

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 APPLICATION FOR SERVICES

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

Date: _____ Name: _____ Address: _____ Apt. No.: _____ City/State/Zip: _____ County: <input type="checkbox"/> Emmet <input type="checkbox"/> Charlevoix <input type="checkbox"/> Cheboygan	Tribal Affiliation _____ Enrollment # _____ Date of Birth _____ / ____ / ____ Social Security # _____ - ____ - ____ Home Telephone (____) _____ Work Telephone (____) _____ Relationship to children <input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent* <i>*If Foster Parent, attach copy of the Court Order Placement</i>
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Please complete if mailing address is different from physical address:

Address	City/State/Zip
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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
		<input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Winter
		<input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Winter

PROVIDER INFORMATION

Provider Type:	<input type="checkbox"/> Day Care Center <input type="checkbox"/> Relative Care <input type="checkbox"/> Unlicensed Non-Relative <input type="checkbox"/> 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	
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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: _____

**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

If applicable:

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

**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 _____