

AVCP  
Association of Village Council Presidents  
Education, Employment, Training, and Child Care Division  
Pouch 219 \* Bethel, AK 99559  
1-800-478-3521

**CHILD CARE ASSISTANCE PROGRAM**

**PARENT APPLICATION PROCESS**

This application packet includes the Application for Services and the Child Care Assistance Program Application.

**Without the following photo copies of documents your application will be considered incomplete and will not be processed until they all have been received:**

- Income Tax Papers Form 1040. Year: 2007
- Check stubs (both parents or your significant other) for the months of: \_\_\_\_\_ (The last three months pay stubs copies)
- Immunization Records for the children needing child care services
- Your Tribal ID Card copy and your child(ren)'s enrollment number(s) copy forms or Tribal ID card copy (**No hand written number(s) are not acceptable**)
- If attending school or training a copy of School/University Acceptance Letter and class schedule (both parent and/or your significant other)
  1. You must select your own child care provider and they must submit a criminal background check and have been tested for TB with a negative result.
  2. An agreement must be made by you and your provider to the following location options that will best meet the needs of your child: ***Child's Home, Provider's Home, or a Child Care Center.*** The requirements are different for each location and they can be found in the Child Care Providers Application.

**\*\*NOTE\*\* AVCP Child Care cannot determine eligibility, until we have all the required paperwork and completed application form. Child care is approved from the date we receive ALL the necessary document to determine your case. No child care is approved before that date. You are responsible for all of your child care expenses unless otherwise notified by AVCP Child Care.**

If you need assistance in completing these forms, call 1-800-478-3521. The extension number(s) for Pauline Palacios - 7457, Frederika Chaney - 7458, Crystal Samuelson- 7456, and Gabriel Brink - 7459

**Your application will not be processed until all the required documents are submitted!**

# AVCP

Association of Village Council Presidents  
Pouch 219 \* Bethel, AK 99559 \* 1-800-478-3521

## EDUCATION, EMPLOYMENT, TRAINING & CHILD CARE DIVISION

### Child Care Application

Applicant:	Social Security Number:
Mailing Address:	Date of Birth:
City and Zip Code:	Telephone Number:
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female Degree of Native Blood:	Message Telephone:

MARITAL STATUS:         Single         Married         Divorced         Separated         Widowed

LENGTH OF TIME AT CURRENT RESIDENCE:        \_\_\_\_\_ Number of Years.        \_\_\_\_\_ Months.

TRIBAL MEMBERSHIP: \_\_\_\_\_ REGIONAL CORPORATION: \_\_\_\_\_

SELECTIVE SERVICE NUMBER: \_\_\_\_\_ VETERAN:  Yes         No

Please list your household members:

Name	Date of Birth	S.S. Number	Relationship	Occupation
1.			Self	
2.			Spouse or Child	
3.			Child	
4.			Child	
5.			Child	
6.			Child	
7.			Child	
8.			Child	
9.			Child	

Please list the income of all working members of your family including yourself:

Name of Person:	Source of Income:	The last six months:	Annual Income:

**RELEASE OF INFORMATION**

I authorize the individuals or agencies listed below to exchange information related to my current eligibility to participate in AVCP's assistance programs. I understand that I may revoke this consent by a written notice.

Name of individuals or agencies: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CERTIFICATION STATEMENT**

I hereby certify that the information provided herewith is true to the best of my knowledge. I understand that I am subject to immediate termination if I am found ineligible after enrollment. I understand that if I deliberately falsify information on this form, I may be prosecuted for fraud and / or perjury.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY**

ACTION TAKEN:                       Approved                       Disapproved                      Date: \_\_\_\_\_

Determination made by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for ineligibility: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**CHILD CARE ASSISTANCE PROGRAM  
PROGRAM REGULATIONS**

1. **Eligibility for Services:** You may receive and continue to receive Child Care Services for your child(ren) until such time your child(ren) reach the age of 13 years or 19 years if developmentally or physically disabled, or family income exceeds eligibility, or funding is no longer available; which ever occurs first.

