

Child Care Assistance Program Application for Services

Maniilaq Association Workforce Development administers the Child Care Assistance program as components of the Public Law 102-477 Program. These services are available for eligible Alaska Natives and American Indians. Eligibility depends on a variety of factors, including the Tribe you are enrolled with, as some Tribes have elected to manage and receive their funding for some of these services.

NOTE: Applicants MUST submit an application and attach ALL required documentation to be considered a complete application. If the application is incomplete or does not include all required documentation, it will not be processed!

Application Instructions:

1. Applicant must complete all pages of this application.
2. Each adult applicant must complete an Individual Self-Sufficiency Plan (ISP) – (copy page 5)
3. Fill in all blanks of the application. If a question does not apply to you, please write “NA”.
4. Make sure you have signed and dated your application when it is submitted.

Required Documents:

- Tribal enrollment (IRA, Tribal Council, or Native Community card or certificate) for all persons to be included in assistance, Applicants must be Alaska Native/American Indian with proven descent.
- Valid Identification (copy of current Driver’s License or other State or Federal photo identification for applicant);
- Social Security number(s);
- Proof of residency within the Maniilaq service area (voter registration, utility or bank statement, paystub, etc.)
- Verification of Employment
- Submitted State of Alaska Child Care Application (if denied, provide the denial letter)
- Birth Certificate of child (ren) requiring Child Care
- Immunization records for all children that will need Child Care
- Proof of adoption or guardianship (if applicable)
- ICWA/OCS custody decree, tribal custody decree, or divorce decree (if applicable)
- Income verification of parents and children

Whom to include in your application

- Dependent children – including adopted and foster
- Children under 21, if they live with you, even if you cannot claim them as dependents on your tax return
- Dependent Parents – Include ONLY if you claim them on your tax returns
- Dependent siblings and other relatives – Include them ONLY if you claim them as dependents on your tax returns
- Spouse – Include your legally married spouse
- Spouse, legally separated or divorced – Do NOT include, even if you live together
- Spouse, living apart – Include your spouse unless you’re legally separated or divorced
- Spouse (for victims of domestic violence or spousal abandonment) – In these cases, you don’t have to include your spouse (see rules for victims of domestic violence/abuse or spousal abandonment) (income-and-household-information/household size/domestic abuse)
- Unmarried domestic partner ONLY if you have a child together or you’ll claim your partner as a tax-dependent

Child Care Assistance Program Income Table

Family Size	Monthly Household Income Limits (85% State Median Income)	Maximum Monthly Co-Payment Amounts
2	\$5,288.70	\$370.21
3	\$6,533.10	\$457.32
4	\$7,777.50	\$544.43
5	\$9,021.90	\$631.53
6	\$10,267.15	\$718.70
7	\$10,500.05	\$735.00
8	\$10,733.80	\$751.37
Rates and co-payments are subject to change		Additional household members add \$1,464.00

UNIFORM GRIEVANCE & APPEALS PROCEDURE

Maniilaq Workforce Development has established a fair and consistent appeal and grievance procedure that applies to all participants and tribal staff in our Workforce Development programs. This process ensures that everyone is treated fairly and establishes a series of steps beginning with informal resolution at the staff level. The final appeal at the tribal level is presented to the Maniilaq Association Tribal Government Administrator.

Any appeals or grievances must be submitted in writing within twenty (20) business days of the incident being appealed. Participants will receive a response to their written complaint within ten (10) business days of submission. Any participant in our programs who believes that a violation of the Regulations has occurred may seek an appeal/grievance. The following procedure should be used to settle such appeals and/or grievances:

- Step 1.** The participant should first report the incident in writing to their assigned caseworker within 20 days of the incident.
- Step 2.** If the matter is not resolved, the participant should immediately put their complaint in writing and submit it for review to either the TANF Manager or the WFD Deputy Director at P.O. box 256 Kotzebue, AK 99752.
- Step 3.** If the matter is still not resolved, the participant should request in writing that the complaint be reviewed by the Workforce Development Director.
- Step 4.** If the matter remains unresolved, the participant should request in writing a review by the Tribal Government Services Administrator.

ALCOHOL/DRUG-FREE WORKPLACE/NO FIREARMS ALLOWED

Maniilaq Association maintains a safe and secure workplace that is free from drugs and alcohol. It strictly prohibits illegal substances, drug paraphernalia, or firearms on its premises. This policy applies to all employees and guests of the organization. Anyone found violating this policy or breaking the law will face appropriate actions, including but not limited to removal from the building or grounds, termination or suspension of services, and legal proceedings.

