



Child Care Assistance Provider Application Checklist and Requirements

Providers must be approved by TCC before payments will be processed.

- Provider Application completed and signed by the parent(s) and provider.** Non-Related providers who reside in the village-Must also complete Tribal License Application. Non-Related providers who reside in the Fairbanks area-Must be licensed through the State of Alaska.
- Criminal Background Check through the Alaska State Troopers (must be current).** Anyone living in the household over the age of 17 will need to have a criminal background check. Tribally Licensed Provider (Non-Relative) must have valid fingerprints or be fingerprinted before being approved.
- TB Test results if you are not related to the children you are caring for.** Anyone 18 or older that will be present during the child care hours will need a TB test result.
- OCS Clearance - The Authorization for Release of Information AND Clearance for Placement pages will need to be completed.** Anyone 18 years or older living in the household will need to complete these forms.
- Fire Escape Plan**
- Disaster Plan**
- Copy of applicant's photo I.D. and anyone 18 years or older living in the household.**
- Schedule an interview with the Child Care Coordinator.**
- Complete Infant/Child/Adult CPR & First Aid Certification within the first 3 months of approval.**
- Complete the Better Kid Care Health and Safety Basics: Requirements for Certification Bundle within the first 3 months of Approval.** Website is <http://extension.psu.edu/programs/betterkidcare>
- You are aware that you are not an employee of Tanana Chiefs Conference and therefore are Self-Employed. **You understand that you will be responsible to withhold your own taxes.**
- You are aware that payments are not retroactive.** (For example, if you submitted application in May, but started child care in April, we cannot pay for April).



For Office use Only
Date Received:

Child Care Assistance Program

Child Care Provider Application

Each person or agency who provides child care for a parent or guardian or foster parent receiving child care assistance from the TCC, Inc. Child Care & Development Fund Program must complete one of these forms & be approved **before** they are able to get paid.

Payments are not retroactive.

The Tanana Chiefs Conference, Inc. reserves the right to deny approval & payment to any person or agency who is determined by the tribe to be a potential danger to child(ren) because of current or past association with or participation in criminal activities, alcohol or other substance abuse, communicable health problems or unsafe child care practices.

Eligible providers must be related to the children by marriage, blood or court decree. Provider must be a grandparent, great-grandparent, aunt, uncle or sibling to the children. **If you are not related and do not reside in a village/rural area you must be licensed by the State of Alaska.** If you reside in a village/rural area and are not related you must be approved by your tribe as a Tribally Licensed Provider. Applications to become a Tribally Licensed Child Care Provider can be obtained by contacting your local village TWDS or Child Care Coordinator by calling the indicated toll-free number on the first page.

PARENT INFORMATION		INFORMATION OF PARENT YOU WILL PROVIDE CHILD CARE FOR	
Last Name	First, Middle Initial	Telephone Number:	
Mailing / Street Address		Email	
Village or City		Zip Code	

PROVIDER INFORMATION		Return To: Your Village (TWDS) or the TCC-CCDF Program at the TCC Main Office	
Last Name	First, Middle Initial	Date of Birth	Social Security Number or EIN
Mailing / Street Address		Email	Telephone Number:
Village or City		Zip Code	
Care will be provided in:	What is your relationship to the child(ren)?		When checking any of these boxes, you will need to become Tribally Licensed and be fingerprinted. Please fill out the Tribal License form also.
<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Other _____	<input type="checkbox"/> Grandfather <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Uncle/Aunt <input type="checkbox"/> Brother		<input type="checkbox"/> Family Friend <input type="checkbox"/> Other <input type="checkbox"/> Specify: _____

Please list all other members living in your household.

IF YOU ARE CONDUCTING CHILD CARE IN YOUR HOME, YOU & ANYONE 18 OR OLDER MUST HAVE A CRIMINAL HISTORY COMPLETED (DONE WITHIN 30 DAYS) BEFORE YOU ARE ACCEPTED AS A CHILD CARE PROVIDER AND RECEIVE PAYMENT.

NAME OF ALL OTHER HOUSEHOLD MEMBERS	WHAT IS THEIR RELATIONSHIP TO YOU?	WHAT IS THEIR BIRTH DATE?
1.		
2.		
3.		
4.		
5.		
6.		

As a child care provider, I charge the amounts that TCC pays per child per age group: Yes No

If "no", please list your rates: \$____ Per hour \$____ Per day \$____ Per week \$____ Per month per child

Is this the amount that you charge everyone for the same number of child(ren)/ages/hours? Yes No

If "no", please explain: _____

Here are the Names & Ages of the child(ren) I will be caring for in the CCDF Program:

NAMES OF CHILD(REN)	AGE	CHILD'S DATE OF BIRTH	RELATIONSHIP TO YOU
1.			
2.			
3.			
4.			
5.			
6.			

