Y N Child Care & Development Fund
131 Wishpoosh Road, Toppenish, WA 98948
PHONE: (509) 865-5121, Ext. 4359, 4357, 4295

If you have any Questions please call YN CCDF office

YN CCDF office will only accept Completed applications.

The Child Care and Development Fund will lead and coordinate with the Tribal Lead agency, grants & contracts, Applicant/ Providers, and the Granting agency. This program will maintain / establish standards of monitoring process to ensure the Health & Safety practices of Child Care Settings, Support Continuous Quality Improvement. Provide stable child care financial assistance to families, ensure equal access to High Quality Child Care. Promote Culture/Language revitalization and Family engagement through outreach and consumer education.

All Documents you will need to submit with your application:

- ☐ **Identification for both parents/guardian**
- ☐ **Address Verification for both parents, guardian**
- ☐ **Enrollment Verification for parents, guardian & children**
- ☐ **Birth Certificate(s) for Child (ren)**
- ☐ **Immunization Record for Child (ren)**
- ☐ **School Verification for Child (ren) (5 yrs+)**
- ☐ **Employment/Training/Educational Verification for both parents/guardian**
- ☐ **Income Verification (check stubs, gaming per capita, TANF, child support, Etc.) For both parents/guardian**

- ☐ **Supervisor form filled out by your supervisor (Page 5 in application) For both parents.**
- ☐ **Licensed Child Care Provider (Tribal or State) only**

The YN Child Care and Development Fund program is a federally funded program. We will NOT tolerate abuse of the program of Fraud. If your application is approved on false, incomplete or obstructed pertinent information, you will be required to repay all CCDF monies and you will no longer be eligible for services nor permitted to make further application.

Yakama Nation

Child Care and Development Fund (CCDF) Application

Applicant Information:

E-mail: _____

Applicant's Signature: _____ **Date:** _____

PRINT

Mother's Name: _____ **Personal Phone #:** _____

Mailing Address: _____
STREET/ P.O. BOX CITY ZIP

Physical Address: _____
STREET CITY ZIP

Employer/Company: _____ **Bus. P#:** _____

Father's Name: _____ **Personal Phone #:** _____

Mailing Address: _____
STREET/ P.O. BOX CITY ZIP

Physical Address: _____
STREET/ P.O. BOX CITY ZIP

Employer/Company: _____ **Bus. P#:** _____

Marital Status: (Circle One) SINGLE MARRIED SEPARATED DIVORCED

Custody Of Children: **If divorced/separated or never married to biological mother or father of children, do you have legal custody of your child(ren)?** ***YES or NO ----If you have legal custody please attach a copy of the Custodial Agreement issued by either a state court or tribal court is required.***

Legal Guardian: _____ **Personal Phone #:** _____

Mailing Address: _____

Physical Address: _____

Employer/Company: _____ **Bus. P#:** _____

Are you applying for a child who is in Foster Care, Emergency Care or Adoptive Care? YES or NO If yes, please provide all supporting legal documents.

Do you have a child with Medical, Behavioral, Physiical, Emotional Special Needs or Medically Fragile? YES or No

Please attach all current documents received from physician, school, or other agency

Tribal Affiliation:

Are you a tribal member? YES or NO Spouse? YES or NO Child(ren)? YES or NO

Tribe: _____

Tribal Office Address: _____

CCDF APPLICATION SCREENING CHECKLIST:

Documentation of homelessness? YES or NO or N/A

Documentation of seeking permanent housing for family stability? YES or NO or N/A

It is the responsibility of the parent to report any changes in circumstances

LIST ALL PERSONS LIVING IN HOUSEHOLD.

Name	*Date Of Birth*	*Relationship*	*Tribe*	*Child Care Needed*
1		*Self*		YES / NO
2				YES / NO
3				YES / NO
4				YES / NO
5				YES / NO
6				YES / NO
7				YES / NO
8				YES / NO

INCOME INFORMATION:

Must provide this information (Include all persons' income living in the house.)

