



Confederated Tribes of the Umatilla Indian Reservation
 Department of Children & Family Services
 Child Care Development Fund Program
 ChildCareAssistance@ctuir.org
 541-429-7813

Eligibility Criteria

1. Reside in the service area, which is on or near the Umatilla Indian Reservation. This includes: Pendleton, Helix, Adams, Athena, Weston and Pilot Rock.
2. Child(ren) must be enrolled with a Federally recognized Tribe or a direct descendant of Federally recognized tribe- MUST be verifiable.
3. Child(ren) must be under 13 years of age.
4. Applicant(s) must meet the income eligibility based on the Sliding Fee Scale.
5. Applicant(s) must demonstrate a need for child care such as one of the following:
 - a. Employment
 - b. Verified Job Training
 - c. Actively attending a College, University and Trade School

Required Documentation Checklist			
All required documents listed below must be submitted in full before your application will be processed.			
Completed application with signature of Applicant and Co-Applicant			
Verification of Tribal Enrollment or Descendancy (i.e. Tribal ID, Copy of CIB or letter from Tribe's Enrollment Office confirming status of enrollment). <ul style="list-style-type: none"> o Descendants: Official document confirming verification of descendancy. 			
Income <ul style="list-style-type: none"> • Paystub(s) that reflect an entire month from the prior month or employer generated income print out sheet. • Documentation of Child Support Enforcement Involvement and Payment(s). • Guardianship Assistance payment(s) received. • Copy of the page from your most recent income tax return that lists all dependents claimed and annual income. 			
Copy of immunizations -or- copy of state exemption for children receiving services.			
Evidence or proof of an Individualized Family Service Plan or Individual Education Plan.			
Completed Release of Information by Applicant and Co-Applicant.			
Resource/Foster Parents must submit evidence of care.			

Child Care Assistance Application	Date:
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Applicant Information				
Last Name	First Name	Middle Initial	Shirt Size	Employment Status:
Tribal Affiliation		Enrollment Number		
Street Address		Landlord/Property Management		
City, State, Zip Code		Cell Phone		
Reason for Applying:		E-Mail Address		
Have you ever applied for/received Child Care Assistance with:		If yes, please explain when:		
<input type="checkbox"/> CTUIR	<input type="checkbox"/> State of Oregon	<input type="checkbox"/> Other State(s)	Eligibility Period:	
Mailing Address (If different from above)		Preferred method of contact		
Are you a part-time/full-time student? If yes, please provide an unofficial transcript and schedule.		College/University/Trade School		
<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Are you experiencing houselessness?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	

Co-Applicant / Secondary Adult Information- Must be completed by other parent/adult residing in the household, and/or an individual acting as in loco parentis.				
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Last Name	First Name	Middle Initial	Shirt Size	Employment Status
Tribal Affiliation		Enrollment Number		
Street Address		Landlord/Property Management		
City, State, Zip Code		Cell Phone		
Reason for Applying:		E-Mail Address		
Have you ever applied for Child Care Assistance with:		If yes, please explain when:		
<input type="checkbox"/> CTUIR	<input type="checkbox"/> State of Oregon	<input type="checkbox"/> Other State(s)	Eligibility Period:	
Mailing Address (If different from above)		Preferred method of contact		
Are you a part-time/full-time student? If yes, please provide an unofficial transcript and schedule.		College/University/Trade School		
<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Are you experiencing houselessness?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	

HOUSEHOLD INFORMATION

All individuals living in the home

(First, MI, Last Name) <small>List ALL who reside in the home</small>	Age	Social Security#	DOB (MM/DD/YY)	Relationship to Head of Household	TRIBE and Enrollment Number
1					
2					
3					
4					
5					
6					
7					

Child Information

Last Name	First Name	Middle Initial	Shirt	Relationship to Applicant(s)				
Date of Birth		Months		Gender				
Does the child attend Immersion?				Language(s) spoken:				
Age Category: <i>Check the box that the child falls under.</i>				Special Needs: <i>Provide signed documentation.</i>				
<input type="checkbox"/> Infant – Newborn through 11 months <input type="checkbox"/> Toddler – 1 year (12 months) through age 2 (35 months) <input type="checkbox"/> Preschool – 3 years (36 months) through 5 years (age to attend Kindergarten)				<input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> If no, are you interested in an evaluation for intervention services?				
Is your child school age?				School District:				
<input type="checkbox"/> Yes		<input type="checkbox"/> No						
Name of School			Grade	Title VI Eligible?				
Does the child ride the bus?				Which days do they take the bus?				
<input type="checkbox"/> No		<input type="checkbox"/> Yes, please fill in information.		M	T	W	TH	F
School Bus Pick-Up				What time does the bus arrive/depart?				
Location(s):				AM		PM		
School Bus Drop-Off								
Location(s):				AM		PM		
Please use the space below to provide any information you feel is important but was not covered in the above section(s).								

