POKAGON BAND OF POTAWATOMI INDIAN CHILD CARE SERVICES APPLICATION

Department of Social Services
PO Box 180 Dowagiac, MI 49047
1 (800) 517-0777
1 (269) 782-4295 (Fax)

INSTRUCTIONS:
Type or clearly print your answers
Application must be complete
Your signature and date are required on last page.

PLEASE ATTACH:
1040 Tax Statement/Check Stubs/Child Support/Social Security
Copy of Children's Immunizations
All Tribal ID cards/State ID's/Social Security Cards
If in School: Registration and Schedule of Classes
If in Training: Verification/ Compensation Amount

SECTION I: Applicant

_____ _____ _____
Name Date of Birth Social Security Number

_____ _____ _____
Full Address County Email Address

_____ _____ _____
Place of Employment and/or Job Site / School / Training Organization Supervisor

_____ _____ _____ _____
Home Telephone Work Telephone Tribal Affiliation Tribal ID

SECTION II: List all children who need childcare (Child must be under 13 years of age unless disabled/verified by Physician.)

	Child's full name	Birth date	Age	Sex	Tribal #	Social Security Number
1.						
2.						
3.						
4.						
5.						
6.						

SECTION III: List yourself, along with all other persons and/or family members who are currently residing within the household. All household income is considered. *In order to be considered for payment of Day Care, you must attach income verifications for all persons currently residing in your household. Proof of child support payments received or paid is also required.

	Name	Relationship	Birth Date	Tribal ID	Age	Monthly Gross Income *
1.						
2.						
3.						
4.						
5.						
6.						

SECTION VI: RIGHTS AND ACKNOWLEDGEMENTS **(By initialing in this section you acknowledge you have read and understand ALL RIGHTS AND ACKNOWLEDGEMENTS)**

___ 1. APPLICATION: I understand that I have the right to file an application and can expect that the application will be processed and approved or denied within 10 days of its receipt by the Social Services Department. The child care must be provided in Michigan or Indiana by a licensed child care provider.

___ 2. NON-DISCRIMINATION: The Pokagon Band of Potawatomi Indians' CCDF program will not discriminate against any applicant because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If I believe that such discrimination exists I have the right to file a complaint with the Department of Social Services.

___ 3. REPORTING CHANGES:

A. I agree to report any changes in income, persons living in the home, change in training/education, child care provider, change in address or other circumstances to the Department of Social Services within 10 days.

B. I understand that failure to report such changes may result in charges of fraud or perjury.

___ 4. REPAYMENT OF BENEFITS: I understand that if I receive more benefits than I am entitled to receive [through my own or the Lead Agency's error] I must repay any benefits received.

___ 5. AFFIDAVIT: *I swear or affirm that all the information provided above is true and understand that providing false information may result in prosecution for perjury. Deliberate misinformation or intentional omission of information that results in obtaining benefits to which I am not entitled, may result in prosecution for fraud.*

___ 6. **This program is subject to change without advance notice due to funding. If you have questions, the Outreach Social Services Worker can assist.**

RELEASE OF INFORMATION: Permission is given to the tribe to contact my childcare provider before and after application has been approved.

If you are eligible, 93% of an allowable amount defined by CCDF guidelines will be paid to vendor.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHILD CARE COSTS NOT PAID BY THE TRIBAL CCDF PROGRAM, INCLUDING BENEFITS WHICH MAY HAVE BEEN AUTHORIZED, BUT FOR WHICH I NO LONGER QUALIFY BASED ON A CHANGE IN CIRCUMSTANCES.

Name of Provider_____Address_____ _____
_____

Email Address_____ Telephone number_____

County Provider is in:_____

Applicants Signature:_____ **Date:**_____

CCDF SPECIALIST:_____ Date: _____

DIRECTOR: _____ Date: _____