



**RECERTIFICATION APPLICATION CHECKLIST**

**PEORIA TRIBE OF INDIANS OF OKLAHOMA  
118 S. EIGHT TRIBES TRAIL  
P.O. BOX 1527  
MIAMI, OK. 74355  
PHONE: 918-540-2535  
FAX: 918-540-2538**

The documentation can be delivered to the CCDF office by mail, fax, email or hand delivered. The following documentation is required to maintain eligibility for childcare assistance. **Application must be filled out completely or it will be returned for completion.**

- \_\_\_\_\_ APPLICATION—**Page 2 must be signed by daycare provider.**
- \_\_\_\_\_ PROOF OF INCOME FOR ALL HOUSEHOLD MEMBERS – Previous year Federal Tax Return —Children **MUST** be claimed on return.
- \_\_\_\_\_ PROOF OF ADDRESS (Utility bill, lease, **must have physical address, not P.O. Box.** If your address is not in your name, you must fill out a physical address form and return it with your application).
- \_\_\_\_\_ WORK SCHEDULE ON LETTER HEAD OR NOTARIZED. If you are attending college or vocational school you must submit original class schedule and after completion you must submit an unofficial transcript each semester

**INCOMPLETE APPLICATION OR POSTAGE DUE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED FOR YOUR COMPLETION. (examples: birthdates, social security numbers, daycare addresses, employer information).**  
**DAYCARE ASSISTANCE WILL NOT BE PAID UNTIL A DATE OF APPROVAL IS DETERMINED BY THE CCDF STAFF. ANY ASSISTANCE RECEIVED PRIOR TO THE DATE OF APPROVAL WILL BE THE SOLE RESPONSIBILITY OF THE APPLICANT.**

I understand that I must have all the above original documentation delivered to the CCDF office and have a complete application before I will be considered for assistance from the CCDF Program. I also understand that if I falsify information or fail to submit information required for eligibility that I will be suspended or terminated and will be required to reimburse the program.

I understand by signing below I am verifying that my family does not have assets that exceed \$1,000,000.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



**APPLICATION FOR CHILD CARE SERVICES**  
**PEORIA TRIBE OF INDIANS OF OKLAHOMA**  
**118 S. EIGHT TRIBES TRAIL**  
**P.O. BOX 1527**  
**MIAMI, OK 74355**

**ALL AREAS MUST BE FILLED OUT OR APPLICATION WILL BE RETURNED!**

<b>Applicant's Family Name:</b>		<b>Application Date:</b>	
<b>Mailing Address:</b>			
Physical Address, if different from above:			
<b>Email Address:</b>		<b>Phone:</b>	<b>Cell:</b>
<b>County:</b>		<b>City:</b>	<b>State/Zip:</b>
<b>Employer 1:</b>		<b>Phone:</b>	
<b>Work Address:</b>		<b>City:</b>	<b>State/Zip:</b>
<b>Employer 2:</b>		<b>Phone:</b>	
<b>Work Address:</b>		<b>City:</b>	<b>State/Zip:</b>

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**List ALL the People In Household and their information**

First Name	M.I	Last Name	Headstart, Social Security, AFDC, SoonerCare, etc...	Sex	D.O.B.	Age	Social Security Number	Married Single, Live In	✓ Here if need of day care

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<b>Child Care Choice:</b>		<b>Applicant's Signature:</b>	
<b>Address:</b>		<b>County:</b>	<b>Date Signed:</b>
<b>Phone:</b>	<b>Provider License#:</b>	<b>Director/Owner of Child Care Signature:</b>	
<b>Child Care Mailing Address if different from above:</b>		<b>**PEORIA TRIBE WILL FILL OUT BELOW**</b>	
<b>Co-Payment (Per Month-Per Child):</b>		<b>Max. Days Authorized</b>	<b>Hours per Day:</b>
<b>Peoria Tribe Child Care Signature:</b>		<b>Dates Certified</b>	

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**Special Needs, Protective Services and Priority Rules for Children**

Does any child in the home have a special need or disability? \_\_\_ Yes \_\_\_ No

If so then please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is any parent in the home under the age of 19? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does any parent in the home have a work day that begins after 3:00 PM? \_\_\_ Yes \_\_\_ No

Does the child reside in a foster care home? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is anyone in the family unit homeless? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you feel your case should be considered special needs or priority for any other reason not listed above? If so then please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



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## AUTHORIZATION FOR RELEASE OF INFORMATION

**CONSENT:**

I authorize and direct the Peoria Tribe to gather information or materials needed to complete and verify my application for participation in and/or to maintain my continued assistance under the Peoria Tribe services and programs.

**INFORMATION COVERED:**

I understand that previous or current information regarding my household or myself may be needed. Verification and inquiries that may be requested include, but are not limited to:

- |                                |                                  |
|--------------------------------|----------------------------------|
| Identity and Marital Status    | Medical or Child Care Allowances |
| Employment, Income, and Assets | Residence and Rental Activity    |
| Criminal and Drug Activity     |                                  |

**GROUPS AND INDIVIDUALS THAT MAY BE ASKED:** (but not limited to):

- |                               |                                  |
|-------------------------------|----------------------------------|
| Previous Landlords            | Courts and Post Offices          |
| Schools and Colleges          | Law enforcement Agencies         |
| Support and Alimony Providers | Past and Present Employers       |
| Veterans Administration       | State Unemployment Agencies      |
| Welfare Agencies              | Medical and Child Care Providers |
| Utility Companies             | Banks, Credit Bureaus            |
| Credit Providers              |                                  |

**ALL ADULTS IN HOUSEHOLD MUST SIGN FORM BELOW!**

**CONDITIONS:**

I agree that a photocopy of this authorization may be used for the purposes stated above. The original of the authorization is on file with the Peoria Tribe Child Care Department and will stay in effect as long as services are received. This request is effective from June of one year until May of the following year.

\_\_\_\_\_  
Primary Applicant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Secondary Applicant (Spouse, etc)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



PROVIDER & PARENT INFORMATION FORM

Provider (Day Care) Name

Street City State Zip County

Phone

Fax

**Children attending:**

Name Age D.O.B. Days Hours attending  
(AM to PM)

Name Age D.O.B. Days Hours attending  
(AM to PM)

Name Age D.O.B. Days Hours attending  
(AM to PM)

Name Age D.O.B. Days Hours attending  
(AM to PM)

Parent Name

Address City State Zip

Day Phone

Evening Phone

Parent Signature

Date

Applicants please verify information is current and correct. Please complete entire form.