Tanana Chiefs Conference

Child Care Assistance Program
122 1st Ave. Suite 600 Fairbanks, AK 99701
Phone: 907-452-8251 ext. 3360 or 3365
Toll-Free: 1-800-478-6822
Fax: 907-459-3914
Email: childcare@tananachiefs.org

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.

Tanana Chiefs Conference

Child Care Assistance Program

Child Care Assistance Application

For Office use Only
Date Received:

Use this application to apply for child care assistance benefits for children under 13 years of age, or for children 13 years of age up to 19 years of age who have a developmental disability.

PLEASE PRINT CLEARLY

APPLICANT INFORMATION

The applicant is the person who is requesting child care assistance.

Last Name:	First, Middle Initial	Social Security Number (optional)	
Physical Address	City	State	Zip Code
Mailing Address	City	State	Zip Code
Home Telephone / Cell Number	Email Address	Marital Status	Other Names You Have Used/Maiden Name/Alias

HOUSEHOLD INFORMATION

List each person living with you in your household, starting with yourself.

☐ Homeless - The above address is for contact information only

Last Name	First Name, Middle Initial	Date of Birth	Relation to You	Gender M / F	US Citizen? Y / N	Special Needs? Y / N	Ethnicity (*Optional*)	Race (*Optional* - Check all that apply)	
			SELF				☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Alaskan Native ☐ American Indian ☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Black or African American
							☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Alaska Native ☐ American Indian ☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Black or African American
							☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Alaska Native ☐ American Indian ☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Black or African American
							☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Alaska Native ☐ American Indian ☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Black or African American
							☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Alaska Native ☐ American Indian ☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Black or African American
							☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Alaska Native ☐ American Indian ☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Black or African American

*Provide a copy of the alien identification card (front and back) for each child that is not a U.S. citizen.

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: _______	From: _______	From: _______	From: _______	From: _______	From: _______	From: _______
To: _________	To: _________	To: _________	To: _________	To: _________	To: _________	To: _________

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _______	From: _______	From: _______	From: _______	From: _______	From: _______	From: _______
To: _________	To: _________	To: _________	To: _________	To: _________	To: _________	To: _________

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _______	From: _______	From: _______	From: _______	From: _______	From: _______	From: _______
To: _________	To: _________	To: _________	To: _________	To: _________	To: _________	To: _________

Child Care:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
From: _______	From: _______	From: _______	From: _______	From: _______	From: _______	From: _______
To: _________	To: _________	To: _________	To: _________	To: _________	To: _________	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		☐ Weekly ☐ Twice a month ☐ Every 2 Weeks ☐ Monthly	☐ Yes ☐ No
			/month		☐ Weekly ☐ Twice a month ☐ Every 2 Weeks ☐ Monthly	☐ Yes ☐ No
			/month		☐ Weekly ☐ Twice a month ☐ Every 2 Weeks ☐ Monthly	☐ Yes ☐ No
			/month		☐ Weekly ☐ Twice a month ☐ Every 2 Weeks ☐ Monthly	☐ Yes ☐ 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?
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ 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

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

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: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____	From: _____ To: _____

ACTIVITY SCHEDULE "B"

List the times during each day the person participates in the activity.

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

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.

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:_____