



ANISHNAABEK COMMUNITY AND FAMILY SERVICES



CHILD CARE DEVELOPMENT FUND APPLICATION
2218 Shunk Rd. Sault Ste. Marie, MI 49783
1-800-726-0093 or 906-632-5250
FAX: 906-632-5266

1. **CCDF ELIGIBILITY**-Parent(s) must be working, attending school or participating in an approved job training or job search program. Families must meet income guidelines that include assets less than \$1,000,000. Child in need of care must be a Sault Tribe member or eligible to be a member.
2. **COMPLETE THE APPLICATION FOR SERVICES** - Complete all sections of the application which apply to you. If a section does not apply to your family, please write N/A. Do not forget to sign and date the application. Your qualified provider will also need to complete and sign a portion of the application.
3. **VERIFICATION OF TRIBAL MEMBERSHIP** - You must provide proof of Sault Tribe membership for your child. Please make sure your child's card is not expired.
4. **HOUSEHOLD INCOME** – Please be sure to report all household earned and unearned income. Earned income is: wages, tips, salaries, self-employment, contract payments, and payment for service on boards and/or committees. Unearned income is unemployment benefits, adoption subsidies, per capita, lottery winnings, rental property income, Supplemental Security Income (SSI), Social Security Benefits, Survivor Benefits and Military/Veteran Pay/Disability/Allotment.
5. **EMPLOYMENT VERIFICATION OF INCOME** – An Employer Verification form is attached to this application for your employer to complete. We also need a copy of your most recent pay stub and any and all of the following that apply:
 - a) If you are self-employed, please submit the most recent years Schedule C and completed Employer Verification Form.Total gross income will be used to determine eligibility. Please submit verification of all other household income.
6. **EDUCATION VERIFICATION** – If you need child care assistance while you are attending an educational program, (GED, college, trade, on-line) please submit a copy of your school schedule. All schedules must provide the following information; educational program logo, days & times, when and where the class will meet, and the beginning and end date of the term or semester. Online courses are also covered by the CCDF Program. Internet school schedules do not have a logo; please do not submit an internet version. Full or Part-Time Child Care Need will depend on how many classes you are taking.
7. **SPECIAL NEEDS VERIFICATION (Children 13 and up)** - If you have a child with special needs who is in need of child care, documentation from a Licensed Physician is required, stating the condition or circumstances.
8. **FOSTER PARENTS OR FAMILIES INVOLVED IN CHILD PROTECTIVE SERVICE** – If you are a Foster Parent(s), who is working, attending an educational institution, or participating in a qualified job training or job search program, you can choose a Licensed Center or Home or a Relative Care Provider. The Relative Care Provider must be a relative of the child, be at least 18 years of age, not reside with the child needing care, and follow the ACFS CCDF Relative Care Provider Rules and Regulations.
9. **SELECTING A CHILD CARE PROVIDER** – Each family has the right to choose the type of high quality child care that best suits their child care needs without regard to cost. You can choose from a LICENSED Child Care Center or a LICENSED Child Care Home Provider, a Certified Relative Care Provider, Tribal Licensed Family Child Care Provider or Certified In-Home Aide. Please refer to page 3 for more information.

10. **ELIGIBILITY BEGINS THE DAY WE RECEIVE YOUR APPLICATION FOR APPROVED APPLICATIONS**
 -CCDF cannot pay outstanding child care bills.
 -All CCDF Applications are dated for the day they are received by the CCDF Secretary.
 -All completed applications will be processed, audited, approved or denied and a letter will be sent to the Parent(s). If approved, Certificates will be issued to the parent and provider indicating co-payment, date CCDF Payments begin, etc.
 -**Incomplete applications** will only be kept on file for 45 days after it is received. Parents will receive letters and phone calls for missing required paperwork.
 -Certified Relative Care Providers and Certified In-Home Aides must be certified before they can begin caring for children. This date will be the approval date for those types of applications.
 -Child Care Subsidy payments are made according to the Reimbursement Schedule.
10. **RE DETERMINATION ELIGIBILITY** - All approvals are re-determined every twelve (12) months or more frequently if you are a student. However, if there has been a change in circumstances in your household such as change in provider, loss or increase of income, address, telephone number, etc., please report this information within **ten business days**, as this may affect your Reason for Care, or your Co-Payment (may decrease), and by reporting these changes, you will allow us to help you plan for an Exit Strategy, Phase Out, budgeting, etc.
11. **ASSISTANCE** – If you need assistance filling out this application, please contact the CCDF Program at 1-906-632-5250 or 1-800-726-0093, or stop by Anishnaabek Community and Family Services, 2218 Shunk Rd., Sault Ste. Marie, MI 49783.
12. **PLEASE SUBMIT THE FOLLOWING INFORMATION WITH YOUR APPLICATION:**

