LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

Mailing Address: 7500 Odawa Circle, Harbor Springs, MI 49740
Physical Address: 911 Spring Street, Petoskey, MI 49770
Phone: (231) 242-1620 / Fax: (231) 242-1635

CHILD CARE ASSISTANCE OVERVIEW

PURPOSE

The purpose of this program is to assist eligible parents with child care expenses so they can begin or continue employment, employment training or an approved education program.

GENERAL REQUIREMENTS

- Children must be age 12 or younger
- Child care must take place in the covered service areas which are Charlevoix, Cheboygan and Emmet County
- Children or at least one parent must be a member of the Little Traverse Bay Bands of Odawa Indians
- Parents must be employed or enrolled in a job training or education program

INCOME ELIGIBILITY & PAYMENT ASSISTANCE

- Eligibility criteria are based on a family's monthly gross income and cannot exceed the maximum allowed income for household size.
- The percentage paid by LTBB will be determined by the household gross income. The income table is attached.

SELECTION OF CHILD CARE PROVIDERS

- The applicant shall select their provider for child care assistance. More than one provider may be used. The provider(s) selected must be a minimum of 18 years of age.
- Day Care Centers and Group Homes must be licensed by the State of Michigan. A copy of the center's current license is required at the time of application. A copy of all renewed licenses must be submitted within ten days of re-issuance. All unlicensed providers will be subject to a background check and a DHS Central Registry Clearance.
- All providers must sign a provider agreement, complete a W-9 form

OTHER INFORMATION

- Both the parent or guardian and the provider are responsible for accurately documenting hours on timesheets
- The parent is the responsible party for making sure that timesheets are submitted within the required time frame
- Checks will be made payable to the provider only and will be mailed directly to the provider
- Participants must complete and submit a change of information form for all changes made to the initially approved application such as a change in income or household size

CHILD CARE ASSISTANCE
DOCUMENT CHECKLIST

Thank-you for your interest in the LTBB Child Care Assistance Program. To be sure that your application is processed without delay, it is important that your application is complete including all required additional documentation. Please use the following checklist as a guide prior to mailing or bringing in your application packet for processing.

APPLICANT CHECKLIST

- ☐ Completed and signed three page application
- ☐ Documentation of past thirty day's income for all parents in the household
- ☐ Copies of LTBB Tribal ID cards for all LTBB members in the household
- ☐ Copies of all household members' Social Security cards
- ☐ Completed Parent Work Schedule from all parents in the household signed by their supervisors
- ☐ Completed Child School Schedule for all school age children in the household signed by parent

If applicable:

- ☐ Copies of child support court orders, receiving and/or paying
- ☐ Copies of foster care placement orders
- ☐ Copy of class/training schedule

PROVIDER CHECKLIST

LICENSED PROVIDERS:

- ☐ Completed and signed provider agreement
- ☐ Completed and signed W-9 form
- ☐ Copy of state license

UNLICENSED PROVIDERS:

- ☐ Completed and signed provider agreement
- ☐ Completed and signed W-9 form
- ☐ Completed and signed Request for Central Registry Clearance form
- ☐ Copy of Driver's License
- ☐ Completed and signed Authorization for Criminal Background Investigation form

LTBB CHILD CARE ASSISTANCE PROGRAM INCOME GUIDELINES

	GROSS MONTHLY INCOME				
HOUSEHOLD SIZE 2	$0 - $1,226	$1,227 - $2,045	$2,044 - $2,860	$2,861 - $3,678	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $3,679
HOUSEHOLD SIZE 3	$0 - $1,544	$1,545 - $2,542	$2,543 - $3,542	$3,543 - $4,543	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $4,544
HOUSEHOLD SIZE 4	$0 - $1,863	$1,864 - $3,044	$3,045 - $4,226	$4,227 - $5,409	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $5,410
HOUSEHOLD SIZE 5	$0 - $2,181	$2,182 - $3,544	$3,545 - $4,909	$4,910 - $6,275	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $6,276
HOUSEHOLD SIZE 6	$0 - $2,499	$2,500 - $4,045	$4,046 - $5,592	$5,593 - $7,140	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $7,141
HOUSEHOLD SIZE 7	$0 - $2,818	$2,819 - $4,312	$4,313 - $5,807	$5,808 - $7,303	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $7,304
HOUSEHOLD SIZE 8	$0 - $3,136	$3,137 - $4,578	$4,579 - $6,021	$6,022 - $7,465	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $7,466
HOUSEHOLD SIZE 9	$0 - $3,454	$3,455 - $4,844	$4,845 - $6,235	$6,236 - $7,627	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $7,628
HOUSEHOLD SIZE 10 +	$0 - $3,773	$3,774 - $5,111	$5,112 - $6,450	$6,451 - $7,790	NO LTBB ASSISTANCE IF GROSS MONTHLY INCOME IS OVER $7,791
% OF LTBB PYMNT.	100%	75%	50%	25%	