Household Size: _____

Total Household Income: **$** _____

Include All Income, TANF, Food Stamps, Child Support, RAP etc. ***(Application will not be processed without this information.)***

New Federal regulations require that a parent is receiving funding from the federal government for child care, the parent must give a detailed school schedule for each child that will be on the CCDF program. If a schedule is not provided, it will delay payment for your child care provider. If your child is less then 5 years old, no schedule is required. Children from 5 years and up are REQUIRED to show school attendance, along with hours of operation and holidays for school attended. **No current schedule provided, no processing of your application. NO EXCEPTIONS.**

TRAINING PROGRAM:

This TRAINING part of the application is for the ADULTS who are counted in the family & going back to school.

Applicant: _____

Training School Name: _____

Contact Name: _____ **Phone#:** _____

_____ **Message#:** _____

Address: _____

Spouse: _____

Training School Name: _____

Contact Name: _____ **Phone#:** _____

_____ **Message#:** _____

Child Care & Development Fund Emergency Information

Child(ren) Name: _____

_____

Home# & or Cell#: ( ) ( )

Email Address: _____

Emerg. Contact Name: _____ **Phone#:** _____

Home Address: _____

Relationship To Applicant: _____

Name of Relatives and Friends to call, if you cannot be reached

Name: _____ **Phone#:** _____

Relationship to Child: _____

Name: _____ **Phone#:** _____

Relationship to Child: _____

Name: _____ **Phone#:** _____

Relationship to Child: _____

Physician, Dentist, & Hospital Information

Does your child(ren) have a specific physician to be contacted? _____ **YES or NO**

Clinic's Name: _____

Doctor's Name: _____ **Phone#:** _____

Dental Office Name: _____

Dentist Name: _____ **Phone#:** _____

Is there a PREFERENCE of the HOSPITAL to call and/or your child(ren) be taken to:

_____ **Phone#:** _____

Does your child(ren) have any chronic diseases? YES or NO

DESCRIBE: _____

Does your child(ren) have any allergies of any kind? YES or NO

DESCRIBE: Foods? _____

Drugs? _____

Other? _____

Applicant's Signature: _____ **Date:** _____

REVIEW PROCESS OF APPLICATION

PLEASE READ THE FOLOWING ELIGIBILITY, NEED CRITERIA, & DOCUMENTATION & PLEASE INITIAL. THANK YOU FOR YOUR COOPERATION & ASSISTANCE.

The CCDF program is funded by the federal government and such funding is limited by congressional budgetary cut backs. Upon submission of your application to the CCDF Program, it may take up to 1 (month) or more to process. No application will be approved nor fully reviewed if there are missing documents.

Initials: _____

GENERAL REQUIREMENTS EMPLOYMENT/EDUCATIONAL:

To receive Federal subsidized CCDF benefits, families must meet eligibility and need criteria. The child(ren's) parent(s) must be working or attending school. Evidence of a street address or post office address. A work schedule is required. A copy from the educational institution will be required to establish school attendance by applicant.

Initials: _____

CHILDREN'S AGE:

Children requiring child care services must be no older than 12 years of age. Children with exceptional needs may be served through the age of eighteen (18). Parent(s) who have a child with severe medical disabilities must provide documented evidence of the child's disability from a licensed professional. **Initials:** _____

ELIGIBILITY CRITERIA:

1. Family who has children with disablities (Mental, Physical, documented by a specialist.)
2. Famiy involved with Child Protective Services (CPS) as defined in the "Definition"
3. Family is a public assistance recipient (TANF Recipients)
4. Family income falls below the Tribal Income guideline. (Guideline Changes Yearly)
5. Applicant must be working or attending school.
6. Children must be under the age of thirteen (13) years old.
7. Applicant or applicant child(ren) must be an enrolled tribal member. **Initials:** _____

NEED CRITERIA:

Need shall be established by meeting one criteria below:

1. **The parent & any other adult counted in the family size are any of the following: Employed** (including court ordered community service). If the parent (or other adult counted in the family size) works in the home, the nature of the work must preclude the supervision of the family's children. Family child care providers are not eligible for subsidized services because their work does not preclude the supervision of their own children. **Participation in vocational training** leading directly to a recognized trade, paraprofessional or profession. The vocational training will be reviewed by the CCDF Director at the beginning of each semester or quarter to determine that progress is being made toward the vocational goal specified in the certification and eligibility documents. **Homeless and seeking permanent housing** for family stability is taken into consideration for application purposes. Families in this situation are given three (3) Months to find permanent housing while receiving CCDF benefits.