CHECKLIST

- | | |
|--|---|
| <input type="checkbox"/> Employer Verification Form(s) AND | <input type="checkbox"/> Most Recent Pay Stub Showing Year-To-Date Income |
| <input type="checkbox"/> All Earned/Unearned Income | <input type="checkbox"/> Tribal Cards for all Household Members |
| <input type="checkbox"/> Social Security Cards for all Household Members | <input type="checkbox"/> Certified School Schedule, if Applicable |



Sault Ste. Marie Tribe of Chippewa Indians
Anishnaabek Community and Family Services
CCDF Program

Dear CCDF Parent(s),

You have the right to choose from high quality child care services that best meets your child care needs without regard to cost.

You can choose from the following types of providers:

1. Licensed Child Care Center that is located on or off the reservation;
2. Licensed Family/Group Child Care Home Providers on or off of the reservation;
3. Relative Care Provider;
4. In-Home Aide.

If you are choosing a **Relative Care Provider** they must meet the following criteria **before** they can provide care:

- must be a relative of the child(ren) needing care (Grandparent, Great Grandparent, Uncle, Aunt, Sibling)
- be of at least 18 years of age;
- live in a separate residence;
- must care only for children they are related to;
- obtain a clear MDHHS Clearance;
- obtain a clear ICHAT (ACFS runs this report);
- obtain a clear Tribal Registry Clearance (ACFS runs this report);
- Provide a signed Open Door Policy, Provider Registration Form, and a signed Client/Provider Agreement;
- follow the CCDF Payment schedule and payment paperwork requirements
- Completed an initial Home Visit with CCDF Coordinator

If you are choosing an **In-Home Aide** they must meet the following criteria **before** they can provide care:

- be of at least 18 years of age;
- live in a separate residence;
- must care only for children on the application during the requested times and dates and at the child's address;
- have successfully passed the FBI Fingerprint background checks;
- obtain a clear MDHHS Clearance;
- obtain a clear ICHAT (ACFS runs this report);
- obtain a clear Tribal Registry Clearance (ACFS runs this report);
- Provide a signed Open Door Policy, Provider Registration Form, and a signed Client/Provider Agreement;
- follow the CCDF Payment schedule and payment paperwork requirements
- Completed an initial Home Visit with CCDF Coordinator

Our payment rates for a Relative Care Provider is \$2.75 per hour for children 0-2 ½ years and \$2.00 per hour for children over 2 ½ years. Payment rate will change as the child's age changes.

We offer an incentive rate for care during non-traditional hours of pay i.e. overnight, weekends.

If you have any further questions regarding your choices, please feel free to contact Angel Peer or myself at 906-632-5250.

Sincerely,

Trish Sterling, CCDF Coordinator

**SAULT TRIBE OF CHIPPEWA INDIANS
CHILD CARE ASSISTANCE APPLICATION**

2218 Shunk Rd., Sault Ste. Marie, MI 49783
906-632-5250 or 1-800-726-0093
FAX:906-632-5266

SECTION I – APPLICATION INFORMATION

Full Name of Applicant:		Former/Maiden Name:	
Mailing Address: (Number & Street):		Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
City:	State: MI	Zip Code:	County:
Home Phone:		Work Phone:	
Social Security Number:		Date of Birth:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		In what Tribal Unit do you reside? Unit: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V	
Family Size: _____		Are you a foster parent? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, who is your Case Manager? _____	

Why do you need child care services (Check all that apply)
 To Work To Attend an Educational Program Other _____
Classes Begin: _____ **Classes End:** _____.

How many miles do you travel from (one way) your place of employment and/or educational program? _____	Are you receiving child care assistance through DHS? <input type="checkbox"/> Yes <input type="checkbox"/> No What percentage is covered? _____. Provide a copy of your award letter.
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Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES you MUST provide the most recent Schedule C. _____ I certify family assets do not exceed \$1,000,000 <input type="checkbox"/>	Do you have a Licensed or Registered Child care Provider <input type="checkbox"/> Yes <input type="checkbox"/> No
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SPOUSE OR 2nd ADULT IN THE HOME INFORMATION

Full Name of Spouse or 2nd Adult in the Home:		
Social Security Number:	Date of Birth:	Work Phone:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	How many miles do you travel from your place of employment (one way) and/or educational program? _____	

For Office Use Only:	Date Received:	CCDF Max Allowable: _____.
Approved <input type="checkbox"/> Denied <input type="checkbox"/>		TOTAL HOUSEHOLD INCOME: _____.
Application: <input type="checkbox"/> New <input type="checkbox"/> Renewal		Family Co-Pay: _____.
		Family Case #: _____.