LTBB CHILD CARE ASSISTANCE PROGRAM RATES

	Day Care Center	Relative Care/ Group Homes	Unlicensed Provider-Non-Relative
AGE			
0 - 2 ½ yrs	$3.75	$2.90	$1.85
2 ½ - 12 yrs	$2.50	$2.40	$1.60

CHILD CARE ASSISTANCE
APPLICATION FOR SERVICES

Please complete this application thoroughly and submit all required documentation. All information contained in this application is confidential.

Date: _____

Tribal Affiliation _____
Enrollment # _____

Name: _____

Date of Birth ____/____/____

Address: _____

Social Security # ____-____-____

Apt. No.: _____

Home Telephone ( ) _____

City/State/ Zip: _____

Work Telephone ( ) _____

County: ☐Emmet ☐Charlevoix ☐Cheboygan

Relationship to children ☐Parent ☐Foster Parent*
If Foster Parent, attach copy of the Court Order Placement

Please complete if mailing address is different from physical address:

_____ Address

_____ City/State/Zip

REASON FOR CHILD CARE: ☐Employment ☐School ☐Training

CHILDCARE NEEDS

List the childrens' name, date of birth, grade level and number of weekly hours needed for child care services during the school year and during summer

CHILD'S NAME	DOB	GRADE LEVEL	SCHOOL HOURS	SUMMER HOURS

HOUSEHOLD COMPOSITION INFORMATION

List all individuals other than the applicant and the children listed above who are living in the household. This includes Spouse, Significant Other, and all other children between the ages of 13 - 18. Include the relationship to the children listed under Childcare Needs (i.e. Mother, Father, Brother, Sister)

NAME	DOB	SOCIAL SECURITY #	RELATIONSHIP TO CHILDREN	LTBB ENROLLMENT #

HOUSEHOLD INCOME VERIFICATION

IF YOU ARE A FOSTER PARENT, PROCEED TO PROVIDER INFORMATION SECTION

INCOME INFORMATION

EARNED INCOME – Beginning with the applicant, list all earned gross income for all parents in the household

NAME	EMPLOYER	PAY FREQUENCY	MONTHLY GROSS INCOME	
		Total Earned GROSS Income	$	

UNEARNED INCOME – Beginning with applicant, list all un-earned gross income for all parents members in the household (i.e. social security, pension, disability, child support, per capita payments, education scholarship, etc.)

NAME	SOURCE OF INCOME	PAY FREQUENCY	MONTHLY GROSS INCOME	
		Total UNEARNED GROSS Income	$	

SCHOOL/TRAINING

NAME	SCHOOL	ATTENDING
		☐Spring ☐Summer ☐Fall ☐Winter
		☐Spring ☐Summer ☐Fall ☐Winter

PROVIDER INFORMATION

Provider Type:	☐ Day Care Center ☐ Relative Care ☐ Unlicensed Non-Relative ☐ Group Home		
Provider Name:		Provider Name:	
Provider Address:		Provider Address:	
Provider Telephone:		Provider Telephone:	

APPLICANT CERTIFICATION

I certify that all the answers given are true, complete and correct to the best of my knowledge. This certification is made with the knowledge that the information will be used to determine eligibility for the LTBB Child Care Assistance Program. I agree to report all changes in my household composition and/or household income within ten days of when the date of change occurs.

Signature		Date	

Rights and Acknowledgements

1. **APPLICATION.** I understand that I have the right to file an application for child care services. I understand that I must provide all necessary documentation for my application to be considered. Incomplete applications will not be accepted. I understand that I will receive notice regarding my approval or denial of services within ten days of receipt of a completed application including all supporting documentation from the LTBB Department of Human Services.

2. **AUTHORIZATION FOR SERVICES.** I understand that I am responsible for all child care expenses incurred prior to my application being approved and a letter of approval being sent to me. This includes all pre-existing childcare bills that I may have with my childcare provider.

3. **NON-DISCRIMINATION.** The Little Traverse Bay Bands of Odawa Indians Child Care Assistance 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 LTBB Department of Human Services.

4. **REPORTING CHANGES:**
   A. I agree to report any changes in income, persons living in the home, changes in childcare provider or other circumstances that may affect my eligibility within ten days of when the date the change occurs. A "Change of Information" form must be completed and submitted with every change.

   B. I understand that failure to report all changes, especially financial, will result in my termination from the program and any outstanding payment will be my sole responsibility.