CONFIDENTIALITY

Any information that I provide or is obtained on my behalf will be deemed confidential. I understand that all WFD staff are obligated to maintain the confidentiality of participants, unless otherwise specified in the release of information to which I agree.

RELEASE OF INFORMATION

I certify that the information provided in this application is correct and true to the best of my knowledge and is subject to verification. Falsification of any facts is grounds for immediate termination and may result in prosecution under the law.

I hereby authorize Maniilaq Workforce Development staff to obtain or release information included in this application and my participant file in relation to my eligibility for services, assistance sought on my behalf from other social services programs, for verification of information provided, and for reporting purposes.

Print Name _____ SS# _____ DOB: _____

Carefully read the application instructions on page 1 BEFORE completing this application.

Applicant Information - Please print clearly

Last Name	First Name	Gender	Maiden Name
-----------	------------	--------	-------------

I am a New Applicant	I have previously applied for services	Date of last application
----------------------	--	--------------------------

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	If Male, have you registered with Selective Services? <input type="checkbox"/> YES <input type="checkbox"/> NO	Social Security No.	Blood Quantum
---	---------------	---	---------------------	---------------

Marital Status

Single Single living with significant other Married Separated Divorced Other: _____

Family Status

<input type="checkbox"/> Single Individual <input type="checkbox"/> One-parent family <input type="checkbox"/> Two-parent family	Number of Dependents under 18 _____ Total Number in household _____
--	--

Education Status

High School Year Graduated _____ College/Vocational School Year Graduated - _____

GED Year received _____ Degree _____ Major _____

Certificate of Achievement Year Graduated _____ Currently enrolled/attending school

Contact Information

Mailing Address, City, State, Zip code

Physical Address, City, State, Zip code

Home or Message Phone	Work Phone	Cell Phone	Email Address
-----------------------	------------	------------	---------------

Household Members Living with You

Name	DOB	Relationship	Tribal Enrollment (Village or Community)

Family Income and Available Funds – Provide a list of ALL sources of income that you and your family have received during the last 30 days, include current available funds. To verify your income, provide copies of paystubs.

Source of Income	Amount	Comments
Applicant's net salary (attach pay stub)		
Spouse/Significant other net salary (attach pay stub)		
Tips or gratuities		
ATAP, TANF, ASAP		
General Assistance (GA)		
General Relief (GR)		
Housing Assistance (AHFC, NPRHA)		
Child Support and Alimony		
Foster Care Payments		
Child Care Assistance		
Adult Public Assistance (APA)		
Social Security (SSA)		
Supplemental Security Income (SSI)		
Disability Insurance		
Permanent Fund Dividend (PFD) all HH members		
Cash out of retirement or pension plan		
Alaska Longevity Bonus		
Veteran's benefits		
Unemployment Insurance Benefits		
Workers Compensation		
Food Stamps (EBT)		
Medicare/Medicaid		
Native and Village Corporation Dividends		
Checking account (current balance)		
Savings account (current balance)		
Student loans/grants/scholarships		
Bingo or pull tab winnings		
Other income (specify)		
Other income (specify)		
Total Income for last 30 Days		

Total Household Income for the Past Six (6) Months	\$
---	-----------

I (We) hereby declare that all the information provided in this application is accurate and true to the best of my (our) knowledge and ability. I (We) understand that providing false or fraudulent information knowingly or willfully in any part of this application may lead to prosecution. The prosecution carries a fine of up to \$10,000 or imprisonment for up to 5 years, or both.

Applicant Signature

Date

Applicant Signature

Date

Employment Status:			
Currently employed?	Y / N	If unemployed, last date of employment	
Hourly wage		Have you received a layoff notice?	Y / N
Hours per week		Are you an active union member?	Y / N
Main Occupation		If yes, name of union	
Do you have a valid driver's license	Y / N	Alaska driver's license #:	ADL expiration date:
Do you have a valid commercial driver's license?		If yes, which class?	