Eligibility for Child Care Services will be based on the child(ren)'s family income. The standards used to determine eligibility is based on 75% of the State of Alaska's median income for the family of the same size. The Parent(s) must be participating in one or more of these activities: working, attending a vocational or educational facility or actively living a subsistence way of life.

2. **Parental Choice:** You may choose the following alternatives for Child Care Services:
  - enroll your child(ren) with a eligible Child Care Provider selected by the Parent(s); or
  - enroll your child(ren) in center based child care facilities if available; or
  - enroll your child(ren) in a before and after school program if available.
3. **Child Care Provider Registration:** Selected Child Care Provider's must register with the Child Care Assistance Program. A listing of registered Child Care Providers will be maintained at the Main Office in Bethel and in the Villages where a Child Care Specialist is based. Child Care Providers will be approved based on the following criteria:
  - Must be no less than 18 of age; and
  - Must meet minimum health and safety standards set by AVCP, and agree to have a quarterly inspections conducted by Child Care Staff; and
  - Must submit a negative tuberculosis screening form; and
  - Must agree to attend Pediatric First Aid and Minimum Health and Safety Standards Training sessions.
4. **Refusal of Child Care Providers:** AVCP's Child Care Assistance Program reserves the right to deny a Child Care Provider's application even if selected by the Parent(s), if adverse or detrimental information regarding the person's character is discovered as a result of the background investigation.
5. **Parental Access:** Parents shall have unlimited access to their child(ren) during the hours the child(ren) are in care.
6. **Health and Safety Requirement:** Proof of Immunizations: the Parent(s) of the child(ren) desiring Child Care Assistance must show proof that the required immunizations of the child(ren) are current and updated as necessary. The Child Care Facility must meet the Minimum Health and Safety Standards set by the Child Care Assistance Program.
7. **Orientation Classes:** Parents and Child Care Providers must enroll by application at the same time. During the application process the Child Care Coordinator or Child Care Specialist will explain the Child Care Assistance Program as follows:
  - Parental options / Unlimited access to the child(ren).
  - Complaint Procedures.
  - Responsibilities of the Parent, Child Care Provider, and the Child Care Assistance Program.
  - Agreements and Payments.

All Child Care Providers will be required to attend training classes provided by the Child Care Assistance Program. The training classes will cover these areas: Pediatric First Aid, Child Abuse and Neglect Prevention, Child Abuse and Neglect Reporting, and Minimum Health and Safety Standards.

8. **Attendance Policies for Head Start Program:** the Parent's must ensure that their child(ren) will attend the Head Start Program if offered in their village on the child(ren)'s scheduled school days.
9. **Agreement:** Both the Parent(s) and the Child Care Provider will sign an agreement with the Child Care Assistance Program outlining the terms and responsibilities of each party. The agreement will also outline conditions under which Child Care Services will be provided.
10. **Payments:** Child Care Services will be paid only for reasonable service costs as determined by the Child Care Coordinator. Payments will be made to the Parent only after the Child Care Assistance Program receives timesheets and a work verification form. The Receipt of Payment that the reimbursement check is taped to must be mailed back to the Bethel Office to continue receiving assistance.
11. **Sliding Fee Scale / Co-payments:** the Parent will pay a share of the child care costs as determined by the sliding fee scale. Failure to pay the Parent's share of the costs in any month will terminate any and all eligibility in the Child Care Assistance Program.
12. **Transportation of the Child(ren):** The Child Care Provider is advised not to transport the child(ren) of the Parents to and from appointments, school, etc. The Child Care Assistance Program will not be held liable for any accidents or problems that may occur if the Parent allows the Child Care Provider to transport the child(ren). Transportation to and from School or Head Start shall be the responsibility of the Parent.
13. **Release of the Child(ren):** The child(ren) should not be picked up by an unauthorized individual. If there is suspicion of intoxication or illegal drug use by the Parent's or others authorized to pick up the child(ren), the Child Care Provider is advised not to release the child(ren) in their custody. The Child Care Provider is advised to make other arrangements before the child(ren) can be released. If endangerment to the child(ren) is suspected, the Child Care Provider is advised not to release the child(ren). The Child Care Provider is advised to contact the local Police Department and the Division of Family and Youth Services.
14. **Waiver of Liability:** The Association of Village Council Presidents shall not be held liable for any accidents, injuries, or damages that may occur to the Parent, Child Care Providers, or the Child(ren) participating in the Child Care Assistance Program.
15. **Complaints:** If you have a complaint against AVCP, the Child Care Assistance Program, or the Child Care Provider concerning discrimination, violation of your rights, etc., you must submit a complaint in writing to the Division Director. The written complaint must be dated and signed. All complaints will be investigated and substantiated before action is taken. A record of all complaints will be maintained at the Child Care Assistance Program's Office.