   C. I understand if I have not actively participated in the LTBB Child Care Assistance Program for a period of sixty or more days, I will be required to complete a "Reinstatement Form" and provide required documentation.

5. **REPAYMENT OF BENEFIT.** I understand that if I receive more benefits than I am entitled to receive, through my own or LTBB's error, I must repay any benefits received to which I was not entitled.

6. **AFFIDAVIT.** I affirm that all of the information provided in this application is true and understand that providing false information will result in my termination from the program. Deliberate misinformation that results in obtaining benefits to which I am not entitled may result in prosecution.

7. **RELEASE OF INFORMATION.** I hereby give my permission to LTBB to contact my designated child care provider to give notice of eligibility and to contact the Michigan Department of Human Services for the purpose of verification of dual participation.

8. **RECORD KEEPING.** I understand that I must document childcare hours on a timesheet on a weekly basis and that I must submit timesheets at a minimum of once monthly, no later than five business days after the last day of that month. Timesheets will only reflect hours for which I am at work, training or school. The timesheet must document the in and out times for each day that my child is in the care of my approved provider. Timesheets must be signed by the parent and the provider and be signed and dated no earlier than the last day services are rendered. I understand that if I fail to adhere to the recordkeeping standards for this program, LTBB reserves the right to refuse payment for childcare services and I may be terminated from the program for failure to comply.

I HAVE READ AND UNDERSTAND THIS FORM

SIGNATURE: _____ DATE: _____

LTBB CHILD CARE ASSISTANCE FUND		
PARENT WORK SCHEDULE		
Parent Name:		
Name of Employer:		
	In Time	Out Time
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

If your schedule varies and changes at times, please make note of that below in as much detail as possible

_____

_____

_____

_____

_____

Supervisor Signature _____

LTBB CHILD CARE ASSISTANCE FUND		
PARENT WORK SCHEDULE		
Parent Name:		
Name of Employer:		
	In Time	Out Time
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

If your schedule varies and changes at times, please make note of that below in as much detail as possible

_____

_____

_____

_____

_____

Supervisor Signature _____

LTBB CHILD CARE ASSISTANCE FUND		
Child's School Schedule-Winter/Spring 2015		
Name of Child:		
	In Time	Out Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If child's schedule varies and changes at times, please make note of that below in as much detail as possible

_____

_____

_____

_____

_____

Parent Signature _____

LTBB CHILD CARE ASSISTANCE FUND		
Child's School Schedule-Winter/Spring 2015		
Name of Child:		
	In Time	Out Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If child's schedule varies and changes at times, please make note of that below in as much detail as possible

_____

_____

_____

_____

_____

Parent Signature _____

CHILDCARE ASSISTANCE
PROVIDER AGREEMENT

This is an agreement between the Little Traverse Bay Bands of Odawa Indians *(hereinafter referred to as LTBB)* Child Care Assistance Program, and

_____ *(hereinafter called Provider)* License # _____

To provide childcare services for: _____ *(hereinafter called Parent/Guardian)*

The Provider attests that the child care setting for which I am providing services for is:

☐ Day Care Center ☐ Relative Care* ☐ Unlicensed Non-Relative ☐ Group Home

***If claiming Relative Care, list your relationship to the children here:**

_____

The Provider hereby agrees to abide by the child care standards set forth by the State of Michigan while providing services for the parent/guardian of the following children:

1. _____ 3. _____
2. _____ 4. _____

The Provider agrees to provide to the parent/guardian the following:

a) Unlimited access to children while in your care
b) Immediate notification of all problems or concerns regarding children in your care
c) Assurances of a smoke-free environment while children are in your care

The Provider agrees to abide by the Child Care Assistance Program reporting requirements and agrees to provide the LTBB Department of Human Services with the following documents:

a) Copy of current daycare license *(if applicable)*
b) W-9 Form *(signed,, dated and business identification number or social security number provided)*
c) Accurate weekly timesheets *(signed by parent and provider and dated no earlier than the last day services are rendered)*

The Provider agrees to abide by the Child Care Assistance Program's mandated annual inspections (twice annually) by providing access to the child care facility or home to an LTBB Department of Human Services representative.

It is the parents' responsibility to submit time sheets for child care services rendered. The Provider understands that upon receipt of weekly timesheets by the LTBB Department of Human Services, the timesheets will be checked for accuracy and completeness and a determination will be made if the parent and/or provider are in compliance with program requirements.

The Provider understands that payment for services rendered will be made payable directly to the provider and that a 1099 form will be issued for tax reporting requirements at the end of each year.

The Provider understands and agrees that in the event that a parent fails to meet program requirements and is determined to no longer be eligible to participate in the Child Care Assistance Program, the parent bears the sole responsibility for total payments due for all services rendered by the provider.