2. The child has a medical or psychiatric special need, including children with exceptional needs, which cannot be met without provision of services, verified by a legally qualified professional. (Provide IEP)

Initials: _____

CHILD CARE PROVIDER INFORMATION:

Name Of Child Care Provider: _____ **Phone#:** _____

Home Address: _____

Email Address: _____

Provider's SSN#: _____

Type Of Care - Please Check One *Thank You!*

____ *Center Based* **Tribal License#:** _____ **State License#:** _____

____ *Family Home* **Tribal License#:** _____ **State License#:** _____

____ *In-Home Care* **SSN#:** ___-___-_____ **DOB:** _____

____ *Relative Care* **Provider's relationship to child(ren):** _____

PARENTAL or LEGAL GUARDIAN CONSENT:

Name Of Child(ren):

1 _____ **DOB:** _____

2 _____ **DOB:** _____

3 _____ **DOB:** _____

4 _____ **DOB:** _____

5 _____ **DOB:** _____

As the parent/legal guardian of the above named mentioned child(ren) hereby voluntarily stipulate the following type of child care services for my child(ren) in conjunction with the Child Care & Development Fund. I agree to register my provider with the CCDF Program_____.

I agree to provide my care provider with emergency medical instructions, immunization records, and approvals in writing within 30 days of my eligibility date_____

I hereby certify that the above listed PROVIDER is one of my own choosing and I am not receiving child care assistance for any above mentioned child(ren) from any other social services program and hereby release the Yakama Nation CCDF of any liability. I agree to fulfill all CCDF requirements and understand that if I am eligible I will receive a certificate of eligibility to begin the receipt assistance and certify under penalty, in reference to 18 USC (Subject to fraud)_____ I have read the above listed definitions and accept them for the application process and for services rendered_____

I give permission to my provider to use whatever emergency measures are judged necessary for the care and protection of my child while under their supervision. In case of emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource deems it necessary. It is understood that in some medical situations, that staff will need to contact the local emergency resource before the parent, child's physician, and/or other adults acting on parent's behalf. In the event of accidental ingestion I understand that my provider will contact the Poison Control Center.

I hereby authorize my provider to act on my behalf in case of any emergency.

Signature Of Parent: _____ **Date:** _____

Signature Of Parent: _____ **Date:** _____

Signature Of Provider: _____ **Date:** _____

Paycheck stubs due every 2 weeks.

Authorization to Release Information:

(Applicant & Spouse MUST have Supervisor fill out.)

Yakama Nation Child Care and Development Fund applicant authorizes the release of information needed to determine eligibility for child care assistance as required per reference 18 USC 1001. Please provide the information requested.

Print Name: _____ **Job Title:** _____

Applicant's Signature: _____ **Date:** _____

1. What DATE did/does employee start: Month _____ Day _____ Year _____
2. What is employee's GROSS salary or wages per month?: _____
   (If UNKNOWN gross please put your hourly wage. Thank You.)
3. Does this employee have any company paid child care benefits?: Yes ____ No ____
   Explain: _____
4. Does this employee receive tips/tokens? Yes ____ No ____ Average Monthly Rate?: _____
5. Does this employee work OVERTIME?: Yes ____ No ____ Average Monthly Rate?: _____
6. Does employee receive "in-kind" (non-cash) or cash benefits as part of their pay; i.e. a housing allowance or apartment? The monthly cash value?: _____

7. Please complete the following work schedule:

START	MON	TUES	WED	THUR	FRI	SAT	SUN
TIME							
END							

If schedule varies please explain why: _____

READ AND SIGN: I certify that this information is true, accurate, correct, and complete to the best of my knowledge and that I have the authority to make such verification on the behalf of this company, and hereby attest in reference to 18 USC 1001.