I. PROVIDER Please mark YES or NO on ALL questions. Do not leave any questions blank.

1. I am 18 Years of age or older (If you marked NO then you cannot become a provider).	<input type="radio"/> Yes	<input type="radio"/> No
2. Either myself or someone living in my home has been convicted of, or has a charge pending for a crime or crimes against child(ren) or has a criminal record which could jeopardize the health &/or safety of the child(ren).	<input type="radio"/> Yes	<input type="radio"/> No
3. I will provide the Child Care Assistance Program a test for TB, signed by my doctor. (CHECK ONE): ONLY NEED TB TEST IF NOT RELATED TO THE CHILDREN YOU ARE CARING FOR. <input type="radio"/> Attached <input type="radio"/> Will be sent from the Health Aide <input type="radio"/> Still need to have a test	<input checked="" type="radio"/> Yes	<input type="radio"/> No
4. I know that I am required by law to report suspected child abuse to the State of Alaska, Division of Family & Youth Services & to the TCC, INC. Child Care Assistance Program	<input type="radio"/> Yes	<input type="radio"/> No
5. I will have completed, or will have begun the required Child Care Assistance Program training Infant/Child/Adult CPR & First Aid Certification within: (CHECK ONE): <input type="radio"/> 3 Months <input type="radio"/> Date Completed: _____ (If completed, please attach verification)	<input type="radio"/> Yes	<input type="radio"/> No
6. All visitors & members of my household shall be in physical & mental health state that will not bring harm to the health & well being of the child(ren) in my care.	<input type="radio"/> Yes	<input type="radio"/> No
7. Any assistant shall be at least 16 years of age & physically & emotionally able to provide responsible child care.	<input type="radio"/> Yes	<input type="radio"/> No
8. Any substitute shall be at least 18 years of age & physically & emotionally able to provide responsible child care.	<input type="radio"/> Yes	<input type="radio"/> No
9. I plan to leave the child(ren) with other people on a non-emergency basis.	<input type="radio"/> Yes	<input type="radio"/> No
10. I will make arrangements with the parent if I am unable to provide care.	<input type="radio"/> Yes	<input type="radio"/> No
11. I will use substitute providers only in emergencies. Here are the names & phone numbers of people (<i>they must be on the TCC-CCDF Program</i>) who may substitute for me: _____	<input type="radio"/> Yes	<input type="radio"/> No

II. COSTS/MEDICATIONS Please mark YES or NO on ALL questions. <u>Do not leave any questions blank.</u> Will you charge me if:		
1. My child(ren) are ill & you care for him or her? What is the cost? \$ _____	<input type="radio"/> Yes	<input type="radio"/> No
2. My child(ren) are occasionally mildly ill, this may include (please describe common illnesses, such as colds or earl infection(s): _____	<input type="radio"/> Yes	<input type="radio"/> No
3. My child(ren) is absent because he or she is ill? What is the cost? \$ _____	<input type="radio"/> Yes	<input type="radio"/> No
4. My child(ren) is absent on holidays? What is the cost? \$ _____	<input type="radio"/> Yes	<input type="radio"/> No
5. My child(ren) is absent on vacation? What is the cost? \$ _____	<input type="radio"/> Yes	<input type="radio"/> No
6. Will you charge me a late fee if my child(ren) stays after the agreed upon time? What is the cost? \$ _____ / If charged, your late fee is?: \$ _____	<input type="radio"/> Yes	<input type="radio"/> No
7. Will you provide care in your home for my child(ren) during the night? If provided, I will bring the following items for my child(ren): _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
8. My child(ren) are allergic to the following medicines & foods: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
9. You may give my child(ren) medication: (CHECK ONE): <input type="radio"/> Anytime after talking it over with me. <input type="radio"/> Never without my specific written permission	<input type="radio"/> Yes	<input type="radio"/> No
10. I am willing to care for child(ren) with special needs, such as: <input type="radio"/> Handicapped <input type="radio"/> Abused/Neglected <input type="radio"/> Other: _____ He or she is diagnosed as having: _____ by his or her physician. Because of my child's disability, I would ask you to carefully follow the following restrictions or directions: _____ _____	<input type="radio"/> Yes	<input checked="" type="radio"/> No
11. Other: _____	<input type="radio"/> Yes	<input type="radio"/> No

Child(ren) under the age of 16 who take aspirin may contract Rey's Syndrome, an illness that may cause seizures, coma and/or death. It is recommended that child(ren) use a non-aspirin pain reliever such as acetaminophen or ibuprofen if such a pain reliever is necessary.

