



Peoria Tribe of Indians of Oklahoma  
118 S. Eight Tribes Trail (918) 540-2535 Fax (918) 540-2538  
PO Box 1527  
Miami, OK 74355

## CHILD CARE PROVIDER PACKET

Please read and complete the following forms and notices as included in the provider packet:

FORMS: Complete, Sign and Return these forms to the Tribe.

- W-9 Tax Form-Please mark the exempt backup withholding box.
- Provider Orientation
- Copy of this letter

Please send in with the above forms:

- Copy of your State License
- Copy of your Star or Tier Level Certificate ( if available in your state)
- Copy of your facility payment rates
- Copy of your States approved payment rates
- Copy of your latest State/Tribe Monitoring Evaluations
- Parent handbook &/or copy of registration forms and copy of employee handbook

Please keep for your records:

- Copy of Provider Orientation
- Monthly Day Care Voucher Form. (Make copies as needed)

Please sign and date below, stating that you received everything stated above. Please call if you did not receive all paperwork.

**I understand that daycare assistance will not be paid until a date of approval is determined by the CCDF program. Any assistance received prior to the date of approval will be the sole responsibility of the applicant. You will receive an approval letter from the CCDF program. MAIL WITH POSTAGE DUE WILL NOT BE ACCEPTED.**

\_\_\_\_\_  
Provider signature

\_\_\_\_\_  
Date



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 PO Box 1527  
 Miami, OK 74355

PROVIDER ORIENTATION

DATE: \_\_\_\_\_

NAME OF FACILITY: \_\_\_\_\_

NAME OF FACILITY DIRECTOR: \_\_\_\_\_

COUNTY: \_\_\_\_\_ LICENSE NUMBER: \_\_\_\_\_

.....  
 Taxpayer Identification Number (Social Security Number or Employer Identification Number): \_\_\_\_\_

**Attach latest Monitoring Report Forms from your State or any other Tribes visits!**

MAILING ADDRESS: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

STAR STATUS: ( ) 1\* ( ) 1\* Plus ( ) 2\* ( ) 3\*

FACILITY STATUS: ( ) Family Child Care Home ( ) Large Child Care Home  
 ( ) Child Care Center

Do you, as a provider meet the State staff-child ratio? ( ) Yes ( ) No

**THIS IS A LEGALLY BINDING DOCUMENT. BE SURE TO READ IT BEFORE SIGNING.**

Check one only: ( ) Sole proprietor ( ) Corporation ( ) Partnership ( ) Other

**DO NOT FAX APPLICATION—MUST HAVE ORIGINAL!**

**Purpose and Performance of the Agreement**

The purpose of this Agreement is to establish eligibility for Provider participation in the Child Care System and to set forth Tribal and Provider responsibilities and assurances. The Child Care System provides eligible clients who receive child care services funded through the Peoria Tribe of Indians of Oklahoma’s CCDF Program, the opportunity to select a child care provider from a list of eligible participants. The Provider must comply with Tribal, State and Federal regulations. If any statute or regulation is enacted or promulgated requiring changes in this Agreement, both parties will consider this Agreement to be automatically amended to comply with the newly enacted statute or regulation as of the effective date of the statute or regulation. The Tribe shall notify the Provider in writing within thirty (30) days of the receipt of any necessary changes or amendments to this Agreement resulting from newly enacted State or Federal statutes or regulations

1. **PEORIA TRIBE/PROVIDER AGREEMENT**

- a. If a provider is licensed by the State, they are automatically approved through the Peoria Tribe. Once the Peoria Tribe receives all documentation requested with the application, they are registered with the Tribe. The Provider **MUST** submit all monitoring reports conducted by the State or any other Tribes to stay registered with the Peoria Tribe. If monitoring reports are not submitted to the Tribe then payment may be held until the Tribe receives the reports.
- b. The Provider is not an employee of the Peoria Tribe. They are considered an independent vendor. No taxes are withheld from their payments. They are not eligible for unemployment, social security, workman's compensation, or medical insurance.
- c. The Provider will not receive a W-2 form at the end of the year. The provider will receive a 1099 Miscellaneous Income Form if they receive more than \$600.00 worth of child care payments. As an independent vendor, the Provider is responsible for federal and state taxes.
- d. The Peoria Tribe reserves the right to cancel services in the event of any violations.
- e. The Provider agrees that private pay clients, receiving substantially the same services, shall not be charged at a rate less than that paid for by clients under this agreement.
- f. The Peoria Tribe will not pay for these HOLIDAYS, UNLESS YOU PAY YOUR EMPLOYEES FOR THESE HOLIDAYS: Your employee handbook needs to state what holidays you pay your employees.
  - New Year's Day
  - Memorial Day
  - Independence Day
  - Labor Day
  - Thanksgiving Day
  - Christmas Day

