Child Care Assistance Program – Parent & Guardian Application

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

The Maniilaq WFD Child Care Assistance Program provides financial assistance to help pay for child care expenses to families with Alaska Native or Native American children living within the Maniilaq Service Area. The Child Care Assistance Program was created to help ensure that families are able to continue working or attend school/training to provide a better future for their children.

Eligibility Criteria

- Children **must** be enrolled into a Federally Recognized Tribe
- Reside within the Maniilaq Service Area (may be able to receive temporary assistance out of region on a case-by-case basis)
- Children must be under 13 years of age or children under the age of 18, if physically/mentally disabled
- Must meet income eligibility criteria (85% or below the State Median Income for Alaska)
- Must participate in an eligible activity which includes any of the following: employment, attending an educational program, treatment/prevention services, TANF work activities, or approved subsistence activities

Please follow up with WFD to complete the application process to avoid any delay or denial of services.

IMPORTANT: The applicant is responsible for paying Provider(s) while Childcare Assistance is being reviewed.

Required Document Checklist:

☐ Complete Childcare Assistance application
☐ Income for the last 30 days - Earned and unearned income for all household members on application
☐ Up-to-date immunization records for each child

Required if not on file:

☐ Tribal Enrollment for all children on application
☐ Birth certificates for all children on application
☐ Child Custody/Foster Care agreement - if applicable
☐ Disability statement for children - if applicable

☐ ***Employed Parents/Guardians:*** Verification of Employment or School Enrollment
☐ ***College Students:*** Class Registration/Schedule
☐ ***GED or Vocational Training Students:*** Verification of Employment or School Enrollment

Child Care Assistance Program Income Table *Income Limits are estimates based on household composition*		
Family Size	**Monthly Household Income Limits** (85% State Median Income)	**Maximum Monthly Co-Payment Amounts**
2	$4,905	$343
3	$6,059	$424
4	$7,212	$505
5	$8,367	$586
6	$9,521	$666
7	$9,737	$682
8	$9,954	$697
* **Rates and co-payments are subject to change**		

Eligibility Formula: Household Monthly Income – (COLA $3500) – ($100 per dependent child) = Household Income Limit

Example: $5,000 (GROSS INCOME) -$3,500(COLA) - $300 (3 children) = $2,200 (MONTHLY HOUSEHOLD INCOME)

Child Care Assistance Program – Parent & Guardian Application

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

Applicant Information

Full Name:	Maiden Name/Alias:
Email Address:	
Mailing Address:	
Physical Address:	
Phone Number: (H) (W) (C)	
Veteran: ◯ No ◯ Yes, Discharge Date:	Selective Services Registration: ◯ Yes ◯ No ◯ N/A
Marital Status: **(Please check one)**	◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed
Household Type: **(Please check one)**	◯ Single Parent ◯ 2 Parent Family ◯ Foster Family ◯ Adoptive Family
Is there an absent parent? No	Yes, Absent parent name:
Does the absent parent provide child support? No	Yes, Please Explain:
Do you receive State Child Care Assistance? No	Yes, Provide Verification of Assistance

Household Information - List all persons residing permanently in your household included on application. If you need additional space use another sheet of paper. PLEASE INDICATE WHICH CHILDREN NEED CHILDCARE BY MARKING THE BOX ON THE LEFT.

*	Name	Relationship	DOB	IRA Tribal Enrollment	SSN	Highest grade completed
		Self				

Do any children listed above have special needs? ◯ No ◯ Yes Please explain and provide verification of Disability.

Child's Emergency Contact - Someone other than the parent, guardian or child care provider(s).

Name:	Phone Number: (H) (W) (C)
Address:	Relationship to Child(ren)

Child Care Assistance Program – Parent & Guardian Application

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

Employment Information - Please provide verification of all earned or unearned income.

Parent/Guardian:		Parent/Guardian:	
Employer:		Employer:	
Phone:	Hourly Wage:	Phone:	Hourly Wage:
Please circle one or more: **Permanent Temporary Full-Time Part-Time**		Please circle one or more: **Permanent Temporary Full-Time Part-Time**	

Education Status

Name of School:	Name of School:
Type of School: **High School GED College or University** (Circle one) **Vocational Training Alternative School**	Type of School: **High School GED College or University** (Circle one) **Vocational Training Alternative School**
Address:	Address:
Phone:	Phone:

Child Care Provider(s)

1. Childcare Provider Name:		Phone Number:	
2. Childcare Provider Name:		Phone Number:	

Address of Care (where care will be provided)

List all household members where care will be provided, all members over 16 years old must pass a background check prior to approval.

