Infant Sleep Permission Form

Prepared by ND Child Care Resource & Referral Health Consultant Team

The American Academy of Pediatrics recommends keeping soft objects and loose bedding (including blankets) out of the crib/playpen to reduce the risk of SIDS, suffocation, entrapment, and strangulation for infants under the age of 12 months. The AAP recommends the use of pacifiers for sleep. Studies have reported a protective effect of pacifiers on the incidence of SIDS. The pacifier is not recommended to be attached to the infant's clothing or to a stuffed animal/toy. The pacifier should be checked for tears before each use.

Effective January 1, 2013, ND Child Care Licensing Regulations state:
With written parental permission, the provider may place one individual infant blanket or sleep sack, a pacifier, and a security item that does not pose a risk of suffocation to the infant in the crib or portable crib while the infant is sleeping or preparing to sleep.

Parent/Guardian Authorization

I have read the information on this form and give UTTC/Infant Toddler Center permission to use the following checked item(s) when my infant _____ is sleeping or preparing to sleep:

Print Name of Provider/Program

Print Infant's Name

☐ One infant blanket (a thin blanket is recommended)
- If infant is being swaddled, the blanket should not come any higher than to the shoulders of the infant.
- Swaddling should be discontinued once the infant shows signs of rolling over.

☐ Sleep sack
- Swaddle sleep sacks (with arm panels) can be used until the infant shows signs of rolling over. Once the infant shows signs of rolling over, sleeveless sleep sacks should be used.

☐ Pacifier

☐ Security item (specify item) _____

☐ Cradle Board

Name of Parent/Guardian (please print) _____

Parent/guardian Signature _____ Date: _____

** *It is recommended to place a copy of this form in the infant's file as well as post near the infant's crib/playpen (out of infant's reach) for providers/staff to reference.*

Sources:

Caring for Our Children National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care, 3rd Edition, 2011

ND Child Care Licensing Regulations

Technical Report -SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment", AAP, Pediatrics 2011

Policy Statement -- SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment", AAP, Pediatrics 2011

Revised 1/13

NORTH DAKOTA CCR&R CHILD CARE RESOURCE & REFERRAL

AUTHORIZATION TO DISCLOSE INFORMATION

UNITED TRIBES TECHNICAL COLLEGE
CHILD DEVELOPMENT CENTER
3315 University Drive • Bismarck, ND 58504 • 701-255-3285

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment of your agreement to authorize disclose of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

INSTRUCTIONS: (Please Print)

Parent/Guardian: (Last, First, Middle Initial)	Social Security Number XXX-XX-	Date of Birth	
Street Address	City	State	Zip Code

PARENT RELEASE AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Agency: BURLEIGH / MORTON COUNTY SOCIAL SERVICES

Street Address	City	State	Zip Code

2. To Release Information To:

Name of Person/Agency to Receive Information: UNITED TRIBES TECHNICAL COLLEGE / CHILD DEVELOPMENT CENTER

Street Address	City	State	Zip Code
3315 UNIVERSITY DRIVE	BISMARCK	ND	58504

3. The Following Information is Requested: (Be Specific)

Application status, missing/needed documentation, missing payment information.

4. The Information Identified Above Will Be Used For: (List Each Purpose)

To determine childcare assistance eligibility. To assist the parent in completing the application. To determine parent's childcare usage eligibility.

5. This Authorization to Disclose Information Expires Twelve (12) Months After the Date Below.

OR: (Specific Event Terminating Operation of Release)

PARENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Parent / Guardian:	Date
Signature of Parent / Guardian:	Date
Signature of CDC:	Date

☐ CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed in which case it may not be protected by state or federal law.

DISTRIBUTION: ☐ To person from whom information is sought
☐ Requesting Agency

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION

CACFP Enrollment Form / Free and Reduced-Price Income Application (Child Care)

Complete one application per household. Please use a pen (not a pencil).

Center Name: Infant Toddler Center

STEP 1 REQUIRED – The parent / guardian must complete Parts 1 and 4. List ALL Children who attend day care

CHILD's Last Name, First Name	Date of Birth	Time of Care		Regular Days of Care							Meals Served During Care						Check all that apply		
		Arrival Time	Leave Time	M	T	W	T	F	S	S	B	AM	L	PM	D	EV	Foster Child	Migrant	Head Start

PARENTS OF INFANTS Your child care center must offer at least one brand of formula if your child is on formula. You have the option of declining that brand and supplying your own formula. Children must be served breast milk or iron-fortified infant formula until they are one year of age. All other food items must be provided by your center when age-appropriate, consistent with CACFP guidelines.