SECTION VI – APPLICANTS RIGHTS, CERTIFICATION, AND SIGNATURE

1. You have the right to apply for child care services.
2. Your application will be reviewed within 10 days upon completion of all application requirements and you will be notified in writing of your approval or denial. Eligibility will begin the day you submit your application.
3. You should be treated fairly and with dignity in all dealings with the Sault Tribe Child Care and Development Fund.

Read the following statement, sign your name and date the application below. If you have any questions, please ask for an explanation.

I wish to apply for child care services. I certify that the information I have given is true and complete to the best of my knowledge. I understand my rights as described above.

I understand that I must report any changes (i.e. address, telephone number, reason for care, substantial increase in pay, child care provider, loss of employment, change in educational facility, and changes in household composition) in my situation to the Sault Tribe Child Care assistance Program within 10 business days of the change. Failure to comply may result in denial of payment of services.

I understand that I will need to renew my application at least every twelve (12) months.

I certify that all the above information is true and correct and that total household income is reported. I certify that my family assets are not over \$1,000,000. I understand that this information is being given for the receipt of Federal Funds and that the CCDF Program may investigate any family on a random basis. I also fully understand that deliberate misrepresentation of the information may be grounds for denial of my application and may subject my family to criminal prosecution.

As a recipient of child care funds, you have full rights to choose any eligible child care provider to best suit your families needs. However, all providers must be approved by the CCDF Program.

Signature of Applicant

Date

Signature of Significant Other

Date

**ANISHNAABEK COMMUNITY AND FAMILY SERVICES
CHILD CARE ASSISTANCE PROGRAM
2218 Shunk Rd., Sault Ste. Marie, MI 49783
1-800-726-0093 or 906-632-5250**

RELEASE OF INFORMATION

I _____ authorize the Child Care Assistance Program to contact my Employer/Educational Institution, Child Support Agency and/or local Department of Human Services (DHS), or other agency as requested.

1. Name of organization to which disclosure is to be made to:

Anishnaabek Community and Family Services
2218 Shunk Rd.
Sault Ste. Marie, MI 49783
Phone: 906-632-5250

2. Type of information to be disclosed:

- a. To determine if client is income eligible for assistance through CCDF.
- b. To determine if client is enrolled or eligible to be enrolled member of Sault Tribe.
- c. Attendance at work or school when child and/or children are in child care.
- d. To determine is client is eligible for Job Search or Job Training.
- e. To determine if client/family is in need of/or participating in Protective Services Program.

The purpose and need for such disclosure:

Parents can only receive Child Care Assistance if working, attending school, participating in an approved job search or job training program or involved in child protective services. Parents must meet program requirements.

This consent will expire for the following reason:

Client is no longer eligible for the child care assistance.

Head of Household Signature

Date

2nd Adult Signature

Date

CCDF Representative

Date

**ANISHNAABEK COMMUNITY AND FAMILY SERVICES
CHILD CARE DEVELOPMENT FUND PROGRAM
2218 Shunk Rd., Sault Ste. Marie, MI 49783
906-632-5250 or 1-800-726-0093**

**PROVIDER INFORMATION/REGISTRATION FORM
(To be completed by PROVIDER)**

PROVIDER: Print full name: _____ D.O.B. _____

Address: _____ City & Zip: _____

County: _____ Telephone: _____

Child Care License Number: _____ License Expires: _____

Social Security Number: _____

Child's Name	Age	Days and Times of Care							Rate Charged Per Hour
		S	M	T	W	Th	F	S	

Type of Provider: Center (Licensed) Family Home (Licensed) Group Home (Licensed)
 Relative (Care in Relative's Home) Aide (Care in Family's Home)

RELATIVE CARE PROVIDERS

Are you related to the children in need of child care? If so, what is your relation?

Do you have any other employment sources in addition to providing child care?

Yes No

If yes, what are hours are you employed?

Do you have a valid driver's license?

Yes No

Are you a Sault Tribe member?

Yes No

Have you had CPR training?

Yes No

I certify the above information is complete and true to the best of my knowledge. If I knowingly provide false information, I understand that payment may be withheld. I also understand that as an approved provider of CCDF funds, I am the only provider authorized to receive payment for the above named children. I understand that these services cannot be contracted out unless prior approval is received from the CCDF Program. CCDF has the authority to conduct any/all criminal history checks necessary to allow for child care to be provided.

Child Care Provider

Date

**ANISHNAABEK COMMUNITY AND FAMILY SERVICES
CHILD CARE DEVELOPMENT PROGRAM
2218 Shunk Rd.
Sault Ste. Marie, MI 49783
906-632-5250 or 1-800-726-0093**

CLIENT/POVIDER DISCLOSURE AGREEMENT

I _____ understand as a client of Anishnaabek Community and Family
(Parent/Guardian Name)

Services Child Care and Development Fund Program, that CCDF is not responsible for any care that is provided to my child(ren). The CCDF Program may not get involved in disputes regarding parent co-pays or any other related matter.

The Child Care and Development Fund is committed to its tribal families. Each family has the right to choose the type of high quality child care that best suits their needs without regard to cost. Any barriers the client or provider may have, they are encouraged to contact the CCDF Program for possible assistance with their needs.

CCDF clients are encouraged to report any provider complaints they may encounter. The CCDF program will keep substantiated parental complaints on file for all CCDF clients.

Head of Household Signature

Date

Child Care Provider

Date

ANISHNAABEK COMMUNITY AND FAMILY SERVICES
CHILD CARE ASSISTANCE PROGRAM
2218 Shunk Rd.
SAULT STE. MARIE, MI 49783
1-800-726-0093 OR 906-632-5250

PROVIDER OPEN DOOR POLICY

As a participating child care provider under the Child Care Development Fund, I agree to offer an open door policy to any CCDF client during the hours of operation while providing child care in my home/center. **Unlimited access to a CCDF child is required by this program.** I understand that failure to comply with these requirements as set forth by the Child Care and Development Fund (CFR 98.32), I will not only jeopardize my reimbursement for child care but also terminate my privilege to be a participating provider under said program without further notice.

The Child Care and Development Fund is interested in hearing any comments that you may have. Feel free to use the space below to list any barriers, limitations or information that you would like to share with us.

Comments: _____

By signing below, I agree to provide the applicant of this program with unlimited access to my home or center, while their child(ren) is in my care, as required by Federal Law.

Provider Signature

Date

**Anishnaabek Community & Family Services
Child Care and Development Fund
Employer Verification Form**

Employer Name: _____
 Address: _____
 City/State/Zip: _____

Employee Name		Social Security Number	
Street Address	City	State: MI	Zip
<i>I authorize the above employer to release this information to the Child Care Development Fund Program.</i>			
Employee Signature _____		Date _____	

EMPLOYMENT VERIFICATION

Current Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Previously Employed <input type="checkbox"/> Never Employed	Date Employment Began:	Date Employment Ended
Type of Employment <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary If Temporary →	Date Employment Expected to End	
Pay Schedule <input type="checkbox"/> Weekly <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other (explain)	Day of Week Paid	
Daily Work Schedule M T W TH F S S Days & Times/Shift: If shift varies, verification of hours may be required.	Rate of Pay \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other (explain) Is this person considered a full or part-time employee?	
Are tips, holiday or vacation bonus or commission received? Y N If yes, are they included in gross income? Please list below:	Average amount of bonuses? \$ _____ Per Hour \$ _____ Per Week	
Reason for Termination <input type="checkbox"/> Quit <input type="checkbox"/> Laid Off <input type="checkbox"/> Fired <input type="checkbox"/> Off Temporarily <input type="checkbox"/> Other (explain) →	Explain termination here	

Period Begins	Period Ends	Date Received	Gross Amount	Tip Amount – if not included in gross	Hours Worked this period	Comments

Employer Signature _____ Date _____ Telephone _____

Please return completed form to: CCDF, 2218 Shunk Rd., Sault Ste. Marie, MI 49783, ATTN: Angel

**Anishnaabek Community & Family Services
Child Care and Development Fund
Employer Verification Form**

Employer Name: _____
 Address: _____
 City/State/Zip: _____

Employee Name		Social Security Number	
Street Address	City	State: MI	Zip
<i>I authorize the above employer to release this information to the Child Care Development Fund Program.</i>			
Employee Signature _____		Date _____	