III. BEFORE CARE BEGINS Please mark YES or NO on ALL questions. <u>Do not leave any questions blank.</u>		
1. I have outlined the hours I need care or the authorization agreement.	<input type="radio"/> Yes	<input checked="" type="radio"/> No
2. Can my child(ren) & I visit you before actual child care begins?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
3. The following documents must be filled out by the parents & given to the child care provider: <input type="radio"/> An emergency record <input type="radio"/> Written permission to give my child(ren) medications. <input checked="" type="radio"/> Other (please specify): _____	<input type="radio"/> Yes	<input type="radio"/> No

IV. HOME Please mark YES or NO on ALL questions. Do not leave any questions blank.		
1. Each floor used for care has at least one unblocked exit & smoke detector.	<input type="radio"/> Yes	<input type="radio"/> No
2. I will provide each room used by child(ren) with good temperature, light & ventilation which is safe & comfortable for them	<input type="radio"/> Yes	<input type="radio"/> No
3. I will make sure my home & outside play area is free from hazards	<input type="radio"/> Yes	<input type="radio"/> No
4. I have the following items out of child(ren)'s reach or locked-up: <input type="checkbox"/> Litter & rubbish <input type="checkbox"/> Medications/drugs <input type="checkbox"/> Cleaning supplies, poisons, insecticides <input type="checkbox"/> Plastic bags <input type="checkbox"/> Guns, knives, scissors, & other sharp objects <input type="checkbox"/> Matches, cigarette lighters, & other flammable liquids <input type="checkbox"/> Sewage areas	<input type="radio"/> Yes	<input type="radio"/> No
5. Pets in our home are tolerant of child(ren) & have current rabies shots. List the animals in the home: _____	<input type="radio"/> Yes	<input type="radio"/> No
6. Will the child(ren) have access to your pets?	<input type="radio"/> Yes	<input type="radio"/> No
7. The outdoor play area is fenced &/or free from dangers. If it is not fenced, I will make sure the child(ren) are safe by: _____	<input type="radio"/> Yes	<input type="radio"/> No
8. I will provide areas which will be used by child(ren) in care that provides enough floor space to allow for play &/or activities appropriate to the child(ren)'s age.	<input type="radio"/> Yes	<input type="radio"/> No
9. Floors & walls are cleaned & maintained in a condition safe for child(ren).	<input type="radio"/> Yes	<input type="radio"/> No
10. My home has at least one D-1A10 (or larger) fire extinguisher in the kitchen, which is readily accessible & maintained and in operable condition	<input type="radio"/> Yes	<input type="radio"/> No
11. Combustible & flammable materials are not stored in water heater rooms, furnace rooms, laundry rooms or near a home heating source (stoves) but are stored in a safe place.	<input type="radio"/> Yes	<input type="radio"/> No
12. I have a plan to evacuate the child(ren) in the even of a fire.	<input type="radio"/> Yes	<input type="radio"/> No
13. There are at least two means of exiting the location where the child care will be provided	<input type="radio"/> Yes	<input type="radio"/> No
14. Toys & objects (including high chairs) are safe, durable, easy to clean & non-toxic.	<input type="radio"/> Yes	<input type="radio"/> No
15. Diaper changing or toileting is done in food preparation areas.	<input type="radio"/> Yes	<input type="radio"/> No
16. Storage, refrigeration, & preparation of food will be done carefully.	<input type="radio"/> Yes	<input type="radio"/> No
17. This home has safe drinking water.	<input type="radio"/> Yes	<input type="radio"/> No
18. There will be no smoking around the child(ren).	<input type="radio"/> Yes	<input type="radio"/> No
19. No one else will smoke around the child(ren) while in my home and in my care.	<input type="radio"/> Yes	<input type="radio"/> No
20. At least one smoke detector is installed at an appropriate location in the home	<input type="radio"/> Yes	<input type="radio"/> No
21. The location where child(ren) care will take place, has a first aid kit which is inaccessible to child(ren) & stored in a convenient location.	<input type="radio"/> Yes	<input type="radio"/> No
22. I will do monthly evaluation/fire drills with the child(ren).	<input type="radio"/> Yes	<input type="radio"/> No

V. PROGRAM OF CARE Please mark YES or NO on ALL questions. Do not leave any questions blank.		
1. Will my child(ren) be allowed to bring their own toys on specific days (as for show & tell)?	<input type="radio"/> Yes	<input type="radio"/> No
2. What personal belongings may my child(ren) bring to your home?: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
3. I agree not to hit, spank, shake or use any other form of physical punishment, or any discipline which is frightening to the child(ren), now will I call the child(ren) names which will hurt or threaten him/her.	<input type="radio"/> Yes	<input type="radio"/> No
Discipline should focus on rewarding good behavior, redirecting child(ren) who are misbehaving & setting clear & consistent limits. Cruel, humiliating & damaging disciplines should never be used. I allow NO physical punishment of my child(ren) while in your care.		
4. I am aware of each child's location at all times & will protect the child(ren) from dangers	<input type="radio"/> Yes	<input type="radio"/> No
5. I have a variety of toys & equipment: (Check which ones you have. It is not expected that you have them all). <input type="checkbox"/> Dolls <input type="checkbox"/> Records <input type="checkbox"/> Musical Instruments <input type="checkbox"/> Blocks <input type="checkbox"/> Sandbox <input type="checkbox"/> Small animals & people <input type="checkbox"/> Books <input type="checkbox"/> Stacking Toys <input type="checkbox"/> Play house equipment <input type="checkbox"/> Paints <input type="checkbox"/> Peg Boards <input type="checkbox"/> Clay / play dough <input type="checkbox"/> Puzzles <input type="checkbox"/> Cars & Trucks <input type="checkbox"/> Crayon, paper, scissors <input type="checkbox"/> Wagon <input type="checkbox"/> Dress-up Clothes <input type="checkbox"/> Construction Toys (Lego, Lincoln Logs, etc.)	<input type="radio"/> Yes	<input type="radio"/> No
6. I provide a variety of different things for child(ren) to do during the week. (Check the ones that you offer at least once per week. It is not expected that you provide all of these activities). <input type="checkbox"/> Reading <input type="checkbox"/> Music <input type="checkbox"/> Cooking <input type="checkbox"/> Story telling <input type="checkbox"/> Singing <input type="checkbox"/> Outdoors <input type="checkbox"/> Art activities <input type="checkbox"/> Building / construction <input type="checkbox"/> Dancing <input type="checkbox"/> Walks	<input type="radio"/> Yes	<input type="radio"/> No
7. My daily activities for child(ren) under the age 1 year, include: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
8. My daily activities for child(ren) between the ages 1 & 2 years, include: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
9. My child is ready for toilet training. Here are some guidelines for you to ensure the training is consistent: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
10. Outdoor play will be part of the child(ren)'s daily activities, except when the temperature is below ____ ° or the following extreme climatic conditions exist: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No
11. In cold weather, my child(ren) should wear: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No