My Choice of CACFP Infant Participation is:

- ☐ I choose to supply expressed breast milk to my child care provider to serve at meal time.
- ☐ I choose to accept the iron-fortified infant formula (brand: Enfamil) that my child care center has offered.
- ☐ My child care center has offered the following brand, Enfamil. I have chosen to decline this brand and provide the formula for my infant.

STEP 2 Optional - Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER: ______ Write only one case number in this space.

STEP 3 Optional – Parent / guardian should fill out household income to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our confidential files.

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income $ ______ How often? ○ Weekly ○ Bi-Weekly ○ Monthly ○ 2x Monthly

B. All Other Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members not listed in Step 1 (Last Name, First Name)	Earnings from Work	How often? Weekly / Bi-Weekly / Monthly / 2x Month	Welfare/Child Support/Alimony	How often? Weekly / Bi-Weekly / Monthly / 2x Month	Pensions/Retirement/Social Security/SSI/VA Benefits	How often? Weekly / Bi-Weekly / Monthly / 2x Month
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○

Total Household Members (Children and Adults) ______

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member: X X X - X X - ______ ☐ Check if no SSN

STEP 4 REQUIRED - Sign and date the application. The form must be signed by the parent or guardian.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form ______ Signature of Adult ______ Today's Date ______

Address ______ City ______ State ______ Zip ______ Phone/Email ______

UNITED TRIBES TECHNICAL COLLEGE

UTTC/Child Development Center Registration Form

Person Completing Child Registration Form

Printed Name of Person Completing Form _____ Relationship to Child _____

Signature of Person Completing Form _____ Date _____

Child Information

Last Name_____ First _____ Middle_____
Preferred Name (if different than above) _____
Home Phone _____ Gender ☐ Male ☐ Female
Date of Birth _____
Ethnicity (circle one): American Indian Caucasian African American
Hispanic Asian Pacific Islander
Is this child an enrolled member of federally recognized tribe? ☐ Yes ☐ No
Tribal Enrollment Number: _____

Address Information

Child Mailing Address_____ City _____ State _____ Zip _____
Street Address (if different) _____ City _____ State _____ Zip _____

Parent/Guardian Information

Father's Name _____ Home Phone _____ Cell Phone _____

Mother's Name _____ Home Phone _____ Cell Phone _____

Guardian's Name _____ Home Phone _____ Cell Phone _____

Living Arrangements

(Circle one)

Does this child live in a single-parent household? Yes No

Child currently lives with: Both Parents Mother Only

Father Only Other _____

(OVER – please fill out back side of form)

Emergency Information

(Indicate local contact persons other than parent – must live in Bismarck/Mandan/Lincoln)

Contact 1 _____ Relationship _____
Daytime Phone _____ Type of Phone: Home Work Cell

Contact 2 _____ Relationship _____
Daytime Phone _____ Type of Phone: Home Work Cell

Contact 3 _____ Relationship _____
Daytime Phone _____ Type of Phone: Home Work Cell

Medical Information

Doctor _____ Phone _____
Dentist _____ Phone _____
Allergies (list) _____
Medications (list type and purpose) _____
Health Conditions: (circle and describe any that apply)

Glasses	Diabetes	Seizures	Frequent Ear Infections
Hearing Aids	Ear Tubes	Asthma	Other

Describe: _____

Has any health condition resulted in an emergency? ☐ Yes ☐ No
Describe: _____

I give permission for the center to apply bug spray/sun screen to my child: ☐ Yes ☐ No

Photo/Video Release Authorization

I give the Child Development Center Staff permission to take pictures/video of my child:

_____
(Child's Name) ☐ Yes ☐ No

Closed Facebook Page

I give the Child Development Center Staff permission to take photos/share daycare information:

_____
(Child's Name) ☐ Yes ☐ No

This Section should be completed By Child's Legal Decision Maker

Has your child ever received service(s) for a disability? ☐ Yes ☐ No
If "yes" indicate which service(s) _____

Where were services provided? _____

In case of a medical emergency, and I cannot be reached, I give my child's doctor or any attending physician permission to administer medical treatment. ☐ Yes ☐ No

Beginning Date _____ your child will attending UTTC/Child Development Center.

_____
(Print Name) (Signature) (Date)

Infant Toddler Center (only)
Developmental History

Child's Name: _____ Birthdate: _____

Nicknames: _____
(Name you would prefer us to call your child)

Has your child been in a daycare setting before? Yes / No

****

Brand of Formula Used: _____ (Center provides Enfamil/Simply Right (Sam's Club)

Liquid Used with formula: (please circle) Tap Water / Nursery Water / Doesn't matter

How many ounces does your baby drink per feeding: _____

If any of the above changes - please make sure that the daycare center knows immediately.