The Provider understands that payment for services rendered are not covered by LTBB until the parent/guardian has been approved for program participation.

The Little Traverse Bay Bands of Odawa Indians Child Care Assistance Program operates on limited annual funding and is intended to assist in payment of child care services for qualified families. LTBB does not promise or guarantee that funding will be available for the duration of the entire fiscal year. In the event that program funds become depleted, LTBB will not be liable for any child care expenses incurred by program participants.

The Provider agrees to abide by the terms listed in this agreement and will not attempt to defraud or misrepresent any service or time reported to the LTBB Child Care Assistance Program. The provider further understands that LTBB reserves the right to prosecute for misrepresentation and/or fraud.
I understand that if I receive more benefits than I am entitled to receive, through my own or the LTBB's error, I must repay any benefits received to which I was not entitled.

Provider Signature: _____ Date _____

Form **W-9**
(Rev. October 2004)
Department of the Treasury
Internal Revenue Service

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 reported on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requester's name and address (optional)
Little Traverse Bay Bands of Odawa
7500 Odawa Circle
Harbor Springs, MI 49740

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 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

or

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. person (including a U.S. resident alien).

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 ▶

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.

U.S. person. 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.

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.*

For federal tax purposes you are considered a person if you are:

- an individual who is a citizen or resident of the United States,
- a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- any estate (other than a foreign estate) or trust. See Regulation section 301.7701-6(a) for additional information.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

CENTRAL REGISTRY CLEARANCE REQUEST
Michigan Department of Human Services

INSTRUCTIONS:

- An enlarged and clear copy of individual's photo identification must be attached.
- For Michigan employers, individuals and volunteer agencies, submit this request to the local County Department of Human Services. To obtain the address and fax number of **your local county DHS, access www.michigan.gov/dhs->Inside DHS.**
- For individuals seeking clearance on themselves, the results will be sent to the address on the picture identification provided.
- Outstate Children's Protective Services workers, law-enforcement, and court officials fax request to 517-241-7047 (Outstate only) on agency letterhead with cover sheet.
- All fields must be completed for processing.

COPY PHOTO ID HERE AND RETAIN A COPY FOR YOUR RECORDS

OR ATTACH A CLEAR COPY OF YOUR ID ON A SEPARATE PAGE

SECTION 1
INFORMATION ON PERSON BEING CLEARED

Name First, Middle, Last	AKA (Also Known As) (Maiden Name)	Social Security Number	Signature Required for individual being cleared
Address	**Phone Number**	**Date Of Birth**	

SECTION 2
REQUESTOR INFORMATION

Please Check Appropriate Box

- ☒ Child Welfare Agency
- ☐ Individual ☐ I would like to pick up my results in _____ county
- ☐ Law-Enforcement/Dept of Corrections
- ☐ Prosecuting Attorney/Court (please provide docket number if available) _____ MI
- ☒ Employer
- ☐ Volunteer Agency
- ☐ Out-of-State Adoption and Foster Home Screening
- ☐ Other _____

Name of Employer/Volunteer Agency/Individual	Name of CPS/Law-Enforcement or Court
Little Traverse Bay Bands of Odawa Indians	Department of Human Services
Name	**Title**
Melanie Gasco	Program Generalist

Address	City	State	Zip Code
7500 Odawa Circle	Harbor Springs	MI	49740

Phone	Fax	E-mail	Date
231-242-1626	231-242-1635	melgasco@ltbbodawa-nsn.gov	

Employers/volunteer agencies – will ONLY receive responses of NO central registry if the name being cleared has approved this request with their signature. Employers/volunteer agencies will NOT receive notification if the name submitted has any central registry history hits per CPL 722.627.

For questions about completing this form, please contact the local Michigan Department of Human Services, Children's Protective Services or CPS Program office at 517-373-6028. Mail questions to PO Box 30037, 235 S. Grand Avenue, Suite 510, Lansing, Michigan 48909

This clearance does not identify individuals who may have child abuse/neglect history in other states, territories or tribal trust land.

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION FOR CRIMINAL BACKGROUND INVESTIGATION

Name:_____

Maiden name or other names used:_____

Date of Birth:_____ Race:_____

Phone Number:_____

Please list ALL criminal history information charges/convictions and dates:

_____

_____

_____

I understand that my signature allows the LTBB Department of Human Services to run a criminal background investigation on myself. I agree that the information above is all accurate and true to the best of my knowledge.

_____
Printed Name

_____
Signature Date

Mailing Address: 7500 Odawa Circle, Harbor Springs, MI 49740
Physical Address: 911 Spring Street, Petoskey, MI 49770
Phone: (231) 242-1620 Fax: (231) 242-1635