Supervisor's Signature: _____ **Date:** _____

Title: _____ **Phone#:** _____

Employer/Company: _____

Yakama Nation Child Care and Development Fund
Authorization for the Release of Information

I Authorize the YN-Child Care and Development Fund to conduct an investigation to obtain information relating to my program eligibility such as employment, living situations, and other areas necessary to consider for assistance with Child Care costs.

I understand the information is required for eligibilty and supplied to the Child Care and Development Fund and I will be liable if my information is incomplete. This is an agreement to share information between Yakama Nation programs or an outside entity whose records are not limited to Personnel, Employment Status, Hourly Rate, Yakama Enrollment, Higher Education, WIOA, AVT, Vocational Rehabilitation, Indian Health Services, Nak Nu We Sha, Tribal Court and Housing Authority. The Director of the Child Care and Development Fund makes final decision.

I understand the information released to the Child Care & Development Fund is confidential and will stay within their department. Any portion of the file is held confidential and only made available on a need to know basis to the YNCCDF Chain of command.

I Understand that this authorization supersedes any other document that may deny such divulgence of information. With the understanding that at any time these documents can be assessed for one calendar year of my signature.

Applicant's Signature: _____ **Date:** _____

Applicant Full Name: _____

(Print Legibly Please)

Other Names Used: _____

Current Address: _____

Spouse's Signature: _____ **Date:** _____

Spouse Full Name: _____

(Print Legibly Please)

Other Names Used: _____

Current Address: _____

Yakama Nation

Child Care and Development Fund (CCDF) Approval form

Initial here_____

Phone#: _____

Message#: _____

E-Mail: _____

Participant name: _____ Date: _____

Provider name: _____ Date: _____

Initial on blank spots

All information on application is correct (names, birth dates, address, emergency contact) _____

If you have a CoPay the Full **COPAY** amount is to be paid in full to provider each month. _____

Make sure you sign provider time sheet/also make sure it is filled correctly. If it is not filled correctly including (time/# of hours/daily fee) the time sheet will be sent back to provider until filled out properly.

Both participant & provider sign time sheet

YNCCDF pays up to 10 hours a day, no more than 40 total work hours a week, 2 day break between each week.

Time over 10 hours a day paid by the participant

IF/When I am approved as a CCDF participant and I acknowledge all the information above.

Participant

Sign Here _____ Date: _____

Provider

Sign Here _____ Date: _____

All CHILD CARE CERTIFICATE are mailed out to the participant and to the provider If/When approved for CCDF

Yakama Nation Child Care & Development Fund
Child Care Schedule

CCDF Participant: _____

Childs Name: _____ Childs Age: _____

Providers Name: _____

Providers Mailing Address: _____

Month: _____ Services Provided

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
In															
Out															
# of hours															
Daily Fee															

Date	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
In																
Out																
# of hours																
Daily Fee																

Total Cost for Child Care Services (Please fill in) $_____

I Certify, in reference to 19 USC 1001, the information stated for child care services is true and accurate. (Note: Attendance will be verified with attendance records)

CCDF Participant Signature_____ Date_____

*Provider Signature*_____ *Date*_____

OFFICE USE ONLY

Co-Pay Requirement, which is the parent's responsibility, is in the amount of $_____ for this billing.
CCDF payment to provider in the amount of $_____

CCDF Certificate Specialist Date

YAKAMA NATION CHILD CARE & DEVELOPMENT FUND

The Child Care and Development Fund will lead and coordinate with the Tribal Lead Agency, Grants and Contracts, applicant/provider, and the Granting agency. This program will maintain/establish standards of monitoring process to ensure the Health & Safety practices of Child Care settings, support continuous quality improvement, provide stable child care financial assistance to families, ensure equal access to high quality child care, promote culture/language revitalization and family engagement through outreach and consumer education.

Contact your YN CCDF staff at the following 865-5121, to answer any questions you may have.

