

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

CHILD CARE ASSISTANCE FUND OVERVIEW

PURPOSE: The purpose of this program is to assist eligible parents with child care expenses so that 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 area, of which are the counties of Charlevoix, Emmet and Cheboygan, children or at least one parent must be a member of the Little Traverse Bay Bands of Odawa Indians and parent(s) 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 current licenses is required at the time of application. A copy of all renewed licenses must be submitted within 10 days of reissuance. All unlicensed providers will be subject to a background check and a DHS Central Registry Clearance. All providers must sign a Provider Agreement and complete a W-9.

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 30 day 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.

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

CHILD CARE ASSISTANCE FUND 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 submitting your application packet for processing.

APPLICATION CHECKLIST

- Completed and Signed 3 Page Application
- Documentation of past 30 days income for all parents in household
- Copies of LTBB Tribal ID for all LTBB members of household
- Copies of Social Security Cards of all members of household
- Completed Parent(s) Work Schedule Signed by Their Supervisor
- Completed Child School Schedule Signed by Parent

IF APPLICABLE:

- Copies of Child Support Court Orders/Receiving 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
- Copy of State License

UNLICENSED PROVIDERS:

- Completed and Signed Provider Agreement
- Completed and Signed W-9
- Completed and Signed Request for Central Registry Form
- Copy of Driver's License
- Completed and Signed Authorization for Criminal Background Investigation Form

TODAY'S DATE: _____

Little Traverse Bay Bands of Odawa Indians

Childcare Assistance Application

To be considered for childcare assistance each question should be fully and accurately answered. No action can be taken on this application until all required information is submitted. PLEASE PRINT except for your signature. All information contained in this application is confidential.

NAME: _____ TRIBAL AFFILIATION _____

ADDRESS: _____ ENROLLMENT #: _____

CITY/STATE/ZIP: _____ SOCIAL SECURITY NUMBER: _____

COUNTY: _____ PHONE #: (_____) _____

EMAIL ADDRESS _____

RELATIONSHIP TO CHILDREN PARENT FOSTER PARENT

REASON FOR CHILDCARE: EMPLOYMENT SCHOOL TRAINING

CHILDCARE NEEDS

List the number of weekly hours needed for childcare services during the school year and during the summer.

CHILD'S NAME	DOB	GRADE LEVEL	SCHOOL HOURS	SUMMER HOURS

HOUSEHOLD COMPOSITION

List all individuals other than the applicant who are living in the household. This includes spouse, significant other and all others. Include the relationship to the children listed under childcare needs.

NAME	DOB	SOCIAL SECURITY #	RELATIONSHIP TO CHILDREN	LTBB ENROLLMENT #

HOUSEHOLD INCOME VERIFICATION

If you are a foster parent please proceed to provider information section

EARNED/UNEARNED INCOME INFORMATION

Beginning with applicant, list all earned GROSS income for all parents in household.

NAME	EMPLOYER	PAY FREQUENCY	MONTHLY GROSS
NAME	SOURCE OF INCOME	PAY FREQUENCY	MONTHLY GROSS
		TOTAL GROSS INCOME	\$

SCHOOL/TRAINING

NAME	SCHOOL	SEMESTER

PROVIDER INFORMATION

Provider Type:

Day Care Center
 Relative Care Unlicensed Non-Relative Group Home

Please check here if care is in Provider's home

Provider Name: _____

Provider Address: _____

Provider Telephone: _____

APPLICANT CERTIFICATION

I certify that all 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 income within 10 days of when the date of change occurs.

SIGNATURE _____ **DATE** _____

RIGHTS AND ACKNOWLEDGEMENTS

- **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 10 days of receipt of a completed application including all supporting documentation from the LTBB Department of Human Services.
- **AUTHORIZATION FOR SERVICES** I understand that I am responsible for all child care expenses incurred prior to my application being approved and an approval letter being sent to me. This includes all pre-existing childcare bills that I may have with my childcare provider.
- **NON-DISCRIMINATION** The Little Traverse Bay Band 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.
- **REPORTING CHANGES**
I agree to report any changes in income, composition of household, changes in childcare provider or other circumstances that may affect my eligibility within 10 days of when change occurs. A "Change of Information" form must be completed and submitted with every change.
I understand that failure to report all changes; especially financial, will result in my termination from the program and any outstanding payments will be my sole responsibility.
I understand if I have not actively participated in the LTBB Child Care Assistance Program for a period of 60 or more days, I will be required to complete a "Reinstatement Form" and provide required documentation.
- **REPAYMENT OF BENEFITS** 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.
- **AFFADAVIT** 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.
- **RELEASE OF INFORMATION** I hereby give my permission to LTBB to contact my designated child care provider to give notice of eligibility and contact the Michigan Department of Human Services for the purpose of verification of dual participation.
- **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 every 30 days. I understand that LTBB Human Services will only pay 30 days retroactive from the date timesheets are submitted to their office. I understand that I will be responsible for any childcare costs incurred should timesheets be submitted past 30 days. Timesheets will only reflect hours for which I am at work, training or school for a weekly maximum of 5 days. 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** _____