Child Information				
Last Name	First Name	Middle Initial	Shirt Size	Relationship to Applicant(s)
Date of Birth		Months	Gender	
Does the child attend Immersion?			Language(s) spoken:	
Age Category: <i>Check the box that the child falls under.</i> <input type="checkbox"/> Infant – Newborn through 11 months <input type="checkbox"/> Toddler – 1 year (12 months) through age 2 (35 months) <input type="checkbox"/> Preschool – 3 years (36 months) through 5 years (age to attend Kindergarten)			Special Needs: <i>Provide signed documentation.</i> <input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> Are you interested in an evaluation for intervention services?	
Is your child school age?			School District:	
<input type="checkbox"/> Yes		<input type="checkbox"/> No		
Name of School		Grade	Title VI Eligible?	
Does the child ride the bus?			Which days do they take the bus?	
<input type="checkbox"/> No		<input type="checkbox"/> Yes, please fill in information.		
School Bus Pick-Up			What time does the bus arrive/depart?	
Location(s):			AM	PM
School Bus Drop-Off				
Location(s):			AM	PM
Please use the space below to provide any information you feel is important but was not covered in the above section(s).				

Child Information				
Last Name	First Name	Middle Initial	Shirt Size	Relationship to Applicant(s)
Date of Birth		Months	Gender	
Does the child attend Immersion?			Language(s) spoken:	
Age Category: <i>Check the box that the child falls under.</i> <input type="checkbox"/> Infant – Newborn through 11 months <input type="checkbox"/> Toddler – 1 year (12 months) through age 2 (35 months) <input type="checkbox"/> Preschool – 3 years (36 months) through 5 years (age to attend Kindergarten)			Special Needs: <i>Provide signed documentation.</i> <input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> Are you interested in an evaluation for intervention services?	
Is your child school age? (6 years/60 months through 12 years /155 months)?			School District:	
<input type="checkbox"/> Yes		<input type="checkbox"/> No		
Name of School		Grade	Title VI Eligible?	
Does the child ride the bus?			Which days do they take the bus?	
<input type="checkbox"/> No		<input type="checkbox"/> Yes, please fill in information.		
School Bus Pick-Up			What time does the bus arrive/depart?	
			AM	PM

Location(s):	AM	PM
School Bus Drop-Off		
Location(s):	AM	PM
Please use the space below to provide any information you feel is important but was not covered in the above section(s).		

Child Information							
Last Name	First Name	Middle Initial	Shirt Size	Relationship to Applicant(s)			
Date of Birth	Months			Gender			
Does the child attend Immersion?			Language(s) spoken:				
Age Category: <i>Check the box that the child falls under.</i>			Special Needs: <i>Provide signed documentation.</i>				
<input type="checkbox"/> Infant – Newborn through 11 months <input type="checkbox"/> Toddler – 1 year (12 months) through age 2 (35 months) <input type="checkbox"/> Preschool – 3 years (36 months) through 5 years (age to attend Kindergarten)			<input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> Are you interested in an evaluation for intervention services?				
Is your child school age?			School District:				
<input type="checkbox"/> Yes <input type="checkbox"/> No							
Name of School		Grade	Title VI Eligible?				
Does the child ride the bus?			Which days do they take the bus?				
<input type="checkbox"/> No <input type="checkbox"/> Yes, <i>please fill in information.</i>			M	T	W	TH	F
School Bus Pick-Up			What time does the bus arrive/depart?				
Location(s):			AM	PM			
School Bus Drop-Off							
Location(s):			AM	PM			
Please use the space below to provide any information you feel is important but was not covered in the above section(s).							

Emergency Contact Information	
Name	Relationship
Address	Phone Number

CHILD CARE PROVIDER

Child Care Provider/Center		E-Mail		Phone
Address	City	State	Zip	How did you hear about this provider?
Owner Name:				
Certification/License			License Number	
<input type="checkbox"/> State	<input type="checkbox"/> Tribe	<input type="checkbox"/> Other		

Provider Type: *Check one.*

<input type="checkbox"/> Center	<input type="checkbox"/> Relative Provider	<input type="checkbox"/> In-Home Provider	<input type="checkbox"/> Other
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Are all child(ren) currently enrolled with this provider?

How long has your child(ren) attended this provider?

Do you have a signed agreement or enrollment paperwork with this provider?	When does this agreement end/begin?
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Does this provider use the Brightwheel app?

