



Cowlitz Indian Tribe

Child Care and Development Program

****IT'S TIME TO REQUALIFY****

WE NEED TIME TO PROCESS YOUR RENEWAL

DO NOT WAIT UNTIL THE LAST MINUTE TO SUBMIT YOUR PAPERWORK!

Re-qualification needs to be completed by renewal date per funding requirements.

Lack of re-qualification may result in withholding child care payment until is complete. You will be responsible for any cost that may occur.

YOUR RENEWAL DATE:

Month/Year

Need extra time? Changing providers? Family circumstances change? Moved out of the area?

Contact CCDP ASAP

You can call, email or stop by and ask our staff to help.

PLEASE REVIEW EACH FORM TO ENSURE ALL REQUIRED FORMS ARE FULLY COMPLETED.

Please send re-qualification packets and documents to:

IN PERSON

1004 Fir St.

Longview, WA 98632

Fax & Text

360-353-9909

Please call a half hour after sending your fax to ensure it has been received.

MAILING ADDRESS

Child Care and Development Program

PO Box 2457

Longview, WA 98632

EMAIL ADDRESS

CCDPintake@cowlitz.org



Cowlitz Indian Tribe

Child Care and Development Program

Requalification Application Checklist:

Please have all documents in within 10 days of expiration date to better ensure no gaps in service:

APPLICATION (must be completed)

RELEASE OF INFORMATION (Please review before signing)

PARENT/GUARDIAN RESPONSIBILITIES (Please initial before signing)

PROOF OF INCOME per adult applicant member-MUST have 8 weeks of most recent check stubs

If **SELF EMPLOYED**, provide previous year's tax return. *(see employment verification below)

PROOF OF RESIDENCE (Current rental or lease agreement, mortgage or property tax statement, utility bill)

ID OR DRIVER'S LICENSE (For all additional adults listed on requal. application or ID expired since initial approval)

COURT ORDERED PARENTING PLAN OR GUARDIANSHIP – If custody is shared or a guardianship is in place, it is required to show that the child lives with the applicant at least 50% of the time and that the applicant has the right to seek child care for any child(ren) in question.

EMPLOYMENT VERIFICATION:

NON-TRADITIONAL HOURS must submit an Hours Verification Form provided by CCDP for each working household member, listed on application, if non-traditional hours are required

***SELF-EMPLOYED** must submit an *Income Verification Form* provided by CCDP

I certify that all the information I have provided is true and correct to the best of my knowledge.

Signature of primary applicant: _____ Date: _____

Signature of other adult: _____ Date: _____

**If you have limited access to required documents, please ask CCDP staff for assistance, extensions, or alternatives.*

CCDP staff signature: _____ Date: _____

CCDP staff signature: _____ Date: _____

**If you have limited access to required documents, please ask CCDP staff for assistance, extensions, or alternatives.*



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: _____



Cowlitz Indian Child Care and Development Program

Application

Assigned #

New

Re-Qual.

Update

Form to be completed by the Parent/Guardian

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 Before & After	Other Types Holiday/ Closure 1 on 1
		S M T W T F S Drop off Pick Up		
		AM PM	Hours Needed	Alternative Non-Trad. Over Time
		S M T W T F S Drop off Pick Up		
		AM PM	Type of Hours Needed	Alternative Non-Trad. Over Time
		S M T W T F S Drop Off Pick Up		
		AM PM	Type of Hours Needed	Alternative Non-Trad. Over Time
		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.

Signature:	Date:
Signature:	Date:



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: _____



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?

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

Comments:
