

Cheyenne River Sioux Tribe
Child Care Assistance Program

GUIDELINES

***** Applicants are subjected to a monthly selection process and selected based upon qualifying status *****

For purposes of determining eligibility and priority for the Child Care Assistance program, the program must define the following terms:

1.) Attending a job or educational program:

Applicant must be attending job training, an educational program, or employment. If the applicant is on leave from work or school, the program will **NOT** pay for child care services. (i.e.; funeral leave, annual leave, Administrative Leave, etc.)

Night-shift employment (6:00 pm-8:00 am) will be allowed sleep time (up to 5 hours) during the day
(Documentation reflecting night-shift schedule must be attached with work verification.)

2.) Indian reservation or service area:

Definition of Indian Reservation or Tribal Service Area as it pertains to Child Care Assistance eligibility; is within the boundaries of the Cheyenne River Sioux Reservation. Communities that are within the reservation boundaries are Dupree, Eagle Butte, Isabel, and Timber Lake.

3.) Indian child:

Child, receiving subsidy, must be an enrolled member of a Federally Recognized tribe or must have a pending application for enrollment with a Federally Recognized tribe. (Please attach documentation.)

4.) Current Immunization Schedule:

Applicant must provide a copy of an immunization record for a child receiving subsidy, which reflects updated inoculations. (Please attach record.)

5.) Job training and educational program:

Applicant must be attending a type of public service program that provides job training or educational training. i.e., TANF program, Single Mother's program, high school and any other type of school program. (Please attach documentation.)

6.) Working:

Applicant must be in attendance in employment that pays minimum wage or more. A work schedule must also be attached to the application. (Please attach supporting documentation.)

7.) Protective Services:

Applicant must have a CURRENT protective or temporary custody court document for child receiving subsidy. Services will be provided to a child when an adult person is acting in the place of the child's biological parent. This process must be done through a court order.

Waiving child care fees / co-payment for children receiving (or in need of) protective services may only be done on a case by case basis. (Please attach custody documentation.)

CRST has elected to include special needs children in the definition of protective services.

8.) Special Needs:

Child, under the age of 13, whom requires staff to have additional training to meet additional care or medical health issues for him / herself. (Medical documentation must be provided to detail the child's medical health issues which may require additional staff training to meet the needs of the child prior to placement so program may evaluate and / or review the child's needs.) Documentation submitted to CRST child care program must include individual education plan (IEP) required under the Individual's with Disability Education act (IDEA).

Child above the age of 13 and under the age of 18, who is physically or mentally incapable of self-care. (Medical documentation must be provided to detail the child's medical health issues which may require additional staff training to meet the needs of the child prior to placement so program may evaluate and / or review the child's needs.) Documentation submitted to CRST child care program must include individual education plan (IEP) required under the Individual's with Disability Education act (IDEA).

9.) Residing with:

The applicant will be required to sign a release of information form verifying specific persons residing within the same household that are listed on the Child Care Assistance application. *Please note: Unannounced home visits will be conducted and valid at any time.

10.) Additional terms relating to eligibility or priority established by CCAP:

- A.) All household income, including non-married couples, must be listed on the application.
- B.) If the biological father or mother is not residing in the home, the applicant must obtain a court order for child support within six months of receiving child care assistance.
- C.) Time report and sign in/out forms must be completed by BOTH the provider and parent before payment is processed. Verification of work and/or school hours must be attached to each time sheet by the parent. Late time reports may be subject to nonpayment. Pay period schedules to follow tribal schedules.
- D.) Travel time: If applicant must travel to get to work or school and the provider lives in the same community, travel time (up to 1 ½ hours) will be permitted and dependent upon miles one would travel to get to the work place or school.
- E.) High School students: If an applicant is attending high school, the applicant must submit school verification and will only be responsible for 0% of the total child care cost.
- F.) Families are determined eligible for six-month time period, but are required to report any changes that may affect the amount of assistance received. Changes must be reported in writing within 5 days of when change occurs. Failure to do so may result in termination of services.
- G.) Provider payment rates are available in the Plan and effective October 1, 2018. Please refer to page 20. Should further clarification be needed, see Child Care Director.
- H.) Applicant must choose the type of provider for services:
 - 1.) Center Based Child Care Provider
 - 2.) Group Home Child Care Provider
 - 3.) Family Child Care Provider
 - 4.) In-Home Child Care Provider

Child care providers will be required to follow some health and safety requirements. These requirements will be explained to the provider and parent when services are approved. Relative providers may be exempt from the some health and safety requirements by the parent.

- I.) All providers must be 18 years of age as they will be required to do a background check through the State of South Dakota every year. The provider may also be required to obtain training hours throughout the year whereas the program will pay for training costs. (CPR, First Aid, Food Handlers, Health & Safety Standards, child development, child abuse prevention and reporting, and physical examination, etc. such as but not limited to)
- J.) **IMPORTANT:** Should a parent fail to make their co-payment, the provider may issue a written complaint. The parent will, then, be suspended from the program until the provider is paid. Reporting false information may result in termination.