Training and Education:		
School attended:		Major course of study:
Dates attended: From: To:	Graduation date:	Degree or Certificate:
School attended:		Major course of study:
Dates attended: From: To:	Graduation date:	Degree or Certificate:

Employment History - List most recent job first

Job Title	Start Date	End Date	Hourly Wage
Employer/Company Name	Employer/Company Address		Phone Number
Immediate Supervisor		Reason for Leaving	
Duties & Responsibilities			
Job Title	Start Date	End Date	Hourly Wage
Employer/Company Name	Employer/Company Address		Phone Number
Immediate Supervisor		Reason for Leaving	
Duties & Responsibilities			
Job Title	Start Date	End Date	Hourly Wage
Employer/Company Name	Employer/Company Address		Phone Number
Immediate Supervisor		Reason for Leaving	
Duties & Responsibilities			

INDIVIDUAL SELF-SUFFICIENCY PLAN (ISP)

Name of Applicant _____ Date of Plan _____

Are you currently employed? Yes No **If yes, where?** _____ **How long?** _____

Highest grade level completed (please circle) 1 2 3 4 5 6 7 8 9 10 11 12 GED CERT College/Vocational

Date Graduated _____ Date of GED or Cert _____ Date last attended school _____

What are your short-term employment goal(s) to reach self-sufficiency?

What are your long-term employment goal(s) to become self-sufficient?

Barriers to you and/or your family (check all that apply)

<input type="checkbox"/> Currently employed/low income <input type="checkbox"/> Living in Rural Area <input type="checkbox"/> Lack of work in Village/Town <input type="checkbox"/> High school dropout/no GED <input type="checkbox"/> Unemployment (15 or more weeks) <input type="checkbox"/> Long Term Public Assistance (30 or more months) <input type="checkbox"/> In treatment (Substance, Grief, other)	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> Disabled <input type="checkbox"/> Lack of degree <input type="checkbox"/> No Driver's License <input type="checkbox"/> Foster Care <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Homelessness	<input type="checkbox"/> Public Assistance <input type="checkbox"/> Criminal History <input type="checkbox"/> Domestic Violence <input type="checkbox"/> 477 Participant <input type="checkbox"/> Teen Pregnancy/Parenting <input type="checkbox"/> In correction facility/Third-party Release date: _____
--	--	--

Goal # 1 (Example: Get Driver's License)	Date you plan to start this goal/step?	Date you plan to complete this goal/step?
Step 1 (Example: Study DMV manual)		
Step 2 (Example: Take written test)		
Step 3 (Example: Take driving test)		
Goal # 2 (Example: Update my Resume)	Date you plan to start this goal/step?	Date you plan to complete this goal/step?
Step 1 (Example: Get employment history added to my resume)		
Step 2 (Example: Find a computer to use to update resume)		
Step 3 (Example: Finish final official Resume)		

I understand that the purpose of this plan is to help me achieve my goal of gaining employment, education, or related activities. To remain eligible for the services offered, I must comply with specific steps outlined in this plan. These steps will aid in promoting my self-sufficiency and may include participation in employment, training, or related activities. Failure to follow these steps may result in the suspension of my services for a period of 60 to 90 days. Additionally, if there are any changes to my circumstances, I am responsible for reporting them to my caseworker in a timely manner.

Signature of Applicant **Date** **Workforce Development Staff** **Date**

Caseworker ONLY - Complete 30 – 180 days after the plan date.

Follow-up completed on _____ by _____

Outcome: _____

Each adult applicant must complete this form. If there are two adult applicants, a copy of this page must be made or requested.

Child Care Assistance is available to income-eligible parents who reside in the service area and who are employed or undergoing training. The program pays a percentage of child care costs incurred when the parent(s) are engaging in employment or school. Parents are encouraged to apply for employment services and/or vocational training tuition assistance to enable them to obtain reasonable employment and self-sufficiency.

Child Information - attach a copy of each eligible child's birth certificate, Certificate of Indian Blood/Tribal Enrollment & age appropriate immunization records. **Child Care Assistance will not be approved until all documents are received.*

Children eligible for program benefits under age 13		Children NOT eligible for program benefits age 13+	
Name	DOB	Name	DOB

Do both biological parents reside in the household with the child(ren)? Yes No

Does the child(ren) live with you full-time? Yes No

If so, are both employed or in a training program? Yes No, if no please be aware that this application may not be considered as parents must be participating in an approved activity.

Do you presently have a child care provider? Yes No

If yes, list the name(s):

Your Child Care Provider must apply separately to become approved under the Maniilaq Child Care Assistance Program.

If no, what plans do you have for child care while you work or go to school?

Income Data - You must provide copies of proof of income for the last 30 days as verification of employment and income. Income sources include employment pay stubs, Unemployment Benefits, Social Security benefits, General Assistance, Foster Care payments, child support, TANF, settlements and other income received. This information must be updated if it changes at any time during the approval period, by completing a change report and providing documentation verifying such change(s).

Employment & Training Data - The information below concerns your day/hours of employment or training.

Day	Hours of employment/training	Name of employer/school & position held	Comments
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Child Care Program Standards & Requirements

Parent Agreement & Requirements

As a parent applying for the Child Care Assistance Program, you are required to agree to the following.