VI. TRANSPORTATION Please mark YES or NO on ALL questions. Do not leave any questions blank.		
1. Will you be transporting my child(ren) while in your care?	<input type="radio"/> Yes	<input type="radio"/> No
2. Will you provide transportation to & from school or Head Start programs for my child(ren)?	<input type="radio"/> Yes	<input type="radio"/> No
3. Will there be a charge? What is the cost? \$ _____	<input type="radio"/> Yes	<input type="radio"/> No
4. If so, do you have car seats & seat belts in your care for my child(ren)	<input type="radio"/> Yes	<input type="radio"/> No
5. In a medical emergency, how will my child(ren) be taken to a hospital or physicians office?: _____ _____	<input type="radio"/> Yes	<input type="radio"/> No

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the Office of Children's Services to release the following:

- a. Information pertaining to any open child abuse investigation in which I have been identified as the alleged perpetrator, and
- b. dates of any substantiated reports of harm in which I have been identified as the perpetrator of child abuse and/or neglect, and
- c. dates of any negative foster care licensing actions.

(Complete a separate form for each foster parent and household member age 16 and older. The application provides only two Authorization for Release of Information forms. You may need to make extra copies.)

Last Name

First, Middle Initial

Maiden Name

Date of Birth

Social Security Number

Signature

Date

SPACE BELOW THIS LINE WILL BE FILLED OUT BY THE OFFICE OF CHILDREN'S SERVICES

Is the applicant identified as the alleged perpetrator in a substantiated Report of Harm or as a perpetrator in an open child abuse or neglect case? Yes No

Has the applicant ever been licensed? Yes No

Were there any negative licensing actions? Yes No

Signature and title of person completing the OCS portion of this form:

Printed Name & Title

Signature

Date

Child Care Assistance Program

Clearance for Placement

(Complete a separate form for each foster parent and household member age 16 and older. The application provides only two clearance for placement forms. You may need to make extra copies.)

Last Name		First Name		Middle Name
Date of Birth		Sex		Social Security Number
Address		City	State	Zip code
Aliases, Maiden Name, Previous Married Name(s)				Driver's License Number
Have you been previously licensed to care for any child(ren)? If yes, indicate city, state and type of care and dates of licensure: _____				<input type="radio"/> Yes <input type="radio"/> No
Have you ever had a license to care for children revoked or denied in Alaska or any other state? If yes, attach an explanation.				<input type="radio"/> Yes <input type="radio"/> No
Have you ever been investigated for child abuse or neglect? If yes, attach an explanation.				<input type="radio"/> Yes <input type="radio"/> No
Do you have physical, health, mental health, or behavior problems that might pose a risk to the health, safety, or well-being of children? If yes, attach an explanation.				<input type="radio"/> Yes <input type="radio"/> No
Do you have a domestic violence problem or an alcohol or other substance abuse problem that might pose a risk to the health, safety, or well-being of children? If yes, attach an explanation.				<input type="radio"/> Yes <input type="radio"/> No
Have you been convicted of or charged with a crime involving an imitation or controlled substance, violence, sexual assault, molestation, exploitation, arson, prostitution, or crimes against persons? If yes, attach an explanation.				<input type="radio"/> Yes <input type="radio"/> No

I authorize Tanana Chiefs Conference Inc Child Protection Program staff to review criminal justice, protective service, and licensing records and to share this information with the applicant/licensee. I certify the contents of this form and information provided with it are true, accurate, and complete.