Cheyenne River Sioux Tribe Child Care Assistance Program APPLICANT INFORMATION		Circle one: NEW / UPDATE / RENEWAL	
Applicant's Name		MI:	Last:
Mailing Address:		City/ST/Zip:	
Community:	County:	Parish (optional):	
Directions to your home:			
Directions to your provider:			
Work#:	Home#:	Cell/Msg#:	

Tribal Affiliation(s) of children:			
Name:	Name:	Name:	Name:
Enrollment#:	Enrollment#:	Enrollment#:	Enrollment#:

Marital status: (circle one)			
<input type="radio"/> Single/Divorced	<input type="radio"/> Married	<input type="radio"/> Separated	<input type="radio"/> Widowed

Reason for subsidy (circle one)			
<input type="radio"/> Work	<input type="radio"/> Training	<input type="radio"/> Education	<input type="radio"/> Child Protective Services
<input type="radio"/> Specials Needs	(description)		

Income Sources/Benefits: (Check all that apply)

- Employment Income**
- Child Support**
- TANF**
- SSI**
- Housing Assistance**
- Food Stamps**
- Medicaid**
- WIC**
- Educational Aid**
- Other Federal Program(s)**
- Other**

Office use:

Family Size:

Monthly Income:

Parent Co-Pay:

Sliding Fee Scale:

Child care provider is a: <i>(Circle one)</i>		
• Family Caregiver (care is in provider home)	• In-Home Caregiver (care is in child's home)	Group Home Caregiver (care is in provider home for more than 1 family)
• Centerbase Name:		

HOUSEHOLD INFORMATION:				
List self & Others:	Birth date:	Relationship:	Income: (per hr)	Social Security #:

PROGRAM REQUIREMENTS:

Child care providers must pass a Central Registry screening through the State of South Dakota.

Child care payments for eligible parents will be directly to your provider. Please be sure your provider's address is correct. Eligible families must pay their percentage amount of childcare costs directly to their provider. I understand that the amount of childcare assistance I receive will be based upon the information I have provided on this form.

I, also, understand that Child Care Services will verify the information I have provided and that federal and state laws provide for fine and/or imprisonment of any person who fraudulently receives, or attempts to receive public assistance, to which that person is not entitled.

I understand that my child care provider will bill the Cheyenne River Sioux Tribal Child Care Assistance Program only for the hours of child care I actually use.

I declare and affirm under penalty that, to the best of my knowledge, the information I have provided herein is true and correct.

Applicant Signature:	Date
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Return To: CRST Child Care Center / PL 102-477
 Child Care Assistance Program
 P.O. Box 590
 Eagle Butte, SD 57625

Tele: (605) 964-7151
 Tele: (605) 964-6415
 FAX: (605) 964-7150

AUTHORIZATION TO FURNISH AND RELEASE INFORMATION

To Whom It May Concern:

I, hereby, authorize any person, agency, or institution, to supply information requested by the Cheyenne River Sioux Tribe, Child Care Assistance Program, concerning myself or my family, and allow inspection and reproduction of records in their possession pertaining to myself or my family, by any duly authorized representatives of the Child Care Assistance Program.

I, further, authorize the Cheyenne River Sioux Tribe, Child Care Assistance Program to release such information to cooperating state and federal agencies.

I, hereby, release any person, agency, or institution from any and all liability to me or my family for supplying such information.

This authorization is given only in connection with its use by the Cheyenne River Sioux Tribe, Child Care Assistance Program, in its administration of its program and for no other purpose. It shall continue in effect until such time as I state in writing.

Applicant Signature	Date
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1. Information requested:	Date:
SOURCE:	
PRINT name of authorized person furnishing information:	Title:
Signature of authorized person:	Date:

2. Information requested:	Date:
SOURCE:	
PRINT name of authorized person furnishing information:	Title:
Signature of authorized person:	Date:

3. Information requested:	Date:
SOURCE:	
PRINT name of authorized person furnishing information:	Title:
Signature of authorized person:	Date:



PROVIDER INFORMATION SHEET

Provider Name: _____ Vendor#: _____
 Mailing Address: _____ Telephone#: _____
 City: _____ Msg/Cell: _____
 State: _____ Zip: _____ County: _____

Child care setting: <i>(Circle one)</i>			
<input type="radio"/> Child's Home	<input type="radio"/> Provider's Home	<input type="radio"/> Group Home	<input type="radio"/> Center

Substantiated Abuse and Neglect screening?	Background Check?	CPR?	First Aid?	Food Handlers?
Yes or No	Yes or No	Yes or No	Yes or No	Yes or No

Are you: <i>(Circle one)</i>				
<input type="radio"/> State licensed?	<input type="radio"/> Regulate?	<input type="radio"/> Unregulated?	<input type="radio"/> Tribal?	<input type="radio"/> Relative?

Child care for: <i>(Parent name)</i>	
Child:	Child:
Child:	Child:

PROVIDER SIGNATURE:	DATE:

Office Use ONLY:	
Provider status: Active / Inactive	Accreditation Type:
Comment:	

REQUEST FOR SCREENING FOR SUBSTANTIATED REPORTS OF CHILD ABUSE OR NEGLECT

I authorize the Department of Social Services/Child Protection Services to screen my name against South Dakota's Central Registry of Child Abuse/Neglect, and to search any information systems for substantiated abuse or neglect reports and release the findings only to me.

My reason for requesting this screening is _____
(Must Specify)

Full name _____
First Middle Last

Maiden and former names or any alias: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

List full birth name and birth date of **all** your biological children, including those that are adults.

Name (First, middle, last) Date of Birth	Date of Birth	Name (First, middle, last)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YOUR Name and Return Address:

Your Name

Your Signature Date

Street Address

Subscribed and sworn to before me, a Notary Public,

PO Box Number / Apt / Suite / Unit / Lot

this _____ day of _____, _____.

City State Zip

Notary Public Signature

My Commission Expires: ____/____/____

Your return email address (if requesting results via email)

YOUR SCREENING WILL ONLY OCCUR IF THIS FORM IS PROPERLY NOTARIZED.

Return completed form by mail to:

DSS-Licensure & Accreditations

Attn: Kyli Klinger

910 E Sioux Ave

Pierre, SD 57501-2291

Or email completed form to: DSSCRS@state.sd.us