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

CHILD CARE ASSISTANCE FUND

PARENT WORK SCHEDULE		
PARENT NAME:		
EMPLOYER:		
	TIME IN	TIME OUT
SUNDAY		
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		

COMMENTS: If your schedule changes at times, please make note of changes below in as much detail as possible. _____

SUPERVISOR SIGNATURE _____ DATE: _____

PARENT WORK SCHEDULE		
PARENT NAME:		
EMPLOYER:		
	TIME IN	TIME OUT
SUNDAY		
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		

COMMENTS: If your schedule changes at times, please make note of changes below in as much detail as possible. _____

SUPERVISOR SIGNATURE _____ DATE: _____

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

CHILD CARE ASSISTANCE FUND

CHILD'S SCHOOL SCHEDULE		
CHILD NAME		
SCHOOL		
	TIME IN	TIME OUT
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

COMMENTS: If your schedule changes at times, please make note of changes below in as much detail as possible. _____

PARENT SIGNATURE _____

CHILD'S SCHOOL SCHEDULE		
CHILD NAME		
SCHOOL		
	TIME IN	TIME OUT
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

COMMENTS: If your schedule changes at times, please make note of changes below in as much detail as possible. _____

PARENT SIGNATURE _____

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

CHILD CARE ASSISTANCE FUND

PROVIDER AGREEMENT

This is an agreement between the Little Traverse Bay Bands of Odawa Indians (hereinafter referred to 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 for by the State of Michigan while providing services for the parent/guardian of the following children: 1. _____

2. _____ 3. _____ 4. _____

The Provider agrees to provide to the parent/guardian the following: Unlimited access to children while in your care, immediate notification of all problems or concerns regarding children in your care and 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: copy of current daycare license (if applicable), W-9 Form (signed, dated, business identification number or social security number provided), and 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 a LTBB Department of Human Services representative. *It is the parent's responsibility to submit timesheets 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 verified 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 LTBB's error, I must repay any benefits received to which I am not entitled.