(Director)

Veronica Kaltsukis: Ext 4295
(Administrative Operations Specialist)

(Licensor-Liaison)

Phyllis Smartlowit: Ext 4359
(Intake Assistant)

Relative Provider Required Documents:

- ☐ Photo ID/Enrollment Card
- ☐ Tribal/Washington State Food Handler Card
- ☐ First Aid/CPR Card
- ☐ Diagram of home (with emergency meeting spot)
- ☐ Background Check (Washington State Patrol/WATCH: Name & DOB-Online and SOR)
- ☐ W-9 and Vendor Request
    - Must be completed if you are a new provider or to update information
    - Both forms must have the same address

To be eligible as a Relative Provider you must meet the following definition:

A relative care provider is a "child care provider who is 18 years of age or older who provides child care services only to eligible children who are, by marriage, blood relationship, or court decree, the grandchild, great grandchild, siblings (if such provider lives in separate residence), niece, or nephew of such provider."

*Application must be filled out completely (if section does not apply to you, insert N/A) and all documents must be turned in before being approved as a Relative Child Care Provider.

Name: First Last Middle	**Email:**	
	Phone Number:	
Physical Address:	**City:**	**Zip:**
Mailing Address:	**City:**	**Zip:**

SSN:	**DOB:**	**Enrolled:** □ Yakama □ Other □ Indian Descendent □ Non-Indian

List All Household Members Name	Relationship to You	Date of Birth

Educational	Highest Level Completed	Diploma/Degree
High School:		
Trade/Business School:		
College:		
Other (GED, Training):		

Experience and Training in Child Care Profession:

Special Care Skills and Certificates:

References (3 Required Non-Family Members) Name	Phone Number	Occupation

Which setting will child care take place? □ In Child's Home □ In Provider's Home

Check the following services provided in your care: □ Daycare □ Night Care □ Weekend Care

What children are you caring for?	**Yes/No and amount in care**	**Do you have current training to care for children with:**	**Yes/ No** (If yes, provide certificate)
Infants		Physical Disabilities	
Toddlers		Medically Fragile	
Preschool (3-5)		Development Delay	
School Age (5+)		Emotional Behavior	

Relationship to child(ren) in care: □ Great Grandparent □ Grandparent □ Aunt/Uncle □ Sibling (living outside home)

Provider Signature:	**Date:**
YN CCDF Director Signature:	**Date:**

Relative Provider

YN CCDF PROVIDER GUIDELINES

Health

- Hand washing with warm water and soap is regularly required before meal preparation and after diaper changing.
- Children need to be educated on how to properly hand wash; as well as, the knowledge of why handwashing is important.
- Diaper changing will not take place where food is prepared. _____

Immunizations

- All children will be required to have/or in the process of obtaining immunizations at the medically appropriate time. These records will be kept on file. _____

Medication

- Written permission must be given by parent or guardian before provider administers to child. _____

Conditions

- Any skin conditions, injuries, and illness will be reported to the parents or guardian and recorded by the provider. _____

Smoking

- Smoking is not permitted in the household and transportation vehicle during child care hours. _____

Sanitation

- Provider must keep home, yard clean and sanitary for children. (Proper disposal of garbage, cleaning of bodily fluids, etc.) _____

Other

- The building shall be in a good state of repair from safety standpoint.
- The premises shall be free of undue hazards, indoor and outdoor.
- Clear glass doors shall be plainly marked to avoid accidental impact.
- Provider must have access to a telephone/two-way radio/transportation for emergency purposes.
- Stairways that are inside or outside that are over four steps must have railings. Safety gates must be provided where infants and toddlers are given care. _____

Safety Requirements

- Provider shall be in good physical and mental health.
- An annual physical exam/physician statement, documentation of TB skin test or chest x-ray is required by CCDF in order to maintain certification.
- Provider will not be able to care for children if child has a fever or contagious condition until the infection is under control and doctor release is signed.
- All flammable liquids and/or poisonous materials shall be stored in facilities that are inaccessible to children
- Any play activity that involves water must be constantly supervised. Ponds and pools are not to be left accessible to children on their own.
- Provider must develop an evacuation plan, to safely exit building in the event of fire. Also hold monthly scheduled fire drills and be certain children know expectations to follow, if such an event should occur.
- Animals or household pets are permitted, provided they have been inoculated regularly and do not interfere with sanitary conditions. All children must be instructed in proper ways of treating the

animals so they are not at risk of any danger. Signed agreement from parent on file. _____