2. **RESPONSIBILITIES OF THE PROVIDER**

- a. Children must be supervised by the Provider at all times.
- b. Notify the Child Care Office of any changes in status of our clients (ie. living situation, or change of address)
- d. Notify the Peoria Tribe Child Care Program of any anticipated change of ownership or address. It is further agreed and understood that this contract **shall terminate immediately upon the sale of Caregiver/Provider's facility** to a third party and that the new owner/vendor must obtain their own contract for services with the Peoria Tribe of Indians of Oklahoma Child Care Program.

- e. It is understood by the Provider that by signing and submitting its claim form pursuant to this contract, it certifies that the services claimed actually were provided to the Peoria Tribe Child Care program or its clients. Further, Provider acknowledges it is aware that filing a fraudulent claim for services submitted to the Peoria Tribe Child Care program is a felony punishable by a fine not to exceed \$10,000 and/or imprisonment in the penitentiary for a term not to exceed two years.
- f. It is understood that in the event of an overpayment by the Peoria Tribe Child Care Program to the Provider, the Peoria Tribe at its discretion may (1) demand immediate reimbursement by Provider; (2) withhold up to the full amount of the overpayment from any and all funds due to or to become due and owing the Provider; (3) accept a mutually agreeable written repayment plan; (4) seek collection by any other means including, but not limited to, litigation.
- g. It is understood that Provider must meet and maintain all state/federal and tribal standards applicable to the authorized services being provided pursuant to this contract and Provider hereby acknowledges full awareness of such standards. The Provider shall notify the Peoria Tribe Child Care Program of any person who has an ownership or controlling interest in, or is an agent or managing employee of Provider, who has been convicted of a criminal offense related to such person's involvement under Titles XVII, XIX, or XX of the Social Security Act since inception of these programs. Further, Provider certifies that it is not presently nor has it in the last three years been debarred, suspended, proposed from debarment, declared ineligible by any federal department or agency or convicted of a fraud related crime.
- h. It is understood the Provider has complied and will comply with federal standards and state law regarding safeguarding of information obtained pursuant to the provision of authorized services hereunder; with the Civil Rights Act of 1964 as amended; with the Rehabilitation Act of 1973 as amended and the Americans with Disabilities Act seeking services without regard to age, race, color, religion, sex national origin or handicap. Provider also guarantees that it will provide a drug free workplace.
- i. The Provider understands that they are not an employee of the Peoria Tribe. The Provider is responsible for all self employed fees and taxes.

**3. RESPONSIBILITIES OF THE PARENT**

- a. Responsible to collect co-payments, that is between client and provider.

**4. RECORD KEEPING GUIDELINES**

- a. Payment policy: Approval Notice, Original Claim Forms (no copies accepted) Claims must be submitted monthly, multiple submitted months will not be paid. Parents will not be held financially liable for claims not submitted correctly and on time for payments by the provider.

- b. Payment rates: Part-time (4 hours and less), Full-time (more than 4 hours up to 10). On a case-by-case basis there may be special circumstances, which would allow assistance for extended hours.
- c. Processing time is 30 days from receipt of properly filed claim. Holidays may extend processing time.
- d. Both signatures must be on claim forms and legible.
- e. On envelope, please have ATTENTION: Child Care Department, for prompt delivery and mail to the PO Box 1527, not physical address.
- f. Properly completed claim forms that are in the Child Care Office by the 5<sup>th</sup> day of the month will be issued a check by the 20<sup>th</sup>, barring unforeseen circumstances. **MAIL WITH POSTAGE DUE WILL NOT BE ACCEPTED.**

5. **HEALTH AND SAFETY REQUIREMENTS** – We follow State and Tribal Standards. Please send in Monitoring Report Forms from your State/Tribal visit.