Parent: Read and Initial each item:

Child care assistance funds are for use only when I am engaged in employment or training. If both parents reside in the household I understand that they must either attend a training program or are employed. If a parent/guardian is not working or attending training/school, they will be responsible for paying for child care. The Child Care Program will NOT provide assistance when the parent/guardian is NOT working, in training/school, or participating in subsistence activities. I/We will notify the program within 5 days following a change affecting my eligibility. Changes include employment or training status, days/hours of work or training, number of children in need of childcare, and/or income.

_____ Employment & Training will provide Child Care Assistance for parents who are required to pay for the time their child(ren) are scheduled to be in care, while the parent is working or in a training program.

_____ I will notify the child care case manager and provider within 5 days if I do not work the hours specified.

_____ I will give the provider at least 14 days' notice of my intent to terminate child care services except in the case of immediate program ineligibility or upon mutual agreement between me & and my provider. Program ineligibility includes being fired and laid off, or not reporting changes to my household.

_____ I am responsible for paying the provider for my portion of authorized child care costs and any costs above the authorized subsidy amount that the program will pay, or for making other mutually acceptable arrangements with the provider.

_____ I will provide all requested documentation to the Child Care Case Manager.

_____ I must provide my child's immunization records, certificate of Indian Blood or Tribal Enrollment Card & Birth Certificate as well as other required information.

_____ If I do not comply with these responsibilities, my participation in the program may be terminated.

Parent Certification

I certify that I will adhere to the parent agreement & meet the parent requirements. I have visited the provider's home & ensured that the provider is meeting the safety requirements listed above.

Applicant's Printed Name

Applicant's Signature

Date signed

Co-Applicant's Printed Name

Co-Applicant's Signature

Date signed

Verification of Employment or School Enrollment

Every question must be answered and signed by official staff and will not be considered if left Blank!

Applicant's Name: _____

Employer/ Human Resources or School/ Training Registrar,
The individual named above has applied for services through Maniilaq Association's Employment & Training Program. Please provide the following information for verification.

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:

- Full-time, permanent employee or student (more than 20 hours a week)
- Full-time, temporary employee. If temporary, what is the duration of employment _____
- Part-time, permanent employee or student (less than 20 hours)
- Part-time, temporary. If temporary, what is the duration of employment or school _____
- Other, explain: _____

Actual Date Paid	Gross Wages (before taxes)	Check Amount	Hours Worked

Authorizing Signature _____ Date: _____

Printed Name _____ Job Title: _____

Each adult applicant must have their employer complete this form. If there are, two adult applicants or one applicant has two employers a copy of this page must be made or requested.

477 Program Participant Rights & Responsibilities

- Be treated with respect without regard to creed, national origin, religion, sex, sexual preference, or age.
- Have all personal information treated confidentially.
- Review his or her file with the appropriate staff present.
- Be fully informed regarding all fees associated with the service the client receives.
- Be given clear information regarding participation in all program activities, e.g.: attendance, and completion requirements.

The client has the responsibility to:

- Be accurate and complete when providing information.
- Carry out program rules & requirements related to the services he or she is applying for.
- Actively participate in the creation of a personal employability development plan.
- Inform staff of any changes in name, address, or other personal information.
- Ask for clarification regarding any instructions, guidelines, or service requirements that the applicant does not fully understand.

Denial or Discontinuation of Services

Each applicant or recipient of direct assistance will be given a written, detailed explanation regarding the ultimate denial or discontinuation of services. This explanation will include action needed or issues to be resolved for successful reapplication or reinstatement, if applicable.

FRAUD POLICY

APPLICANTS OR RECIPIENTS WHO KNOWINGLY OR WILLFULLY PROVIDE FALSE OR FRAUDULENT INFORMATION ARE SUBJECT TO PROSECUTION UNDER 18 U.S. 1001, WHICH CARRIES A FINE OF NOT MORE THAN \$10,000 OR IMPRISONMENT FOR NOT MORE THAN 5 YEARS OR BOTH.

I/WE HAVE READ THE CLIENT RIGHTS & RESPONSIBILITIES AND FRAUD POLICY AND STATE THAT I/WE UNDERSTAND MY RIGHTS & RESPONSIBILITIES AND THE FRAUD POLICY.

APPLICANT SIGNATURE

DATE

APPLICANT SIGNATURE

DATE

Whom do I contact if I have questions, need information, or need assistance in completing my application?

For all services, please contact: etprogram@maniilaq.org, Phone: (907)442-7021, Fax: (907)442-7025