Supervision

- During nap time, at least one adult should be physically present in the same room as the children.
- Children will be supervised at all times. _____

Alcohol or Controlled Substances

- Use of alcohol or drugs during child care hours is strictly prohibited and will be cause for revocation of YNCCDF certification. _____

Provider Requirements

- Provider shall have suitable temperament to care for a child and show love and understanding of children.
- Must work cooperatively with respect to the child's individual feelings.
- Provider shall be free from felony convictions and have good community standing.
- Any person convicted of assault and battery, beating, physical violence or abusing children shall be restricted from the premises during child care hours.
- Provider shall immediately report any suspicion of child abuse to the YN CCDF office and/or to the State office. Failure to report these actions is a misdemeanor offense and is punishable by law and will result in revocations of YN CCDF Certification.
- Provider will attend training and obtain a certificate, provide a copy to CCDF for providing developmentally appropriate child care/education.
- Maintain a home environment.
- Refrain from using the following types of disciplines:
  I. Loud profane or abusive language
  II. Corporal punishment
  III. Discipline that is humiliating/frightening to children
  IV. Discipline associated with rest, toilet training or loss of food
- Provider will keep daily attendance record.
- Keep an injury/accident record, record of medication and treatments given to child during care. _____

_____ _____

Provider Signature Date

YN CCDF PROVIDER AGREEMENT

THE YAKAMA NATION CHILD CARE AND DEVELOPMENT FUND RESERVES THE RIGHT TO DENY REGISTRATION AND PAYMENT TO ANY PERSON OR AGENCY WHO IS DETERMINED BY THE TRIBE TO BE A POTENTIAL DANGER TO CHILDREN BECAUSE OF CURRENT OR PAST ASSOCIATION WITH OR PARTICIPATION IN CRIMINAL ACTIVITIES, NOTHING IN MY CHARACTER WILL PREVENT ME FROM WORKING WITH CHILDREN, ALCOHOL OR OTHER SUBSTANCE ABUSE, COMMUNICABLE HEALTH PROBLEMS OR UNSAFE CHILD CARE PRACTICES.

Once you have been approved to be the provider and the participant has been determined eligible, you will receive a "Certificate" by mail that states the participant is eligible. The participant is responsible for payment until a "Certificate" is issued. **DO NOT BILL YAKAMA NATION CHILD CARE AND DEVELOPMENT FUND.** I understand that as a certified YN CCDF child care provider, I am self-employed and not an employee of the Yakama Nation. I understand that a 1099 tax form will be provided to me at the end of the year.

Schedules must be submitted to YN CCDF for payment by the deadline indicated on the calendar. Payment may take 21 days for processing from time of receipt.

You must inform YN CCDF of any changes in circumstances. You must notify the YN CCDF program in writing within one week of change of address with verification of new/changed address.

FRAUD: Lying on an official document, withholding the truth is subject to federal law. YN CCDF pays with federal funds, federal regulations require fraudulent claims must be reimbursed or reported to legal agency. Any over-payments due to fraud or error will be returned to the YN CCDF program. 18 USC 1001.

If there is an involvement of fraud, your certification may be revoked.

Provider understands the following:
(Please Initial)

_____ I affirm that the information, I have provided is true and complete, to the best of my knowledge and belief. I have read the Health and Safety Guidelines and Premises Checklist and that I understand if /when approved, I may have to take some training.

_____ I attest that neither any person nor I in my household has ever been convicted of child abuse or neglect, or any other violent crime. I authorize YN CCDF to verify any/all information provided.