EMPLOYMENT VERIFICATION

Current Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Previously Employed <input type="checkbox"/> Never Employed	Date Employment Began:	Date Employment Ended
Type of Employment <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary If Temporary →	Date Employment Expected to End	
Pay Schedule <input type="checkbox"/> Weekly <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other (explain)	Day of Week Paid	
Daily Work Schedule M T W TH F S S Days & Times/Shift: If shift varies, verification of hours may be required.	Rate of Pay \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Other (explain) Is this person considered a full or part-time employee?	
Are tips, holiday or vacation bonus or commission received? Y N If yes, are they included in gross income? Please list below:	Average amount of bonuses? \$ _____ Per Hour \$ _____ Per Week	
Reason for Termination <input type="checkbox"/> Quit <input type="checkbox"/> Laid Off <input type="checkbox"/> Fired <input type="checkbox"/> Off Temporarily <input type="checkbox"/> Other (explain) →	Explain termination here	

Period Begins	Period Ends	Date Received	Gross Amount	Tip Amount – if not included in gross	Hours Worked this period	Comments

Employer Signature _____ Date _____ Telephone _____

Please return completed form to: CCDF, 2218 Shunk Rd., Sault Ste. Marie, MI 49783, ATTN: Angel



SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS ANISHNAABEK COMMUNITY AND FAMILY SERVICES COMPLAINT RESOLUTION PROCEDURE

SCOPE: ACFS recognizes that at times when people interact, conflicts, complaints, and concerns may arise. This complaint resolution procedure is in place to ensure all individuals seeking services from Anishnaabek Community and Family Services have a process to formally log complaints and concerns and have an opportunity for resolution. The ACFS Complaint Resolution Process will be addressed solely through the ACFS Chain of Command, documented below.

PROCEDURE:

1. If you have a complaint about an ACFS Staff Member or any other issue relating to the services you are applying for or receiving, you are encouraged to bring your concern to the immediate attention of the supervisor of that ACFS Program. If you do not feel comfortable or feel that it is not appropriate to bring your complaint to the immediate supervisor of the ACFS Program, you are encouraged to bring it to the next level in the chain of command.
2. In order to properly address your complaint, you will be asked to submit a detailed description in writing using the ACFS Complaint Resolution form.
 - a. Forms will be available upon request at each ACFS location.
 - b. The written complaint must be received by an ACFS Staff Member within 5 business days of the incident.
 - c. The complaint will be date stamped to ensure the timeframe is adhered to.
3. The ACFS Program Supervisor, or first level in the chain of the command, will respond to your concern within 5 business days of receiving notice of the complaint.
 - a. If the complaint response is in the form of a telephone call or in-person conversation, it shall be followed-up in writing.
4. If you and the ACFS Supervisor/Program Manager are not able to resolve the issue or a response is not received within 5 business days, you may request that the next level in the ACFS chain of command review and respond to your complaint.
5. It your responsibility to inform the ACFS Staff, in writing, within 5 business days that you would like your complaint reviewed by the next level in the chain of command.
6. You may express your complaint in writing up through the ACFS Director. The 5 business day timeframe applies at each step in the complaint resolution process.

We appreciate you signing this document to indicate your understanding of the ACFS Complaint Resolution Procedure. You will receive the original document and we will keep a copy for the file.

Participant Signature & Date

EFFECTIVE: November 9, 2015

ACFS Staff Member Signature & Date



SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS ANISHNAABEK COMMUNITY AND FAMILY SERVICES COMPLAINT RESOLUTION POLICY AND PROCEDURE

Complaint Resolution Form

Client Name: _____

ACFS Staff Member or Program: _____

Please describe your complaint / issue below: (You are welcome to use additional paper.)

Please describe your suggested resolution to your complaint / issue: (Use additional paper, if needed.)

Please provide the following contact information:

Mailing Street Address

Telephone Number:



**SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS
ANISHNAABEK COMMUNITY AND FAMILY SERVICES
COMPLAINT RESOLUTION POLICY AND PROCEDURE**

City / State / Zip Code

E-Mail Address:

Client Signature:

Date:

ACFS Staff Signature Accepting Form:

Date:

The ACFS Complaint Resolution Procedure will be addressed through the following ACFS Chain of Command:

Immediate Supervisor (if applicable): _____

Program Manager: _____

ACFS Director: _____

INTERNAL USE ONLY

Client Name: _____ ACFS Tracking #: _____

Signatures indicate acknowledgement of receipt only and are to track the indicated five business days to respond from the date of receipt.

ACFS Project Specialist Signature

Date of Receipt

Date Transferred to 1st Level

ACFS Supervisor/Manager Signature

Date of Receipt

Date Responded

ACFS Chain of Command Signature (if applicable)

Date of Receipt

Date Responded

ACFS Division Director Signature

Date of Receipt

Date Responded

Final Resolution: _____

Date Resolved:

Finalized By: _____