Physical Street Address # 1:	Street Address # 2 (if applicable):

Name	Relationship	DOB	Name	Relationship	DOB

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

VERIFICATION OF EMPLOYMENT OR SCHOOL ENROLLMENT

Must be completed and signed by Employer or School Official

Applicant's Name: _____

Employer or School/Training Registrar

Employer or Institution Name: _____

Employer or Institution Address: _____

Phone Number: _____ Fax Number: _____

Employee's Job Title: _____ Date of Hire: _____

Employment/Program Start Date: _____ End Date: _____

Disbursement date of first check: _____ Hourly Salary: _____ Hours per Week: _____

Employee / Student Weekly Schedule (Example: 8:00AM-5:00PM)						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Please indicate applicant's employment or school status:

- ☐ Employment: ◯ Permanent Full-time ◯ Permanent Part-time ◯ Relief/On-call ◯ Other: _____
- ☐ College: ◯ Full-Time Student ◯ Part-Time Student ◯ Other: _____
- ☐ Vocational Training: Dates of training: _____
- ☐ Other, explain: _____

Notes (please include any other pertinent information):

Supervisor, HR or School Official Signature_____ Date _____

Printed Name _____ Title: _____

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

VERIFICATION OF EMPLOYMENT OR SCHOOL ENROLLMENT

Must be completed and signed by Employer or School Official

Applicant's Name: _____

Employer or School/Training Registrar

Employer or Institution Name: _____

Employer or Institution Address: _____

Phone Number: _____ Fax Number: _____

Employee's Job Title: _____ Date of Hire: _____

Employment/Program Start Date: _____ End Date: _____

Disbursement date of first check: _____ Hourly Salary: _____ Hours per Week: _____

Employee / Student Weekly Schedule (Example: 8:00AM-5:00PM)						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Please indicate applicant's employment or school status:

☐ Employment: ◯ Permanent Full-time ◯ Permanent Part-time ◯ Relief/On-call ◯ Other: _____

☐ College: ◯ Full-Time Student ◯ Part-Time Student ◯ Other: _____

☐ Vocational Training: Dates of training: _____

☐ Other, explain: _____

Notes (please include any other pertinent information):

Supervisor or HR/School Official Signature_____ Date _____

Printed Name _____ Title: _____

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

Applicant(s) Rights and Responsibilities

I understand Maniilaq Association & the WFD Child Care Program is not liable for my choice in child care provider.

I certify that I have checked the information on the application very carefully and that it is true and complete statement of facts to the best of my knowledge and belief.

I understand subsidized child care payments will not begin until all forms are completed and I have received written notice from the Child Care Program.

I am responsible for paying the provider for cost above the maximum authorized subsidy, I will be responsible to pay for child care costs not paid by the program.

I understand if I deliberately provide false information I will be required to repay the program for services received.

I understand I will be required to document my child's attendance which should reflect the hours of care provided.

I understand I may only document attendance when my child is attending the location where the provider has been approved to provide care.

I understand I must request a provider change to the WFD Child Care Program.

I understand it is my responsibility to report any suspected child abuse and neglect to the proper authority.

I understand parents, step-parents or legal guardians will not be paid as caregivers for their own children.

I understand information concerning my family regarding the Childcare Assistance program, and the services I receive, will be treated as confidential and will be used solely for the administration of the Childcare Assistance program.

I understand payment for my child's care will be made directly to the provider. It is my responsibility to pay the provider for additional services rendered any co-pays.

I understand it is my responsibility to inform my provider of all applicable Internal Revenue Service (IRS) payments for the end of the year reporting.

I must report changes to the Child Care Program within 10 days of a change and provide supporting documents.

I understand I may be asked to cooperate with state and/or federal personnel in any audit or quality assurance review. I further understand my failure to cooperate may result in termination from the program.

