐	☐
[redacted]		S M T W T F S Drop Off Pick Up ☐☐☐☐☐☐☐ AM PM	Type of Hours Needed	Alternative ☐	Non-Trad. ☐	Over Time ☐
			☐	☐	☐	☐
[redacted]		S M T W T F S Drop Off Pick Up ☐☐☐☐☐☐☐ AM PM	Type of Hours Needed	Alternative ☐	Non-Trad. ☐	Over Time ☐

Name (full name of **all** other adults in household)	Date of Birth	Relation to Children	Phone Number	Email

1. Reason child care needed: Please check the box below that best describes your situation:

☐ Work ☐ School ☐ Training ☐ Job Search ☐ Self employed ☐ Other_____

2. Federal requirement for grant: I certify that my family assets do not exceed $1,000,000 ☐ **(initials)**

3. Are you homeless or in unstable housing? *Includes living in a shelter or with family/couch surfing/vehicle* ☐ Yes ☐ No ☐ Sometimes

4. Have you applied with the Cowlitz Indian Tribe Child Care and Development Program in the past? ☐ Yes ☐ No

I hereby certify all the information provided is true and correct to the best of my knowledge. I swear that the children for whom I am requesting child care resides with me at least 50% of the time. I release the Cowlitz Indian Tribe, Child Care and Development Program (CCDP) from any liability while in care of the provider(s) listed. I understand submission of this application does not guarantee services will be provided.

Signiture: **Date:**

Signiture: **Date:**

Assigned file #

Cowlitz Indian Tribe

Child Care and Development Program (CCDP)

Release of Information

I (we),_____ , hereby voluntarily authorize Cowlitz Indian Tribe's CCDP to disclose/access information from the above parent's child care record as defined below:

- ☐ Washington State Agencies (such as state licensing and grant support services)
- ☐ Cowlitz Tribal Services
- ☐ Your tribe _____
- ☐ Other Tribal Lead Agencies (must agree if in Lewis county)
- ☐ Child care provider and staff **(Providers Name)** ☐
- ☐ Other members of your family: _____
- ☐ Other members of your child's family: _____
- ☐ OTHER: _____

About my child(ren) listed below:

Child's name: _____

Child's name: _____

Child's name: _____

Child's name: _____

☐ **I (we) agree** or ☐ **I (we) do not agree** to let CCDP to use photographs of my child/children/family in official publications to promote CCDP or Cowlitz Indian Tribe.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

By signing below, I agree to release and hold harmless the Cowlitz Indian Tribe and any of its employees, agents, advisors, consultants, and officers, from any and all liability, losses, expenses, actions, demands of any nature, claims, including costs and reasonable attorney's fees, and damages or injuries which may be sustained arising directly or indirectly from the services of the child care provider(s).

Signature of primary applicant: _____ Date:_____

Signature of other adult: _____ Date:_____

PO Box 2547 • Longview, WA 98632 • Phone/Fax/Text (360) 353-9909 • Email CCDP@cowlitz.org

Assigned file #

Cowlitz Indian Tribe

Child Care and Development Program

Parent/Guardian Responsibilities

By initialing and signing the following, I agree:

_____ I have provided a true list of all members (including adults) of my household on the application and submitted needed documentations.

_____ I am not using any other form of child care subsidy including Washington State Working Connections Child Care and agree to allow CCDP to verify.

_____ I am responsible for payment of excess days and hours above what the CCDP has agreed to pay. CCDP will pay for care up to 15 hours per day for a maximum of 23 days a month. Preauthorization is needed for regular scheduled care over 10 hours.

_____ I am responsible for requalification every 12 months with CCDP. I understand that failing to do so can result in withholding of payment or termination of services for a minimum of 30 days. I acknowledge I will be responsible for services charged by the day care facility if I fail to renew.

_____ I will provide both CCDP and my child care provider a two week notice before withdrawing. There is a maximum of 3 provider changes per year for families.

_____ I will provide both CCDP and my child care provider a two week notice when my child(ren) is ill or unable to attend child care more than 5 days in a month.

_____ I will notify CCDP of any address and/or phone number change in writing within *10 business days.*

_____ I will promptly pay my copayment to my child care provider. I am responsible for any late fees due to the non-payment of my copay. Failure to do so may result in my child care services being suspended.

My preferred way to stay up to date on CCDP information, events, and resources: (check all that apply)

☐ Newsletter ☐ Facebook ☐ Email ☐ Mail

☐ Phone ☐ Other: _____

Disclaimer of liability on children in a child care center and/or Relative/Non-Relative care

I agree to hold the Cowlitz Indian Tribe CCDP harmless from any liability, claims, or damages that may result from the child care provider of its obligations under the terms of this agreement.

I UNDERSTAND BY SIGNING THIS FORM THAT I AM AGREEING TO ANY AND ALL TERMS OF THIS CONTRACT.

Signature of primary applicant: _____ Date: _____

Signature of other adult: _____ Date: _____

PO Box 2547 • Longview, WA 98632 • Phone (360) 353-9909 • Fax (360) 353-9499 • Email CCDP@cowlitz.org

Cowlitz Indian Tribe Child Care and Dev. Program

Health-Related Social Needs

We are committed to helping you improve your health and quality of life. To that end, we offer client care services and case management that can help reduce your barriers to wellness. We ask that you answer the questions on the other side of this page as honestly as possible, so that we can better serve you. You may be contacted by our staff about your answers to provide you with information and resources. All responses are confidential. Thank you!

Date: _____ Name: _____

Client Number:_____

Housing:

What is your housing situation?

☐ I have housing ☐ I have housing but I am worried about losing it ☐ I do not have housing

Do you have problems with your home?

☐ Bug infestation ☐ Lead paint or pipes ☐ No oven or stove
☐ Mold ☐ No heat ☐ No smoke detectors
☐ Water leaks ☐ N/A

Utilities:

In the last year, have there been times when you did not have access to clean drinking water? ☐ Yes ☐ No

In the last year, has your phone, electric, gas, or water been shut off? ☐ Yes ☐ No

Food:

Hunger Vital Sign ™ Screening Tool **

Over the past 12 months, the food you bought didn't last and you didn't have the money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

Safety:

Does anyone physically hurt you or threaten you? ☐ Yes ☐ No

Do you feel physically and emotionally safe? ☐ Yes ☐ No

Transportation:

Has the lack of reliable transportation kept you from medical appointments, meetings, work, or getting daily necessities? ☐ Yes ☐ No

Do you need help with, or information about, any of the following?

☐ Accommodations (interpreter, wheelchair, home modifications etc.)
☐ Arranging transportation
☐ IEP or Behavioral Support for Pre-K
☐ Child Development Support
☐ Caring for parent or other loved one
☐ Drug or alcohol abuse
☐ Education Opportunities
☐ Employment Support
☐ Insurance (medical, dental, prescriptions)
☐ Kinship Care (Caring children not your own)
☐ Mental Health Support
☐ Landlord/tenant issues
☐ Problem gambling
☐ Social security
☐ Tribal enrollment
☐ Other: _____

Comments: _____

_____

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