Child Care Schedule - Days and Hours – *Establish below your demonstrated child care hours needed.*

Name of Child	Days					Hours of Care Needed		Meals While In Care			
	<i>Indicate with an X</i>					<i>From</i>	<i>To</i>	<i>Indicate with an X</i>			
<i>Please Print</i>	<i>M</i>	<i>T</i>	<i>W</i>	<i>Th</i>	<i>F</i>			<i>BKFST</i>	<i>AM Snack</i>	<i>Lunch</i>	<i>PM Snack</i>
						AM/PM	AM/PM				
						AM/PM	AM/PM				
						AM/PM	AM/PM				
						AM/PM	AM/PM				
						AM/PM	AM/PM				
						AM/PM	AM/PM				

Please use the space below to provide any information you feel is important but was not covered in the above section(s).
Identify any expected modification to the schedule throughout the year, such as any holiday break.

Applicant Employment Information		
Employer	Hourly Wage or Monthly Income: <i>Include paystub(s) that reflect a full month of income.</i>	
Pay Frequency		
Address	Supervisor	
City, State, Zip Code	Phone	
Position/Job Title	Department	E-Mail
Work Schedule <i>Indicate Days & Times below.</i>		
Co-Applicant / Secondary Adult Employment Information		
Employer	Hourly Wage or Monthly Income: <i>Include paystub(s) that reflect a full month of income.</i>	
Pay Frequency		
Address	Supervisor	
City, State, Zip Code	Phone	
Position/Job Title	Department	E-Mail
Work Schedule <i>Indicate Days & Times below.</i>		

Applicant Job Training		
Program/Agency Name	Hourly Wage: <i>Include paystub(s) that reflect a full month of income.</i>	
Program Type	Proof of Enrollment attached?	
Address	Supervisor	
City, State, Zip Code	Phone	
Position/Job Title	Department	E-Mail
Training Schedule <i>Indicate Days & Times below.</i>		
Expected Outcome	Expected Completion Date	
Co-Applicant / Secondary Adult Job Training		
Program/Agency Name	Hourly Wage: <i>Include paystub(s) that reflect a full month of income.</i>	
Program Type	Proof of Enrollment attached?	
Address	Supervisor	
City, State, Zip Code	Phone	
Position/Job Title	Department	E-Mail
Training Schedule <i>Indicate Days & Times below.</i>		
Expected Outcome	Expected Completion Date	

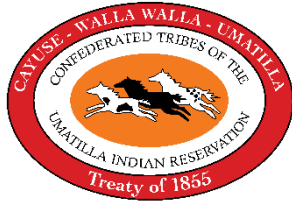
Applicant / Co-Applicant Treatment Information	
Program/Agency Name	Is this court-ordered?
Program/Facility Type	Scheduled to Begin
Address	Supervisor
City State Zip Code	Phone
Type of Treatment	E-Mail
Expected Outcome	Expected Completion Date
Schedule <i>Indicate Days & Times below.</i>	
<i>Please attach a signed verification letter from the treatment provider that includes confirmation, type of treatment, schedule and duration or expected completion date.</i>	

Income Information- <i>All sources of income must be reported.</i>		
Income Type <i>Employment, Child Support, Guardianship Assistance,</i>	Amount (Gross Monthly)	Proof Attached?
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
Total Income	\$	

By signing this application, I/We certify that the answers/information given on this application in reference to household composition, income, and family composition is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements or information are punishable under Federal Law. I/we also understand that false statements or information, misrepresentation, or omission of relevant information are grounds for termination of Child Care Assistance and termination of services. This application will not be valid unless completely filled out and signed by each applicant. I/We understand that submitting this application does not guarantee eligibility, approval, or receipt of services. All applications are subject to review, and additional documentation may be required.

I/We acknowledge that any findings or misrepresentation may result in penalties, including but not limited to a restriction period of 30, 60 or 90 days during which I/We will be ineligible to apply for services. Furthermore, I/We understand that I/We am/are ultimately responsible for all the child care expenses incurred while my child(ren) are applying or enrolled in the CTUIR Child Care Assistance Program, regardless of any financial assistance I may be receiving. Incomplete applications will be returned.

Applicant Signature <i>Required</i>	Date
Co-Applicant Signature <i>Required</i>	Date
DCFS Office Use Only Date and Time Received :	CCDF Staff Signature



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AUTHORIZATION TO RELEASE INFORMATION

I/We hereby authorize the release of information to _____
or its representative and assigns any and all information that they may require about my

This authorization is valid for a twelve-month period from the date of authorization.

Thank you,

Print Name: _____

Signature: _____

Date: _____

Print Name: _____

Signature: _____

Date: _____