



# *Smith River Rancheria Community and Family Services*

110 W. First Street, Smith River, CA 95567-9525  
Ph: (707) 487-9255 Fax: (707) 487-0137

## To Apply for Child Care Assistance Program you must complete the following:

- Submit the Provider's application along with a copy of their contract
- Trust-line provider's application along with a copy of their approval letter
- W9 Form
- Child's birth certificate/proof of tribal enrollment
- (CA Residence) apply at the Del Norte Child Care Council
- (Or Residence) Apply at Oregon Department Human Services (DHS) Child Care
- Return **completed application** and required documentation to the CFS office located at the address above.



# *Smith River Rancheria*

## *Community and Family Services*

110W First St, Smith River, CA 95567-9525  
Ph: (707) 487-9255 Fax: (707) 487-0137

### Application for Child Care Assistance Payment

Name of Parent/Guardian: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ WorkPhone \_\_\_\_\_

Alternate Phone (cell, message, etc.): \_\_\_\_\_

**Please complete for all adults in household:**

Name	Relationship to Parent/Guardian	Relationship to Child/Children	Tribal Affiliation
	SELF		

**Please complete for all children in household:**

Name	Date of Birth	Special Needs	Tribal Affiliation

I/We need child care because: Employment  School  Other

If other, please specify: \_\_\_\_\_

**Please complete for all income to household (ie. wages, child support, cash aid, etc)**

Name	Source	Monthly Amount	Total
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$



# *Smith River Rancheria*

## *Community and Family Services*

### Application for Child Care Assistance Payment (cont.)

#### Agreement

I understand that:

- Any facts I gave, including income and benefit facts will be verified with the appropriate employer or agency.
- If I gave wrong facts, my Child Care Assistance may be denied or stopped.
- I must report to the CFS office within ten (10) days if my household situation changes; if anyone moves in or out, if my/our income increases or decreases or if anyone starts or stops attending school or other activity that would affect my eligibility for child care assistance.
- My file may be selected for quality control review to ensure that eligibility was determined correctly and I must cooperate fully with Tribal personnel in any review.
- I, or other adult household members, will be required to repay any Child Care Assistance Payments I/we should not have received.
- I will be disqualified or suspended from participation in the Child Care Assistance Program if I give wrong facts or fail to report all facts or situations that could affect my eligibility.

I declare under penalty of perjury under the laws of the United States of America, and any other applicable laws, that the information I provided in this application is true, correct and complete.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# Community and Family Services

110 1<sup>st</sup> Street, Smith River, CA 95567-9525  
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## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION



Name (print): \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

The above named individual hereby authorizes Smith River Rancheria Community and Family Services (CFS) to:

- \_\_\_\_\_ Release any and all relevant confidential information;
- \_\_\_\_\_ Receive any and all relevant confidential information, with respect to the following agencies and organizations:
- \_\_\_\_\_ Social Services (county) \_\_\_\_\_
- \_\_\_\_\_ Parole/Probation (county) \_\_\_\_\_
- \_\_\_\_\_ Courts (county) \_\_\_\_\_
- \_\_\_\_\_ Referral Source \_\_\_\_\_
- \_\_\_\_\_ Tribe \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

### PURPOSE OF RELEASE

- \_\_\_\_\_ Facilitate mediation process
- \_\_\_\_\_ Arrange for referral to other partner organization/s
- \_\_\_\_\_ Comply with conditions of parole, probation, case plan or court-ordered services
- \_\_\_\_\_ Other \_\_\_\_\_

### RELEASE OF LIABILITY

\_\_\_\_\_ I understand that this information is or may be protected by federal, Tribal or other regulations and hereby release Smith River Rancheria CFS and the individual named above from any liability associated with the release of such information. I hereby waive any doctor-patient, psychiatrist-patient and/or psychologist-patient privilege with respect to the records released to the above named organization.

### REVOCACTION

\_\_\_\_\_ I understand that I may revoke the above consents at any time, except to the extent that action has been taken in reliance on this consent prior to revocation.

### TERMINATION

This authorization terminates twelve (12) months from the date of execution. A copy of this form shall be considered valid as an original.