Signature of Applicant/Adult Household Member

Date

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
2 Business name/disregarded entity name, if different from above
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ▶ _____
4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
5 Address (number, street, and apt. or suite no.) See instructions.
6 City, state, and ZIP code
7 List account number(s) here (optional)

Requester's name and address (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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number								
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Employer identification number								
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Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Payment Agreement Parent

Tanana Chiefs Conference--Child Care Assistance Program is designed to help working families pay for child care services. Child care providers must be licensed or be approved and registered with Tanana Chiefs Conference to receive payment. Payment will be made directly to the child care provider as an assistance grant. The client/parent is responsible for paying their family co-payment and any additional amount of child care cost that is not covered by TCC Child Care Assistance Program. This total amount must be paid directly to the child care provider by the parent.

Based on the family's monthly income, household size and child care cost, TCC-CCAP can pay up to 100%, but not to exceed the maximum payment amount. (100% may not mean 100% of the monthly bill because some providers charge more than we are allowed to pay them.) This in turn, means that the parent is responsible for any remaining balance after TCC-CCAP pays the amount on the approval letter.

I, _____, understand that I am responsible for paying my child care provider the Family Co-Pay amount each month and that I am receiving Child Care Assistance based on my income, household size and child care costs.

_____ I understand that the child care check will be issued directly to my child care provider.

_____ I understand that I must pay any remaining balance owed to my child care provider each month.

_____ I understand that I am required to report any changes in my household income, family size, or child care needs within 10 days of the change.

_____ I agree to return the attached provider payment agreement, completed by the child care provider and myself to TCC within 10 days from today's date.

_____ I understand that failure to report the above information within the 10 day timeframe could result in no coverage, case closure and/or repayment of all benefits received.

Parent Signature

Date

Parent's Printed Name

Case Worker Signature / Title

Date

Revised - May 2022

Payment Agreement Child Care Provider

(Please complete one form for each child)

Child's Name

Parent's Name

Child's Date of Birth _____

The monthly charge for child care is: \$ _____

Start date of care: _____ Do you charge more than TCC rates? __Yes __No

Child care hours are from _____ am/pm to _____ am/pm

Child care days are: Mon___ Tues___ Wed___ Thurs___ Fri___ Sat___ Sun___

This is: Full-time child care _____ Part-time child care _____

Payment by the parent to the provider is due by the _____ of each month.

Acknowledgment of Services

I understand that this child's parent is responsible for paying for Child Care services and that Tanana Chiefs Conference is providing Child Care Assistance to the provider based on household income, family size and child care costs.

I understand that it is the parent's responsibility to submit paperwork each month in order to receive this assistance and that incomplete or late paperwork may cause a delay in payment/non-payment. Tanana Chiefs Conference has net 30 days from the date of invoice to pay the Child Care Assistance Program's portion of the bill.

Provider's Signature and Date

Parent's Signature and Date

Name of Child Care Facility/Name: _____

Provider Phone Number: _____ Provider Email: _____

Provider Mailing Address: _____

PROVIDER INFORMATION The provider you select must be either licensed or otherwise approved to participate in the Child Care Assistance Program. The provider's full name is not required if you will be using a child care center.

Last Name		First Name, Middle Initial	
Facility Name		Telephone Number	
Physical Address		City	State
			Zipcode

HOURS OF CARE For each child, list the times during each day that care is needed based on your eligible activity. Use the **NOTES** page if more space is needed.

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

INCOME INFORMATION

List money you or anyone in your household receives from employment, including self-employment. Please provide proof. Do not include money belonging to a child under 18 years of age.

Name of Person Employed	Employer	Hourly Wage	# of hours worked	Monthly Gross Income	How often Received?	Do you expect this to change?
			/month		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/month		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/month		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/month		<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER INCOME

List any other money you or anyone in your household receives (not including income listed above). Please provide proof. Do not include money belonging to a child under 18 years of age. For example: Child Support, ASAP/ATAP, Unemployment benefits, VA Benefits, SSA/SSI Benefits, and Native Corp. Distribution (include only if exceeds \$2000 annually)

Name of Person Receiving Income	Source of Income	Amount Received	How often Received?	Do you expect this to change?
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

CHILD SUPPORT EXPENSES

Only legally obligated child support payments may qualify as a deduction. Please provide proof.

Does anyone in your household pay child support to someone outside of the home? Yes No Amount: \$ _____ Per: _____

MEDICAL/DENTAL EXPENSES

Only ongoing payments for allowable medical and dental expenses may qualify as a deduction. Please Provide Proof

Does anyone in your household have medical or dental insurance payments? Yes No Amount: \$ _____ Per: _____

Does anyone in your household have any other ongoing medical or dental payments? Yes No Amount: \$ _____ Per: _____

If Yes, please explain:

FAMILY ASSETS

Assets include but are not limited to items of ownership convertible into cash; notes and accounts receivable, securities, or real estate.

Does your family have combined assets totaling more than \$1,000,000.00? Yes No

Eligible activities include work, seeking work and participation in approved education or training programs. Use the NOTES page if more space is needed.

