



**I. CHILD CARE ASSISTANCE APPLICATION FORM**

Name: \_\_\_\_\_ Nicknames/Maiden Name: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_  
 County \_\_\_\_\_ Mailing Address (if different than above): \_\_\_\_\_  
 Phone: \_\_\_\_\_ Marital Status: S/M/D/W/S e Social Security # \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_  
 Sex M/F Tribal Affiliation: \_\_\_\_\_ Enrollment Number: \_\_\_\_\_

**II. HOUSEHOLD COMPOSITION**

*List all individuals currently residing in the household.*

NAME	RELATIONSHIP TO HEAD	SEX	DATE OF BIRTH	GRADE	SOCIAL SECURITY #
	Head of Household				

**III. HOUSEHOLD INCOME**

Self:  
 Employment \_\_\_\_\_ Phone: \_\_\_\_\_  
 Start Date: \_\_\_\_\_ Hours per week \_\_\_\_\_ Wage\$ \_\_\_\_\_ Hr/Yr. How often are you paid. \_\_\_\_\_  
 May we contact your current employer? \_\_\_\_\_ Name of Supervisor \_\_\_\_\_  
 Spouse/Co-habitant:  
 Employment \_\_\_\_\_ Phone: \_\_\_\_\_  
 Start Date: \_\_\_\_\_ Hours per week \_\_\_\_\_ Wage\$ \_\_\_\_\_ Hr/Yr. How often are you paid. \_\_\_\_\_  
 May we contact your current employer? \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

**IV. COLLEGE**

*List yourself or your spouse/co-habitant if either of you are currently attending any accredited college.*  
 Who: \_\_\_\_\_ Credit Hrs: \_\_\_\_\_ Where: \_\_\_\_\_ Loan or Grant amount: \_\_\_\_\_

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**V. OTHER RESOURCES**

List any other financial assistance you or any other member of the family may be receiving. (Please circle)

AFDC/TANF Social Security Disability Pension Child Support Other \_\_\_\_\_

Amount \$ \_\_\_\_\_ How often: Wkly \_\_\_\_\_ Bi-wkly \_\_\_\_\_ Monthly \_\_\_\_\_

Who: \_\_\_\_\_

**VI. ABSENT PARENT(S)**

For all children listed above, if there is an absent parent, please provide information requested below. For additional children, List on back side of this form.

**Child 1:** \_\_\_\_\_

Absent Parent's name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip: \_\_\_\_\_

Does Parent Pay Child Support for This Child? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

**Child 2:** \_\_\_\_\_

Absent Parent's name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip: \_\_\_\_\_

Does Parent Pay Child Support for This Child? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

**VII. HEALTH**

**Child Name:** \_\_\_\_\_

Any Special needs or handicaps? \_\_\_\_\_

Health problems which caregiver should know? \_\_\_\_\_

He/she currently on any medication? \_\_\_\_\_ Allergies? \_\_\_\_\_

Any activities child(ren) should not engage in? \_\_\_\_\_

If you answered yes to any of the questions above: Please explain here: \_\_\_\_\_

Special Concerns: (Glasses, Hearing Aid, Crutches, other) \_\_\_\_\_

**Child Name:** \_\_\_\_\_

Any Special needs or handicaps? \_\_\_\_\_

Health problems which caregiver should know? \_\_\_\_\_

He/she currently on any medication? \_\_\_\_\_ Allergies? \_\_\_\_\_

Any activities child(ren) should not engage in? \_\_\_\_\_

If you answered yes to any of the questions above: Please explain here: \_\_\_\_\_

- For any additional children, please list them on reverse of this page.

**VIII. EMERGENCY CONTACTS**

List only those children for whom you are requesting payment assistance.

Child(ren): \_\_\_\_\_

Person to whom the child may be released by the childcare provider. If none, write none.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Ph: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Ph: \_\_\_\_\_

Person(s) whom the child may be released in the event of an emergency when the parent/guardian cannot be reached. (One name must be given before application can be completed):

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Ph: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ph: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

**IX. PROVIDER INFORMATION**

*Payment assistance will not be allowed for more than two providers at one time.*

1) Name of Provider or Agency: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Mailing Address (if different than above) \_\_\_\_\_

Days of the week care is being requested:

**MONDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **TUESDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **WEDNESDAY:** From \_\_\_\_\_ to \_\_\_\_\_

**THURSDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **FRIDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **SATURDAY:** From \_\_\_\_\_ to \_\_\_\_\_

**SUNDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **OTHER:** \_\_\_\_\_

2) Name of Provider or Agency: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Mailing Address (if different than above) \_\_\_\_\_

Days of the week care is being requested:

**MONDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **TUESDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **WEDNESDAY:** From \_\_\_\_\_ to \_\_\_\_\_

**THURSDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **FRIDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **SATURDAY:** From \_\_\_\_\_ to \_\_\_\_\_

**SUNDAY:** From \_\_\_\_\_ to \_\_\_\_\_ **OTHER:** \_\_\_\_\_

(Weekend care will only be offered if both parents are working on the weekend and verification has been made regarding the hours care is being requested.)

**Applicant Certification**

I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with receipt of federal funds; and that the office of Child Care may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes. I know that whenever there are any changes in the information I have given, I have to report them to the local Ponca Tribal Social Service Representative or Child Care Administrator. I understand that information needed to verify eligibility may be obtained by computer, verbal, or written exchange between authorized state and federal agencies regarding child care assistance, and that the information will be adequately protected against unauthorized disclosure for other purposes. Upon the signing this document, information given or received will be deemed "confidential" and the Child Care Assistance Program will not use or disclose written consent of the program's participants. The information is deemed necessary to determine if I am eligible to receive childcare assistance. Upon signing this document, I agree to all terms applicable to this program under state, federal, local and tribal policy, procedure, and guidelines.

\_\_\_\_\_  
(Applicant Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff/Worker)

\_\_\_\_\_  
(Date)

**For Office Use Only: Notes:**