Signature \_\_\_\_\_

Date \_\_\_\_\_

CFS Signature \_\_\_\_\_

Date \_\_\_\_\_

*Waa-saa-ghitlh-'a~ Wee-ni Naa-ch'aa-ghitlh-ni  
Our Heritage Is Why We Are Strong*



# Smith River Rancheria Community and Family Services

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## CHILD CARE ASSISTANCE EMPLOYMENT VERIFICATION

Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

The following information is requested to justify enrollment in the Child Care Assistance Program for your employee. All information provided will be used only to determine the eligibility status and benefit level for the household. All information provided will be kept confidential. Thank you for your cooperation

Your prompt return of the requested information will be appreciated.

Employment Start Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

Hourly Rate: \_\_\_\_\_

Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Other \_\_\_\_\_

Hours of Employment: from \_\_\_\_\_ to \_\_\_\_\_

Days and Hours per week:

Sunday \_\_\_\_\_

Monday \_\_\_\_\_

Tuesday \_\_\_\_\_

Wednesday \_\_\_\_\_

Thursday \_\_\_\_\_

Friday \_\_\_\_\_

Saturday \_\_\_\_\_

Total Hours per Week: \_\_\_\_\_

RELEASE: I hereby authorize the release of the requested information.

\_\_\_\_\_  
(Signature of Applicant)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## NOTICE:

**If this form is completed and signed by anyone other than the employer, it will be considered void and a new form will be issued for proper completion.**



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## CHILD CARE ASSISTANCE EMPLOYMENT VERIFICATION

Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

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Your prompt return of the requested information will be appreciated.

Employment Start Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

Hourly Rate: \_\_\_\_\_

Full-time \_\_\_\_ Part-time \_\_\_\_ Other \_\_\_\_

Hours of Employment: from \_\_\_\_\_ to \_\_\_\_\_

Days and Hours per week:

Sunday \_\_\_\_\_

Monday \_\_\_\_\_

Tuesday \_\_\_\_\_

Wednesday \_\_\_\_\_

Thursday \_\_\_\_\_

Friday \_\_\_\_\_

Saturday \_\_\_\_\_

Total Hours per Week: \_\_\_\_\_

RELEASE: I hereby authorize the release of the requested information.

\_\_\_\_\_  
(Signature of Applicant)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## NOTICE:

**If this form is completed and signed by anyone other than the employer, it will be considered void and a new form will be issued for proper completion.**



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<p><b>CHILD CARE ASSISTANCE EDUCATIONAL HOURS VERIFICATION</b></p> <p>School: _____ Address: _____ Phone: _____</p> <p>The following information is requested to justify enrollment in the Child Care Assistance Program. All information provided will be used only to determine the eligibility status and benefit level for the household. All information provided will be kept confidential. Thank you for your cooperation</p> <p>Your prompt return of the requested information will be appreciated.</p>	<p>Term Start Date: _____</p> <p>Status: Full-time ____ Part-time ____</p> <p>Classroom Hours: from _____ to _____</p> <p>Days per week: Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____</p> <p>Estimated Additional Study Time: _____ hours</p> <p>Total Hours per Week: _____</p>
<p>RELEASE: I hereby authorize the release of the requested information.</p> <p>_____ (Signature of Applicant)</p> <p>Date: _____</p>	<p>Signature: _____</p> <p>Print Name: _____</p> <p>Title: _____</p> <p>Date: _____</p>
<p><b>NOTICE: Please attach a copy of your current registration to this form before returning.</b></p> <p><b><u>If this form is completed and signed by anyone other than the school counselor/representative, it will be considered void and a new form will be issued for proper completion.</u></b></p>	



# Smith River Rancheria Community and Family Services

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## CHILD CARE ASSISTANCE EDUCATIONAL HOURS VERIFICATION

School: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

The following information is requested to justify enrollment in the Child Care Assistance Program. All information provided will be used only to determine the eligibility status and benefit level for the household. All information provided will be kept confidential. Thank you for your cooperation

Your prompt return of the requested information will be appreciated.

Term Start Date: \_\_\_\_\_

Status:  
Full-time \_\_\_\_ Part-time \_\_\_\_

Classroom Hours:

from \_\_\_\_\_ to \_\_\_\_\_

Days per week:

Monday \_\_\_\_  
Tuesday \_\_\_\_  
Wednesday \_\_\_\_  
Thursday \_\_\_\_  
Friday \_\_\_\_

Estimated Additional Study Time:  
\_\_\_\_\_ hours

Total Hours per Week: \_\_\_\_\_

RELEASE: I hereby authorize the release of the requested information.