I understand Child Care Assistance may be terminated for any of the following reasons:

- Allowing another person to document attendance;
- Failing to pay my co-pay.
- I am no longer employed, in a training, education program or seeking self-sufficiency;
- I have been convicted of welfare and/or Childcare Assistance fraud;
- I falsify any required documentation; or
- My case has been inactive for ninety (90) days or more.

I understand my Child Care Provider may be suspended and/or terminated if failed to comply with any of the following:

- A substantiated health or safety hazard and/ or a conviction;
- Threatening behavior;
- False information on any form connected with the Childcare Assistance program;
- Being under investigation for fraud;
- A conviction or pending abuse or neglect charge against the provider, or a member of the provider's household if care is provided in the their home;
- Loss of licensure or registration when required by State law.

I understand I have the right to file a written complaint if:

- I believe I have been discriminated against because of race, color, age, sex, religion, disability, national origin, or ancestry; or
- My application for services was not promptly acted upon; or
- I disagree with an action taken regarding my eligibility.

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

You have the right to appeal in writing to the Workforce Development Program Director, regarding my program eligibility, percentage of subsidy or hours for which care is authorized.

Disclosure Statement: *18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.*

I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Maniilaq Association Workforce Development Childcare Assistance Program, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Childcare Assistance benefits, and/or the imposition of fines, civil damages, and/or imprisonment.

Printed Name of Applicant	Date	Printed Name of Co-Applicant	Date

Signature of Applicant	Signature of Co-Applicant

_____ **WFD Staff Initials (reviewed with applicant)**

APPLICANT APPEAL AND GRIEVANCE PROCESS

Maniilaq P.L 102.477 program has established a uniform appeal and grievance procedure applicable to all participants within our programs engaged in any type of activity included under the 102.477 Plan. The procedure insures due process and establishes a series of levels, starting with informal resolution at the staff level. The final tribal level of appeal for Maniilaq 102.477 programs is presented and resolved by the Maniilaq Association Tribal Government Administrator.

All appeals and grievances must be in writing and submitted within twenty (20) business days of the action being appealed. Applicants will be advised of determination(s) within ten (10) business days of receipt of written complaint(s). An appeal/ grievance may be sought by any participant within WFD Programs who believe that a violation has occurred with the applicants final determination.

The following procedure shall be used as the means of settling such appeal and/or grievances:

Step 1. The applicant will first make their complaint known to the caseworker within 20 days of the complaint.

Step 2. If the matter is not resolved to the satisfaction of the applicant, they will immediately put such complaint in writing and submit the caseworker's decision for review to the Employment & Training Lead Case worker at P.O. Box 256 Kotzebue, AK 99752.

Step 3. If the matter is not resolved to the satisfaction of the applicant, they will immediately request a hearing that the complaint be reviewed by the Workforce Development Director.

Step 4. If the matter is not resolved to the satisfaction of the applicant, they will immediately request, a request a hearing to review the Workforce Development Director's decision by the Tribal Government Services Administrator.

Step 5. The final tribal level of appeal for Maniilaq 102.477 programs is presented and resolved by the Maniilaq Association Tribal Government Administrator.

Maniilaq Association | **Workforce Development** | P.O. Box 256 | Kotzebue, AK 99752
Phone: (907)442-7021 | Fax: 1-866-832-9350 | email: etprogram@maniilaq.org

Authorization for Release of Information

I (applicant) _____, and (co-applicant) _____, hereby authorize the release of information requested by Maniilaq Association Workforce Development. I authorize Workforce Development to obtain and exchange information related to my application. This release of information shall be in effect while I am an applicant or recipient of Workforce Development Services.

Organizations that may be contacted include, but are not limited to: the Department of Law, the Department of Public Safety, the Department of Fish & Game, the Department of Labor, the Department of Military Affairs, Alaska State Housing Authority, Social Security Administration, local and tribal governments, public assistance program contractors, stock and grantees, Health Care Providers, Tax Assessors, Financial Institutions, Native Corporations, Stock Brokerage Firms, Landlords, Employers, School Authorities, and Tribal Government Services.

- Birth certificate
- Tribal Enrollment
- Income
- Native Corporation Shares and Distributions
- Immunization Records
- Employment or School Information
- Office of Children Services
- Disability Verification
- Other: _____

_____ _____ _____ _____
Printed Name of Applicant Date Printed Name of Co-Applicant Date

_____ _____
Signature of Applicant Signature of Co-Applicant