_____ I understand that, if approved, I may not hold any other employment, which would interrupt the safe, nurturing care of children (or prevent me from adequate sleep/rest)

_____ I authorize the YN CCDF to verify any or all information provided on this form.

_____ I agree that the YN CCDF program will investigate any complaints regarding child care, and this registration may be revoked based on failure to comply with applicable regulations.

_____ I agree to provide a bill only for approved child care when the parent/guardian is in approved work, education, training program, homeless, or protective services.

_____ I agree to obtain emergency medical instructions and approvals in writing from the parent during my first 30 day of child care.

_____ I agree to provide child care to the eligible children at the established rates, to accept and require co-payment by the eligible parent/guardian on the sliding fee schedule of this program and report to the program if I do not receive co-payment.

_____ I agree to provide immediate access by the parent/guardian of the child(ren) in my care during child care hours, and to provide access to the child care facility to the parent and YN CCDF staff.

I have read and understood the above mentioned to me as a Yakama Nation CCDF Provider.

_____ _____

Provider Signature **Date**

BUILDING AND PREMISES SELF INSPECTION

Address: _____

Self-Inspector: _____ Date of self-inspection: _____

General Condition of Facility/Site:	Yes	No	N/A	Comments
Facility in good repair, free of infestation, clean And sanitary?	☐	☐	☐	
Adequate facilities to store and handle food?	☐	☐	☐	
Operable emergency lighting?	☐	☐	☐	
Adequate lighting?	☐	☐	☐	
Adequately heated and ventilated?	☐	☐	☐	
Access to adequate laundry facilities? Separate from children	☐	☐	☐	
Free of hazards (old cars, nails, pipes, old bikes, garbage, recycling etc.)	☐	☐	☐	
Pools/hot tubs inaccessible when not in use?	☐	☐	☐	
Do stoves or heaters block exits?	☐	☐	☐	
Wood stoves installed according to Tribal or Local code? If any	☐	☐	☐	
Fire extinguishers, smoke detectors?	☐	☐	☐	
Public water/sewage discharge (or approved Private system)	☐	☐	☐	
Record keeping established? (Brief description)				

Bathroom(s):	Yes	No	N/A	Comments
Ventilated? (Window or mechanical)	☐	☐	☐	
Tub or shower, Sink and toilet?	☐	☐	☐	
Grab bar or approved non-skid surface?	☐	☐	☐	
Toilet training equipment for toddlers?	☐	☐	☐	
Door can be unlocked from outside?	☐	☐	☐	

Medicine/First Aid Supplies:	**Yes**	**No**	**N/A**	**Comments**
First aid supplies?	☐	☐	☐	
Valid First Aid/CPR?	☐	☐	☐	
Medicines properly stored?	☐	☐	☐	
Access/disbursement controlled?	☐	☐	☐	
Health care plan; for individual child	☐	☐	☐	
Emergency phone number?	☐	☐	☐	
Vehicles:	**Yes**	**No**	**N/A**	**Comments**
Licensed driver(s)?	☐	☐	☐	
Seat belts/car seats?	☐	☐	☐	
Liability/Medical insurance?	☐	☐	☐	

If children are transported, provide the following to YN CCDF:

- Washington State Driver's License
- Liability Insurance
- Signed parental permission in writing

Provider Signature: _____ Date: _____

YN CCCDF Director Signature: _____ Date: _____

Clear Form

REQUEST FOR VENDOR

FY 2020

Instructions: New Vendor, check mark "ADD" and complete the entire form. If this is an "Up-date" please include the JDE vendor # and complete entire form.
Name is how they are requesting to be paid.
Address is the location payment is to be sent to.
Tax #'s is the Federal Tax ID number and/or Social Security number matching the Internal Revenue Service records. **Required attachments**: W-9 completed by the company (signed) and a copy of the invoice or letterhead (address verification).

PLEASE BE SURE TO COMPLETE THE ENTIRE FORM, ONCE COMPLETE SUBMIT TO PROPERTY & ACQUISITIONS.

ADD: ☐ Update: ☐ Vendor#: _____

Mark all that apply: ☐ Name ☐ Tax ID # ☐ Address ☐ Phone #

NAME: _____

*Please verify invoice name if different from W-9. This should read how vendor is requesting to be paid.