\_\_\_\_\_  
(Signature of Applicant)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTICE: Please attach a copy of your current registration to this form before returning.**

**If this form is completed and signed by anyone other than the school counselor/representative, it will be considered void and a new form will be issued for proper completion.**



## Provider Information

### **AGREEMENTS:**

- I will allow Tribal Child Care Eligibility Staff visit my home, facility or other place where care is provided;
- I will follow the Tribe's Provider requirements checklist and/or In-Home Provider checklist;
- I will charge the same rate for subsidized children as non-subsidized children;
- I understand that failing to complete required attendance and billing information may result in late or non-payment of fees from the Tribe;
- I will not discriminate against any parent or child because of race, creed, color, or disability;
- I will comply with all applicable licensing regulations;
- I will allow parents/guardians full access to their children at any time.

**Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Child Care Assistance Program  
Required Health and Safety Standards  
Provider Checklist**

These standards are mandatory for all providers and shall be completed by child care provider and applicant/participant and reviewed by Child Care Assistance Staff before payment can be made.

Child care providers may receive a Home Visit to verify safety standards compliance. CFS staff is available to provide instruction and assistance.

1. Home has smoke detector(s). yes \_\_\_ no \_\_\_ will get \_\_\_ date: \_\_\_\_\_
2. Home has at least one working fire extinguisher. yes \_\_\_ no \_\_\_ will get \_\_\_ date: \_\_\_\_\_
3. Provider has appropriate safety car seat(s) when transporting child(ren) and a current valid state-issued driver's license. yes \_\_\_ no \_\_\_ will get \_\_\_ date: \_\_\_\_\_
4. All dangerous chemicals or cleaning supplies out of the reach of small children inside and outside. yes \_\_\_ no \_\_\_ working on \_\_\_ completion date: \_\_\_\_\_
5. Provider agrees to read all informational mailings on Health and Safety Standards and other program information. yes \_\_\_ no \_\_\_
6. Home has an over all clean, safe and sanitary environment. yes \_\_\_ no \_\_\_
7. All guns in locked cabinets. yes \_\_\_ no \_\_\_
8. Home has safe outdoor play area with constant supervision. yes \_\_\_ no \_\_\_
9. All dangerous animals and pets out of reach of children. yes \_\_\_ no \_\_\_
10. Home has all unused electrical outlets capped with plastic plugs. yes \_\_\_ no \_\_\_ will get \_\_\_
11. Provider has TB (tuberculosis) testing and results on file for all staff. yes \_\_\_ no \_\_\_ will get \_\_\_
12. Provider has a disaster plan with practice drills not less than monthly. yes \_\_\_ no \_\_\_ working on \_\_\_
13. Provider and all staff fingerprinted and background checked. yes \_\_\_ no \_\_\_ working on \_\_\_ completion date: \_\_\_\_\_
14. Home has five-foot fence and locking gate around swimming pool/spa area. yes \_\_\_ no \_\_\_ working on \_\_\_
15. Home has not less than 2 exits/entrances accessible. yes \_\_\_ no \_\_\_

\_\_\_\_\_  
*Provider Signature and Date*

\_\_\_\_\_  
*Applicant/Participant Signature and Date*

\_\_\_\_\_  
*CCAP Signature and Review Date*

\_\_\_\_\_  
*Follow Up Review Date*

**Child Care Assistance Program  
Health and Safety Standards  
Relative Provider Checklist**

Certain relative providers (grandparents, aunts, uncles, adult siblings not living in the home) are exempt from some licensing, fingerprinting, background checks and health and safety standards. In order to receive this exemption, you and your provider must prove the relationship linkage by providing documentation of the connection. Birth certificates are the preferred method of documentation; however, other reliable documents may be allowed.

Relative providers must have:

1. Working smoke detectors \_\_\_\_\_
2. At least one working fire extinguisher \_\_\_\_\_
3. Appropriate car seat(s) for transportation and a valid state-issued driver's license \_\_\_\_\_
4. Dangerous chemicals and cleaning supplies out of reach of children in locked cabinets \_\_\_\_\_
5. Agree to read all informational mailings on Health and Safety Standards and other program information \_\_\_\_\_
6. An overall clean, safe and sanitary environment \_\_\_\_\_
7. All guns stored in locked cabinet \_\_\_\_\_
8. Safe outdoor play area with constant supervision \_\_\_\_\_
9. All dangerous animals or pets out of reach of children \_\_\_\_\_
10. Not less than 2 exits/entrances accessible at all times \_\_\_\_\_

\_\_\_\_\_  
*Provider Signature and Date*

\_\_\_\_\_  
*Applicant/Participant Signature and Date*



**SUBJECT: Complaint Resolution Procedure**

**OBJECTIVE: To establish a procedure by which complaints are swiftly heard and resolved.**

**INTENT: Program related complaints are heard and resolved or referred within 20 business days.**

**PROCEDURE:**

The complaint resolution procedure is a problem-solving mechanism in which every attempt is made to resolve issues at the lowest level of authority with the least amount of program disturbance. Complaints or grievances that can be heard under this process are written complaints alleging Program Regulations or Department Policies and Procedures (as applicable) were: a) not followed; b) administered in a discriminatory (unequal) fashion; or c) administered in an arbitrary and capricious (unfair) fashion.

