

INTER TRIBAL COUNCIL OF NEVADA, INC.

Parent Name:	SEKTIFICAT		ATION FO	K ASSIS	TANCE				
Date of Birth:	Relationship to child:	ationship to child: Have you previous			sly received assistance from CCDF?				
Mailing Address:		City:	City:		Zip Code:				
Home Phone:	Cell Phone:		Email:						
Co-Applicant Name (If spouse, legal guardian or biological parent of child(ren), residing in the same household):									
	EMPLO	YMENT IN	FORMATI	ON					
Current Employer:		Hourly Wage/Weekly Salary:		Months/Years Employed:					
Employer Address:		City:	City:		Zip Code:				
Employer Phone:	Position:	<u>'</u>			Full-Time Part-Time (Please circle)				
If unemployed, please check here *If unemployed, reason for needing care: School Job Training Job Search Other									
Co-Applicant Current Employer:		Hourly Wage/Weekly Salary:		1	Months/Years Employed:				
Employer Address:		City:	City:		Zip Code:				
Employer Phone:	Position:	l l		Full-Tir	me Part-Time (Please circle)				
If unemployed, please check here *If unemployed, reason for needing care: School Job Training Job Search Other									
	HOUSE	HOLD INF	ORMATIO	ON					
Family Size:	Number of Adults:		nber of Children:	7.	Single Parent: Yes No				
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
Name of Child:		DOB:	Gender:	Hours of Care Needed: per day / week					
	PROV	IDER INFO	ORMATIO	N					
Provider Type: Licens			amily Home	Grandparer	nt Other				
Name of Provider:	·	<u> </u>	(Attac	h Copy of License)					
Provider Address:		City:	City: State:		Zip Code:				
Provider Phone:					·				
Tax ID or SSN: Provide		ovider Rates:		(Pleas	se attach rate sheet)				

It is the applicant's responsibility to notify the ITCN CCDF program of any changes that may affect eligibility. The applicant must also notify CCDF, in advance, if the applicant requests to change providers. CCDF is a parental choice program. The applicant determines the child care that is best for their family. Because of this, Inter-Tribal Council of Nevada, Inc. is not responsible for any accidents or liabilities. Once approved for child care subsidies, no reimbursements for child care costs will be made until CCDF has received a contract, signed by the provider and parent, and the parent has reviewed the parent orientation, and completed the Parent Survey acknowledging all rules, regulations and parent responsibilities. The applicant will notify CCDF if their child needs, or needs to receive protective services, and/or Must submit supporting documentation that substantiates any special needs the child may have. It is the applicant's responsibility to make arrangements with the child care provider for any and all fees related the care of their child. CCDF reimburses for direct services only. The applicant is responsible for all other costs, including, but not limited to: tuition, activity, registration or late fees, etc. The applicant must allow sufficient time for CCDF to verify that all information is correct, determine eligibility and process the application. Assistance will not begin until all necessary documentation has been received and all forms have been signed and submitted. In some instances, the application will be placed on hold and/or the applicant will be placed on the waiting list. CCDF will re-determine the status of your eligibility every four-months, or will re-determine the status of your eligibility based upon your class schedule, job training, and/or other factors. By initialing and signing this document, the applicant agrees that all information provided is true and accurate to the best of their ability. Any attempt to falsify information can result in denial of subsidized c	Applicant	t's Rights & Resp	oonsibilities			
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