REMITTING ADDRESS: _____

_____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

MUST HAVE IRS TAX ID#: _____

INDIVIDUALS MUST HAVE SOCIAL SECURITY NUMBERS#: _____

YAKAMA NATION TRIBAL ENROLLMENT #: _____

CHECK ONE: INDIVIDUAL/SOLE PROPRIETOR ☐ CORPORATION ☐
PARTNERSHIP ☐ OTHER ☐

EX-EMPLOYEE: YES ☐ NO ☐

FEMALE: MAIDEN NAME _____
MARRIED NAME: _____

Requested by: _____ **Program:** _____ **Ext. #:** _____

Property & Acquisitions Staff Only

HAS VENDOR EVER BEEN SUSPENDED OR DEBARRED? Yes_____ No_____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

CHILD CARE PROVIDER INFORMATION:

Name Of Child Care Provider: _____ **Phone#:** _____

Home Address: _____

Email Address: _____

Provider's SSN#: _____

Type Of Care - Please Check One *Thank You!*

____ *Center Based* **Tribal License#:** _____ **State License#:** _____

____ *Family Home* **Tribal License#:** _____ **State License#:** _____

____ *In-Home Care* **SSN#:** ___-___-_____ **DOB:** _____

____ *Relative Care* **Provider's relationship to child(ren):** _____

PARENTAL or LEGAL GUARDIAN CONSENT:

Name Of Child(ren):

1 _____ **DOB:** _____

2 _____ **DOB:** _____

3 _____ **DOB:** _____

4 _____ **DOB:** _____

5 _____ **DOB:** _____

As the parent/legal guardian of the above named mentioned child(ren) hereby voluntarily stipulate the following type of child care services for my child(ren) in conjunction with the Child Care & Development Fund. I agree to register my provider with the CCDF Program_____.

I agree to provide my care provider with emergency medical instructions, immunization records, and approvals in writing within 30 days of my eligibility date_____

I hereby certify that the above listed PROVIDER is one of my own choosing and I am not receiving child care assistance for any above mentioned child(ren) from any other social services program and hereby release the Yakama Nation CCDF of any liability. I agree to fulfill all CCDF requirements and understand that if I am eligible I will receive a certificate of eligibility to begin the receipt assistance and certify under penalty, in reference to 18 USC (Subject to fraud)_____ I have read the above listed definitions and accept them for the application process and for services rendered_____

I give permission to my provider to use whatever emergency measures are judged necessary for the care and protection of my child while under their supervision. In case of emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource deems it necessary. It is understood that in some medical situations, that staff will need to contact the local emergency resource before the parent, child's physician, and/or other adults acting on parent's behalf. In the event of accidental ingestion I understand that my provider will contact the Poison Control Center.

I hereby authorize my provider to act on my behalf in case of any emergency.

Signature Of Parent: _____ **Date:** _____

Signature Of Parent: _____ **Date:** _____

Signature Of Provider: _____ **Date:** _____

Yakama Nation

Child Care and Development Fund (CCDF) Approval form

Initial here_____

Phone#: _____

Message#: _____

E-Mail: _____

Participant name: _____ Date: _____

Provider name: _____ Date: _____

Initial on blank spots

All information on application is correct (names, birth dates, address, emergency contact) _____

If you have a CoPay the Full **COPAY** amount is to be paid in full to provider each month. _____

Make sure you sign provider time sheet/also make sure it is filled correctly. If it is not filled correctly including (time/# of hours/daily fee) the time sheet will be sent back to provider until filled out properly.

Both participant & provider sign time sheet

YNCCDF pays up to 10 hours a day, no more than 40 total work hours a week, 2 day break between each week.

Time over 10 hours a day paid by the participant

IF/When I am approved as a CCDF participant and I acknowledge all the information above.

Participant

Sign Here _____ Date: _____

Provider

Sign Here _____ Date: _____

All CHILD CARE CERTIFICATE are mailed out to the participant and to the provider

If/When approved for CCDF