**ACKNOWLEDGEMENT:** We, the undersigned, acknowledge that we have reviewed and understand the Child Care Assistance Program's Policies and Procedures, and the complaint procedures.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1<sup>st</sup> Child Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2<sup>nd</sup> Child Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child Care Specialist or Coordinator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CHILD CARE ASSISTANCE PROGRAM**  
**PARENT RESPONSIBILITIES**

As a parent participating in the Child Care Assistance Program, I agree to the following requirements:

1. I understand that program funds are for use only when I am participating in approved employment, education, training, or subsistence activities.
2. I understand that I will be reimbursed for a percentage of my monthly child care expenses. I understand that I must pay the remaining percentage.
3. I understand that I must pay the Child Care Provider the full amount of the reimbursement check once received or jeopardize my eligibility in the program.
4. I will secure a Child Care Provider who will accept my child(ren) on an attendance or scheduled enrollment basis, and provide them with a copy of the Letter of Authorization before child care services begin.
5. I will notify the Child Care Coordinator or Specialist serving my village and Child Care Provider within 7 days if authorized child care benefits will not be used, or if there are any changes to my original application.
6. I will give my Child Care Provider at least 14 days notice of my intent to end child care services, except in the case of immediate program ineligibility, or upon mutual agreement between myself and the Child Care Provider.
7. I will renew my Child Care Assistance Application or reapply early enough so child care services will not be interrupted.
8. I may use more than one (1) Child Care Provider as long as they are licensed, however, any costs incurred exceeding the authorized amounts are my responsibility.
9. I will fill out an emergency information record for each of my children for the Child Care Provider.
10. I understand that it is my responsibility to pay my Child Care Provider(s) for services provided if my application is not approved, or both parties applications are incomplete.
11. I understand that in order to get approved for Child Care Assistance both my and the Child Care Provider's Application must be complete.

**CHILD CARE ASSISTANCE PROGRAM PENALTY WARNING**

I certify that I have read and understand my responsibilities under the Child Care Assistance Program. I understand that it is fraud to misrepresent facts in order to receive reimbursement for child care services provided. I understand that fraud will result in removal from the program and that I will have to repay funds wrongfully obtained.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CHILD CARE ASSISTANCE PROGRAM

Please provide details on why you are in need of child care services. The information that you provide will help to determine your child care hours. Fill in the ones that apply to your situation.

### CURRENT EMPLOYMENT

Father's place of work: \_\_\_\_\_ Starting Time: \_\_\_\_\_ Quitting: \_\_\_\_\_  
 Work Days (circle the days that apply): SU, MO, TU, WE, TH, FR, SA. Hourly Wage: \$ \_\_\_\_\_  
 Mother's place of work: \_\_\_\_\_ Starting Time: \_\_\_\_\_ Quitting: \_\_\_\_\_  
 Work Days (circle the days that apply): SU, MO, TU, WE, TH, FR, SA. Hourly Wage: \$ \_\_\_\_\_

**Do you receive survivor's benefits for your child(ren)** \_\_\_\_\_ yes \_\_\_\_\_ no

**Do you receive Spousal or Child Support** \_\_\_\_\_ yes \_\_\_\_\_ no

**If yes, how much per month \$** \_\_\_\_\_

### EDUCATION OR TRAINING FACILITY

Include acceptance letter and class schedule.