Provider Signature _____ Date _____

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

CHILD CARE ASSISTANCE

AUTHORIZATION FOR CRIMINAL BACKGROUND INVESTIGATION

NAME _____

MAIDEN NAME OR OTHER NAMES USED _____

DATE OF BIRTH ____/____/____ RACE _____

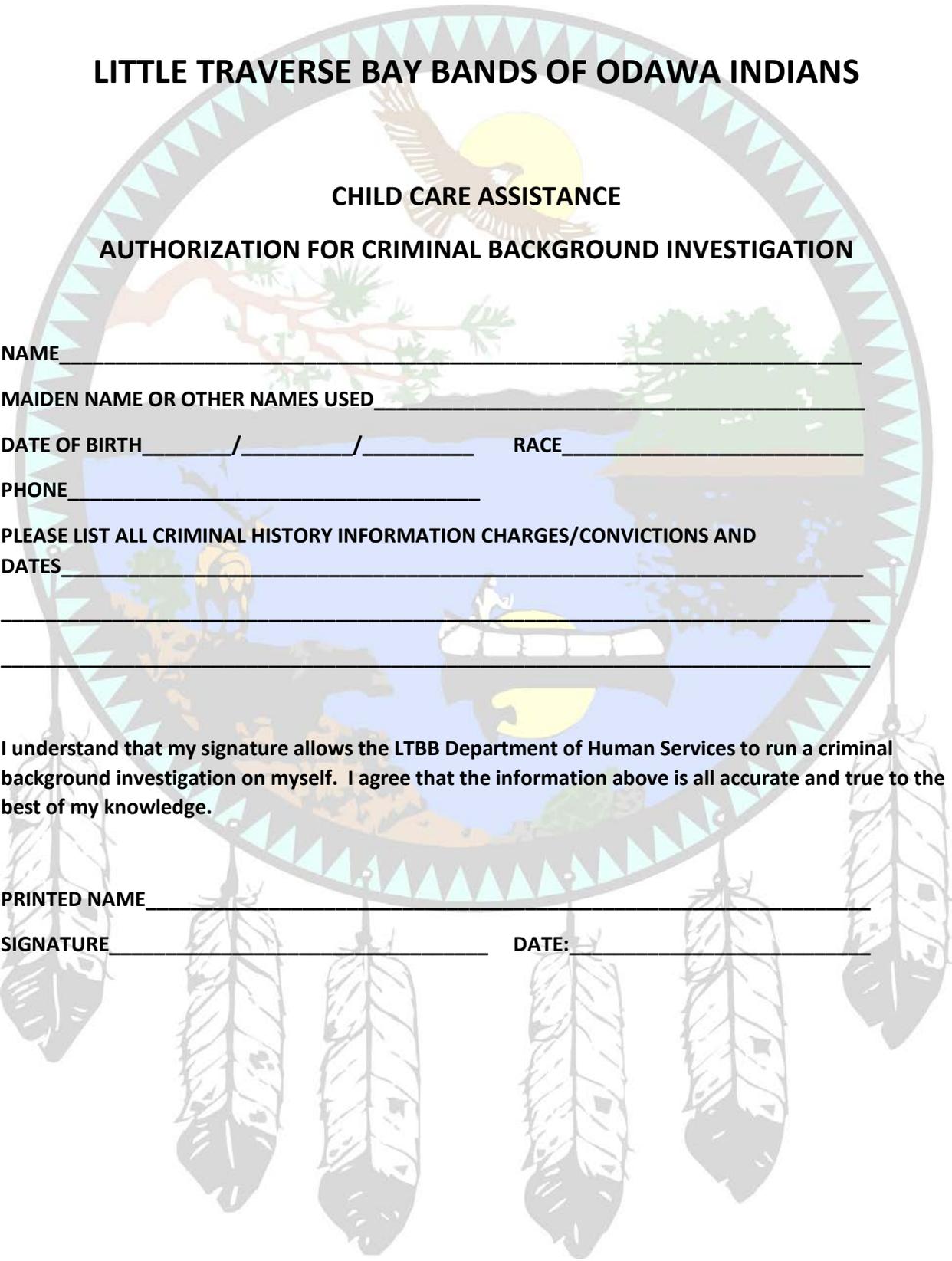
PHONE _____

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: _____



CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services

Copy Photo ID Here

or

Attach a Separate Page

SECTION 1 INFORMATION ON PERSON BEING CLEARED

Name, (First, Middle, Last)	Signature Required for Individual Being Cleared		Date
Also Known as Name (AKA)	Social Security Number		Date of Birth
Address	City	State	Zip Code
Phone Number	Email		
<input type="checkbox"/> I am completing this for myself. <input type="checkbox"/> I would like to pick up my results in		County (For Michigan Residents Only).	

SECTION 2 REQUESTER INFORMATION

Check Appropriate Box <input type="checkbox"/> Employer <input type="checkbox"/> Volunteer Agency <input type="checkbox"/> Adoption/Foster Care Home Screening <input type="checkbox"/> Court/Law-Enforcement/Department of Corrections/Prosecuting Attorney <input type="checkbox"/> Other			
Name of Agency or Organization LTBB Department of Human Services	Name of Requester Melanie Gasco		
Address 7500 Odawa Circle	City Harbor Springs	State MI	Zip Code 49740
Email melgasco@ltbbodawa-nsn.gov	Fax 231-242-1635	Phone Number 231-242-1626	

Employers/Volunteer Agencies will ONLY receive responses of NO central registry if the person being cleared has approved this request with their signature. Employers/volunteer agencies will NOT receive notification if the name submitted has any central registry hits per CPL 722.627. For questions about completing this form, please contact the local Michigan Department of Health and Human Services, see attached contact list.

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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

INSTRUCTIONS FOR FILLING OUT THE DHS-1929

Michigan Department of Health and Human Services

Michigan residents requesting clearance on themselves (You must possess a Michigan identification) Complete section one and sign the form in the box provided. Include a copy of your Michigan picture identification (driver's license or passport are most acceptable). Please NOTE, the results will only be sent to the address on your picture identification. Submit your DHS-1929 form with identification to MDHHS for processing. See the attached list for MDHHS county office locations and contact numbers.

Michigan agencies, schools, preschool, daycare providers, employers and volunteer agencies The person being cleared completes section one, signs the form and adds a copy of their picture identification (driver's license or passport are most acceptable). The requester completes section two with name of agency, name of requester, address, phone, email and fax number. Submit the DHS-1929 with identification to MDHHS for processing. See the attached list for MDHHS county office locations and contact numbers.

Individuals outside of Michigan

For out of state Individuals requesting clearance on themselves, complete section one and sign the form. Include a copy of your state picture identification (driver's license or passport are most acceptable). Please NOTE, the results will only be sent to the address on your picture identification. Submit your request to Michigan Department of Health and Human Services fax 517-763-0280.

Agencies, schools, preschool, daycare providers, employers and volunteer agencies outside of Michigan

For out of state agencies, the person being cleared completes section one, signs the form and adds a copy of their state picture identification (driver's license or passport are most acceptable). The requester completes section two with name of agency, name of requester, address, phone, email and fax number. Submit your request to Michigan Department of Health and Human Services fax 517-763-0280.

Out-of-State Adoption and Foster Home Screening

Please access our website at www.michigan.gov/MDHHS and follow the instructions for submitting an outstate request for adoption and foster home screening. For questions contact 517-284-9740.

Michigan Camp Volunteers and Employees (All Types)

Please contact the Department of Licensing and Regulatory Affairs, Bureau of Community Health Systems at 866-685-0006 or www.michigan.gov/lara
Submit completed form BCHS-camp 001 (Rev 1/16) to the address on the form.

Outstate government agencies requesting information, please access our website at www.michigan.gov/DHHS follow the links to child abuse and neglect or call 517-241-9794.

If a person is listed on central registry the results will only be sent to the individual at the address on their photo identification.

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: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	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.

Social security number

or

Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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.