ELIGIBLE ACTIVITIES				
Name of person in Activity	Type of Activity (work/education/training)	Activity Schedule (A or B) Complete Below	Date Activity Begins	Anticipated Date of Completion (if applicable)

ACTIVITY SCHEDULE "A" List the times during each day the person participates in the activity.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _____	From: _____	From: _____	From: _____	From: _____	From: _____	From: _____	From: _____
To: _____	To: _____	To: _____	To: _____	To: _____	To: _____	To: _____	To: _____

ACTIVITY SCHEDULE "B" List the times during each day the person participates in the activity.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _____	From: _____	From: _____	From: _____	From: _____	From: _____	From: _____	From: _____
To: _____	To: _____	To: _____	To: _____	To: _____	To: _____	To: _____	To: _____

STATEMENT OF TRUTH

Under penalty of perjury of unsworn falsification, I certify that the statements made on this application and during my interview for assistance regarding the persons in my home, my household income, participation in eligible activities, and all other items that pertain to my possible eligibility for child care assistance are true and correct to the best of my knowledge.

I have read, or had read to me, and understand my rights and responsibilities as described on page 8 of this application.

Signature of Applicant _____ Date _____

Signature of other Adult Applicant _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information requested by the Department of Health & Social Services, its grantees, or its agents within the Department of Law. The requested information will only be in the administration of the Child Care Assistance Program, and will not be released to any other person or agency outside the Department of Health & Social Services, its grantees, or its agents within the Department of Law.

This release of information will be in effect while I am an applicant or participant of the Child Care Assistance Program, and for any later investigations pertaining to my eligibility and program benefits.

Persons or organizations that may be contacted include, not are not limited to, the Department of Law, the Department of Labor, the Department of Revenue, the Immigration of Naturalization Service, the Alaska Housing Finance Corporation, the Social Security Administration, local governments, public assistance program contractors and grantees, Native corporations, landlords, employers, school authorities, and private individuals.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

Your Signature

Signature of other Adult Household Member

Printed Name

Printed Name

Social Security Number

Social Security Number

Address

Address

Phone Number

Phone Number

Date

Date

NOTES

Lined area for notes.

YOUR RIGHTS AND RESPONSIBILITIES

SOCIAL SECURITY NUMBERS

Social security numbers are optional in accordance with 45 CFR 98.71 (a) (13). Social Security Numbers are not required for child care assistance eligibility. Eligibility may not be denied or withheld due to the failure of the applicant to provide a Social Security Number. When provided, Social Security Numbers are used to collect research data sets that do not identify specific individuals.

YOUR RIGHTS

You have the right to discuss any action taken on your application or case with your caseworker or with you caseworker's supervisor. Administrative Reviews If you disagree with a determination made by the local child care assistance office, you may request an administrative review of the determination to the Child Care Coordinator. You can do this by submitting a written request, along with all required documentation, within 15 working days of date you received the notice of determination from Tanana Chiefs Conference Child Care Program Office.

Send your request to:

Tanana Chiefs Conference
Attention: Child Care Assistance Program
122 1st Avenue, Suite 600 Fairbanks, AK 99701

Hearings

If you disagree with a decision made on a request for an administrative review, you may file a notice of appeal and request a formal hearing on the decision of the Child Care Assistance Program. You can do this by submitting a request for hearing in writing to the Department of Health & Social Services within 15 calendar days of the date you received the decision from the Child Care Program Office.

Civil Rights

Federal laws and regulations prohibit discrimination or the denial of participant on the basis of race, color, national origin, religion, sex, age, handicap or political beliefs in programs receiving federal financial assistance.

Americans with Disabilities Act of 1990

The Alaska Department of Health & Social Services and its grantees comply with Title II of the Americans with Disabilities Act of 1990

Your Responsibilities

As a participant in the Child Care Assistance Program you must:

- Notify your local child care assistance office within seven days following an income change in excess of \$200.00 a month, or any other change that would affect your family's program benefits or eligibility.
- Give your provider at least 14 days written notice of your family's intent to terminate child care except: -In case of sudden program ineligibility
- In the case of an allegation of abuse, harm, or serious risk of harm to a child in the provider's care
- Upon mutual agreement between the provider and yourself
- Pay the portion of authorized child care costs not paid on your behalf
- Renew your child care authorization in a manner timely enough to provide for continuity of care
- Review the provider's monthly billing statement to verify that care was billed only for hours of eligible activity; and
- Pay for child care costs if alternative care arranged during an unscheduled facility closure is unreasonably refused.

Penalty Warnings Erroneously Obtained Benefits

If the local child care assistance office determines that there is reasonable evidence you erroneously obtained benefits, steps shall be taken to reduce or withhold payment, to establish a repayment schedule, or to take other corrective action, as necessary, including probation, suspension or termination from the program.

Erroneously obtained benefits means program benefits received by a family that the family was not entitled to or that were received while noncompliance with a program requirement.

Child Care Assistance Evacuation Plan

Provider Name: _____

Physical Address: _____

GET OUT ALIVE! A FIRE ESCAPE PLANNER

This is your fire escape planner. If a fire starts, smoke and heat can kill you unless you plan in advance to escape quickly. You may have only a few minutes to reach safety. Everyone needs to know how to get out so they can act quickly and without panic.