Father's place of training: \_\_\_\_\_ Starting Time: \_\_\_\_\_ Quitting: \_\_\_\_\_  
 Training Days (circle the days that apply): Su, M, T, W, R, F, Sa. Expected Graduation Date: \_\_\_\_\_  
 Mother's place of training: \_\_\_\_\_ Starting Time: \_\_\_\_\_ Quitting: \_\_\_\_\_  
 Training Days (circle the days that apply): Su, M, T, W, R, F, Sa. Expected Graduation Date: \_\_\_\_\_

### SUBSISTENCE ACTIVITIES

Up to 5 or 10 days per month.

Father's subsistence activities: \_\_\_\_\_  
 \_\_\_\_\_

Mother's subsistence activities: \_\_\_\_\_  
 \_\_\_\_\_

Care will be provided at:  Child's Home  Provider's Home  Other \_\_\_\_\_

Name of Child Care Provider: \_\_\_\_\_

Is the Child Care Provider related to the Parent?  Yes  No What is the relationship? \_\_\_\_\_

### CHILD(REN) IN CARE

I am requesting \_\_\_\_\_ hours of child care services per day for the following children who are under the age of 13 (up to age 19 if disabled):

Name of Child(ren)	Date of Birth	School Days	School Hours
1.			
2.			
3.			
4.			
5.			
6.			
7.			

**CHILD CARE ASSISTANCE PROGRAM**

**EMERGENCY CHILD RECORD**

Name of Child (last, first, middle initial):	Date of Birth	Allergies (including foods, drugs, other):
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Special dietary needs for child(ren): (yes) or (no) \_\_\_\_\_

Medication or medical or other treatment required by the child(ren): (yes) or (no) If yes, \_\_\_\_\_

**HOW TO REACH PARENT(S) OR LEGAL GUARDIAN(S)**

Mother:	Father:
Home Address:	Home Address:
Home Phone:	Home Phone:
Business Place:	Business Place:
Business Phone:	Business Phone:

**Usual Physician/Health Clinic**

Name of Health Care Provider:	Address:	Telephone Number:

Person(s) who can assume responsibility if the parent or legal guardian cannot be reached during an emergency.

Name of person:	Address:	Telephone Number:
1.		
2.		
3.		

**Person(s) authorized to take the child(ren) from care.**

Name of person:	Address:	Telephone Number:
1.		
2.		
3.		

**CONSENT FOR EMERGENCY MEDICAL OR SURGICAL CARE**

This authorizes \_\_\_\_\_, my child care provider, to give permission to appropriate medical or hospital personnel to provide emergency medical or surgical care for the above named child(ren) in the event that I cannot be reached immediately. It is understood that a conscientious effort will be made to locate me or my child(ren's) other parent or legal guardian before any action will be taken. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care.

Signature of Parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of a witness: \_\_\_\_\_ Date: \_\_\_\_\_

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**REQUEST TO RELEASE INFORMATION**

I, \_\_\_\_\_ request that the Division of Public Assistance or \_\_\_\_\_  
Signature of Applicant other organization

release the following information from their files or records:

- ATAP/TANF BENEFIT HISTORY - Print out.
- Food Stamp Eligibility.
- Work hours and days. Supervisor must complete highlighted area.
- Other: \_\_\_\_\_

Employment Date: \_\_\_\_\_ Starting Time: \_\_\_\_\_ Quitting Time: \_\_\_\_\_ Starting Hourly Wage: \_\_\_\_\_

For the purpose of establishing eligibility in AVCP's Child Care Assistance Program. Program Year: \_\_\_\_\_.

Name of person receiving services: \_\_\_\_\_.

Social Security Number: \_\_\_\_\_ Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. Expires in one year.

Community: \_\_\_\_\_

Witness (if signed with an X): \_\_\_\_\_.

**FOR OFFICE USE ONLY**

**FORWARDING INSTRUCTIONS**

1. Mail the information to this address: AVCP  
Child Care Assistance Program  
Pouch 219  
Bethel, AK 99559

2. Mail to the Child Care Specialist at this address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Fax the information to the Attention of Pauline Palacios, Gabriel Brink, Fredrika Chaney, or Crystal Samuelson at 1-907-543-4261.

4. Fax the information to the Attention of \_\_\_\_\_ at \_\_\_\_\_.