The following concepts shall apply when lodging a complaint or grievance:

- A. All information shall be submitted in writing, signed and dated by the applicant/participant;
- B. Anonymous complaints will not be accepted or considered;
- C. Complaints must be presented within 30 calendar days of the adverse action;
- D. Supporting information may be submitted, and shall be shared with all parties;
- E. The content of all meetings shall be kept confidential. If the complainant chooses to discuss the process with outside parties, staff may discuss the issue with the same parties;
- F. All reasonable efforts shall be made to keep the complaint resolution local, involving as few people as possible;
- G. Complaints or grievances alleging criminal acts or immediate danger to children or other vulnerable people are dealt with immediately by program officials, parents, and other authorities as appropriate;
- H. Program staff will maintain a file of program complaints at the CFS office. This file, not including confidential information, may be reviewed by interested parties by request during normal business hours. The contents of the file are the property of Smith River Rancheria and may not be copied or distributed in any manner.

1. Before a formal complaint or grievance can be filed by an applicant/participant, direct discussion between the person(s) whom the complaint involves is encouraged. Involved parties should record the date and time of all informal discussions.
2. If the complaint is not resolved, or if no action occurs within five working days, the complaint may be presented in writing to the Community and Family Services Director, who will review the matter and give a written response within 10 working days.
3. If the complaint still cannot be resolved, or if no action occurs within the ten working days, the complaint may be presented in writing to the Tribal Administrator, who will review the matter as an administrative issue and will give a written response within five working days.
4. If the complaint is not resolved at the administrative level, the Tribal Administrator shall declare an impasse, and the matter shall be referred to Tribal Court



# *Smith River Rancheria*

## *Community and Family Services*

13140 B Highway 101 Smith River, CA 95567-9525  
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### **TYPES OF INCOME AND TYPES OF PROOF REQUIRED** **ALL PROGRAMS**

#### **A. EMPLOYMENT INCOME BEFORE ANY DEDUCTIONS, INCLUDING TIPS AND INCOME FROM BUSINESS (SELF EMPLOYMENT INCOME)**

1. Statement from employer showing gross income, including tips, from the past twelve (12) months or indicating dates of employment. If less than 12 months, the two most current check stubs; or
2. W-2 Forms from each employer you worked for during the previous year; or
3. If self-employed, a complete, signed Income Tax Return, including any Schedule C (Small Business), Schedule E (Rental Property Income), Schedule F (Farm Income) and any other applicable schedule, from the previous year.
4. If documents above are not available, sworn statements and/or affidavits may be accepted, on a case by case basis.

#### **B. UNEARNED INCOME**

1. Social Security Award Letter or other document supplied by Social Security showing your income.
2. Any other official document(s) showing income received from Pensions, Disability Income, Regular Insurance or Annuity payments or Military Allotment, including any other Retirement benefits received.
3. Bank Statements showing automatic deposits.
4. For Tribal disbursements, Per Capita and/or other Indian Trust Income, proof of income received, such as copy of check or letter from Tribe.

#### **C. UNEMPLOYMENT COMPENSATION OR UNION STRIKE BENEFITS**

1. Verification of income form completed by the applicant/participant's State Employment Office.
2. Verification of income form from Union, if applicable.

#### **D. WELFARE, TANF, INDIAN GENERAL ASSISTANCE, WORK TRAINING STIPEND**

1. Written statement from the agency detailing the amount of money currently received, received during the past twelve months, the beneficiaries and how often the income is distributed.

#### **E. ALIMONY AND/OR CHILD SUPPORT PAYMENTS**

1. Copy of Separation or Settlement Agreement or a Divorce Decree stating Amount and Type of Support and Payment Schedules.
2. Copy of latest check.
3. Statement from Support Enforcement Agency showing an effort is being made to collect current payments or back payments if applicable.