6. **TRAINING**

- a. Eligible to attend DHS sponsored training.
- b. Eligible to attend training sponsored by Tribal Child Care and Development Department.
- c. Training information is available through the Child Care Department.

Facility OWNER has authorized the following individuals(s) to sign the Peoria Tribe of Indians of Oklahoma Child Care Claim Form. Only names listed below are authorized to sign claim forms for payment.

\_\_\_\_\_  
Signature: Authorized Individual

\_\_\_\_\_  
Signature: Authorized Individual

By signature below, I request to participate in the Peoria Tribe of Indians of Oklahoma Child Care Program and certify that all documentation presented is true and correct. I understand and accept all the assurances and responsibilities outlined in this Agreement.

I understand that daycare assistance will not be paid until a date of approval is determined by the CCDF program. Any assistance received prior to the date of approval will be the sole responsibility of the applicant.

I understand that the Peoria Tribe Child Care Program will only pay for days and hours the parent/guardian is working or in training/college. If the parent/guardian is not working or in college/training, they are responsible for the childcare expense to the provider.

\_\_\_\_\_  
Facility Owner (if different than Director)

\_\_\_\_\_  
SSN/FIN

## Peoria Tribe of Indians of Oklahoma CCDF Service/Attendance Claim Form

Child's Name:	Age of Child in months:
Guardian's Name	Name of Facility:
Address:	Phone number:
City, State, Zip:	Address, City, State, Zip:

I affirm under penalty of perjury that the information contained on this form is correct to the best of my knowledge and belief and understand that any false statements on my part may result in prosecution for fraud. **Fill in ALL INFORMATION.**

Legible Signature of Guardian:

Legible Signature of Provider:

*Please enter times on dates child was in your care, include the total hours for each day, 4 hrs and under will be at the part day rate.*

Date	Time In	Time Out	Time In	Time Out	Hours
1	A P	A P	A P	A P	F P
2	A P	A P	A P	A P	F P
3	A P	A P	A P	A P	F P
4	A P	A P	A P	A P	F P
5	A P	A P	A P	A P	F P
6	A P	A P	A P	A P	F P
7	A P	A P	A P	A P	F P
8	A P	A P	A P	A P	F P
9	A P	A P	A P	A P	F P
10	A P	A P	A P	A P	F P
11	A P	A P	A P	A P	F P
12	A P	A P	A P	A P	F P
13	A P	A P	A P	A P	F P
14	A P	A P	A P	A P	F P
15	A P	A P	A P	A P	F P
16	A P	A P	A P	A P	F P

Date	Time In	Time Out	Time In	Time Out	Hours
17	A P	A P	A P	A P	F P
18	A P	A P	A P	A P	F P
19	A P	A P	A P	A P	F P
20	A P	A P	A P	A P	F P
21	A P	A P	A P	A P	F P
22	A P	A P	A P	A P	F P
23	A P	A P	A P	A P	F P
24	A P	A P	A P	A P	F P
25	A P	A P	A P	A P	F P
26	A P	A P	A P	A P	F P
27	A P	A P	A P	A P	F P
28	A P	A P	A P	A P	F P
29	A P	A P	A P	A P	F P
30	A P	A P	A P	A P	F P
31	A P	A P	A P	A P	F P

For the month of \_\_\_\_\_ 20\_\_\_\_\_.

**THIS VOUCHER MUST BE IN THE TRIBAL OFFICE BY THE 5<sup>TH</sup> DAY OF EACH MONTH IN ORDER FOR A CHECK TO BE ISSUED ON THE 20<sup>TH</sup>. MAIL WITH POSTAGE DUE WILL NOT BE ACCEPTED!**



Name of Provider:				Charges	
Full Days		X	Per Day	=	
Part Days		X	Per Day	=	
STAR RATING: _____			Total Monthly Charges		
			Minus Client's Co-Pay Due		
County _____			Provider's Claim Due		