Your fire safety plan requires:

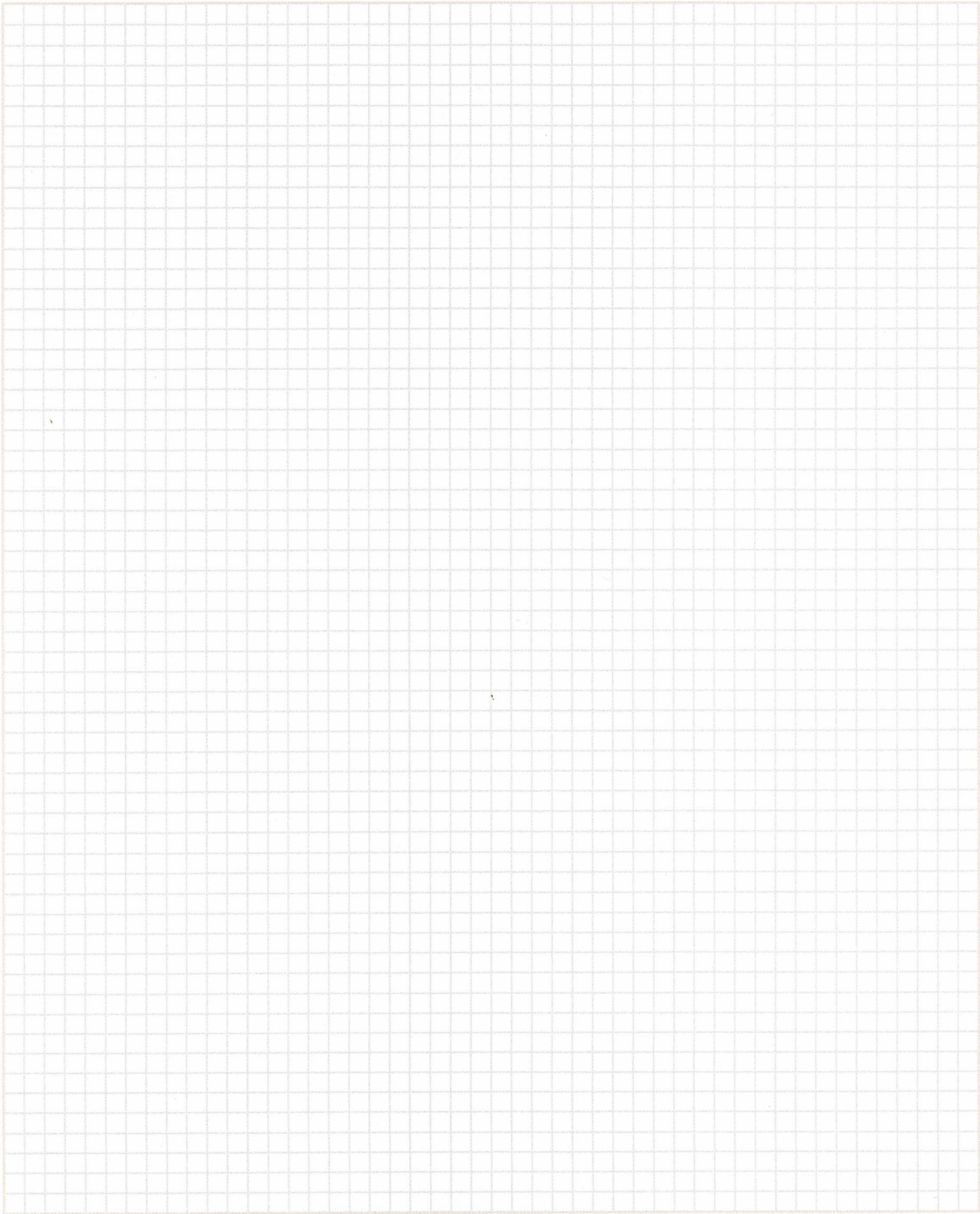
- Smoke detector on each level of your home and in each child's room
- Fire extinguisher on each level of your home
- Escape routes marked on the floor plan
- Specific meeting place outside your home
- Plan to evacuate everyone in 2 1/2 minutes, including children who can't get out by themselves
- Practice your escape plan monthly. Practice at different times of the day and using alternate exits.

Floor Plan:

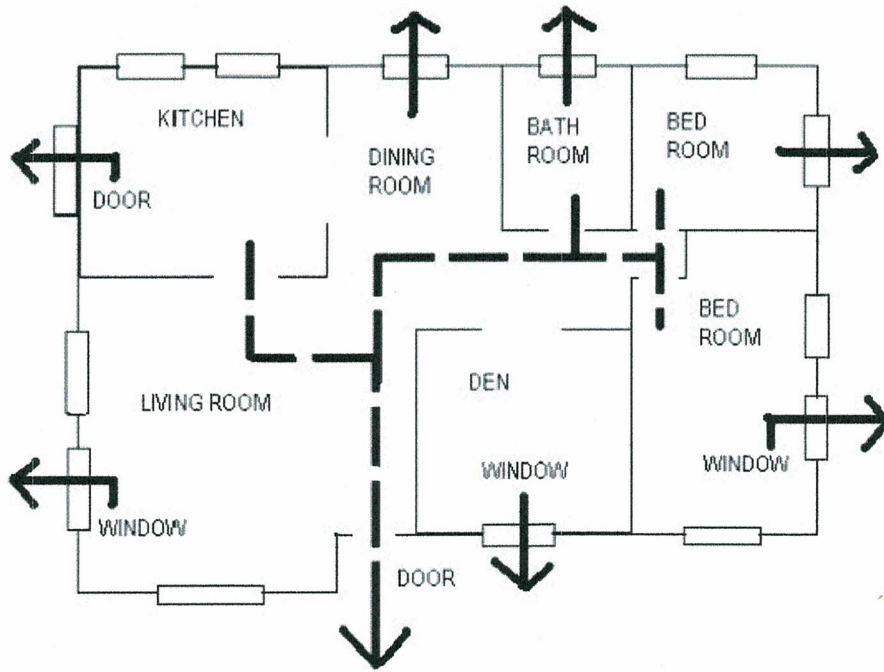
- The next page is a grid-line for you to draw a floor plan of your whole house (drawing does not need to be to scale).
- Shows exits from every room.
- Write down the outside meeting place.
- **See sample on page 13**

Exit Procedures:

- Sleep with bedroom doors closed. They will hold back deadly smoke.
- Teach everyone to recognize the sound of your smoke alarms.
- Test doors before opening them—if hot, use your alternate escape; if cool, brace your shoulder against the door and open it cautiously. Be ready to slam it if smoke or heat rushes in.
- Crawl low under smoke.
- If your clothes catch on fire: STOP, DROP, and ROLL!
- Get out fast!
- Choose a specific meeting place so you can see that everyone is out of the house.
- Don't go back inside once you are out!
- Call the fire department from a neighbor's house.



Sample Escape Plan



Floor Plan:

Show exits from every room (windows, doors).

Write down the outside meeting place.

Schedule monthly evacuation drills with the children.

Child Care Assistance Disaster Plan

Provider Name: _____

Physical Address: _____

Instructions: Create a disaster plan for the family just in case of emergency or in the event that the family needs to leave their home due to a natural disaster or catastrophic event. This form is completed by the provider during the initial licensing process and at each renewal. A copy will be given to the parents.

If the home where the children are being care for is needing to be evacuated, we would relocate to:

First Choice

Name:	Home Phone Number:
Address:	Cell Phone Number:
City, State, Zip Code	E-Mail Address:

Second Choice

Name:	Home Phone Number:
Address:	Cell Phone Number:
City, State, Zip Code	E-Mail Address:

Contact Person: (Contact information for the person with whom we would be in touch with in case of an emergency)

Name:	Home Phone Number:
Address:	Cell Phone Number:
City, State, Zip Code	E-Mail Address:

Local Child Care Coordinator Contact Person: (Contact information of local Child Care Coordinator)

Name: Angela Martinez	Home Phone Number: 907-452-8251 ext. 3365
Address: 122 1st Ave, Suite 600	Cell Phone Number:
City, State, Zip Code Fairbanks, AK 99701	E-Mail Address: angela.martinez@tananachiefs.org

I understand that:

- In an emergency, we are required to check in with the local Child Care Coordinator.
- Should any information included in this plan changes, we are to update the form within 14 days of the change and provide the local Child Care Coordinator with the update.

Printed Name

Signature

Date

Child Care Assistance Application Check List

**In order to process your application in a timely manner,
please provide the required items:**

- Completed and signed application with all areas completed. If your household is a two parent household both parents must sign the application.
- A copy of your unexpired government issued photo I.D. (Two parent household need both I.D's). We accept Tribal I.D's.
- Copies of official birth certificates for each child who will be receiving child care assistance.
- Tribal Enrollment or Certificate of Indian Blood (CIB) for all children who will be receiving child care assistance.
- Proof of income received by you or anyone in your household, excluding children under 18 years of age. This includes wages, tips, self-employed income, dividends and interest payments from Native corporations, Social Security, Supplemental Security Income (SSI), child support, and any other earned or unearned income.
- For gross wages amount, provide proof of income for the 4 most recent payments received (pay stubs).
- If you are attending high school, GED classes, vocational training, or college, we will need a copy of school schedule/training and your academic budget forecast.
- Proof of child support that you are paying, if applicable. Only legally obligated child support payments may qualify for a deduction
- Proof off ongoing medical and dental payments, if applicable. Only ongoing payments may qualify as a deduction.
- Completed Parent Payment Agreement. TCC Child Care assistance Program will only pay state licensed providers who are listed online at <https://dpaworks.dhss.alaska.gov/FindProviderVS8/zSearch.aspx>. Thread Resource and Referral can also help you find a licensed provider at 907-479-2204 or 866-878-2273. If you have requested to have a relative provide care for you your relative provider will need to complete a Relative Provider Registration.