While in the center, bottles will be used at mealtimes/naptimes, not given to a child to walk around with during activity times

Type of Bottle/Nipple Used (be specific): _____

Bottle/Feeding Schedule: _____ Bottle Temp: Room Temperature / Warmed

History of Colic: Yes / No Child Full Term: Yes / No Birth Weight: _____
If premature, how early: _____

History of Asthma: Yes / No

Child Currently Breastfed: Yes / No

Does your child use a pacifier? Yes / No Treatments Given: Yes / No
***ITC does not administer breathing treatments**

Does your child suck a thumb? Yes / No

Children ages 1-2 what type of milk? _____ ***Center provides whole milk/lactose (skim) anything else parent must provide***

Suggestions for teachers when bottle feeding your child: _____

****

Amounts & Kinds of solid foods given: _____

** **(If not currently on solid foods – please make sure the daycare knows when you begin to feed your baby solid foods such as baby cereal, baby food, table food, etc...)** Baby cereal, baby food, and table food is provided by the center.**

****

Does your child have a history of ear infections: Yes / No Does your child have tubes: Yes / No

(Over – please fill out back side of form)

Foods your child may be allergic to: _____ *If food allergies separate form must be completed*

Suggestions for teachers during mealtimes: _____

Bowel movements regular: Yes / No How many/day: _____

Diarrhea / Constipation a problem? (Circle if applicable)

Baby's skin is highly sensitive: Yes / No Frequent diaper rash: Yes / No

Do you use: (Circle) Wipes Powder Lotion Ointment Other: _____

Attempting toilet training: Yes / No

How would you like us to help you with this? _____

Suggestions for teachers while diapering/toilet training your child: _____

After **each** diaper change a wipe is used to wipe your child

****

Time my child wakes up in the morning: _____ Time my child goes to bed at night: _____

Does your child: please circle Sleep in their own bed/crib Sleep with a parent Sleep in a swing/carseat

Typical nap time(s) during the day: _____

How long is naptime: _____

What does your child take to bed with him/her: _____

Does your child like to be wrapped at naptime? Yes / No Likes to lay on:(circle) tummy/back/side (older children)

Suggestions for teachers about your child's naptime: _____

****

Suggestions to help better serve your child at ITC: _____

Please make sure that daycare knows at all times what your baby/child eats and how much – thanks for your cooperation!

Updated 6/15

PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS

SFN 847 (Rev. 11-2008)

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility. This form is completed by a parent or guardian of the child.

Full Legal Name of Child:	Birth Date:	Enrollment Date:	Please check one: ☐ FT ☐ PT ☐ Dropin ☐ B/A School
Full Legal Name(s) of Parent or Guardian:			Relationship:
Address:		City:	State: / ZIP Code:
Home Telephone Number:	Work Telephone Number:	Family Dentist:	
Family Physician:		Clinic:	Telephone Number:
Hospital:			Telephone Number:
Last Visit to Doctor:	Child's Height:		Child's Weight:

Does The Child Have Any food, medication or environmental allergies: ☐ Yes ☐ No

If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Heart Condition ☐ Hearing Impairment ☐ Behavioral Issues

☐ Diabetes ☐ Seizure Disorder ☐ Frequent Earaches ☐ Other Conditions (please specify): _____

☐ Vision Impairment

Please Explain All Checked Items:

Is The Child Under Current Medical Treatment? ☐ Yes ☐ No If yes, please list:

Are There Any Medications That The Child Takes Daily? ☐ Yes ☐ No If yes, please list:

Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:

Is there a health care plan for your child? ☐ Yes ☐ No If yes, please attach

INSURANCE:
Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

CERTIFICATION:

I certify that the above information is true to the best of my knowledge.

Parent or Guardian's Signature	Date

CHILD INFORMATION SHEET

ND DEPARTMENT OF HUMAN SERVICES
CHILDREN AN D FAMILY SERVICES
SFN 845 (12-2013)

Every Early Childhood Program is required to have certain information on file. These requirements are set forth in the rules and regulations for Early Childhood Services as adopted by the North Dakota Department of Human Services. All information requested herein is required and shall be kept confidential.

Child's Name	Date Child Enrolled	Preferred or Nickname of Child	Date of Birth
Mother's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work
Father's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work

EMERGENCY AUTHORIZATION

In case of an emergency and parents cannot be reached, who should be contacted?

Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Physician to Call in an Emergency			Clinic Telephone Number
Dentist to Call in an Emergency			Clinic Telephone Number

I hereby authorize the Early Childhood Program to secure emergency medical treatment for my child under the following conditions:

1. An emergency or unanticipated condition necessitates immediate action for the preservation of the life or health of the child, and
2. Reasonable attempts to contact me have failed.

Parent Signature	Date	Parent Signature	Date

AUTHORIZATION TO RELEASE CHILD

Unless otherwise authorized by you in writing, only the parent or legal guardian may pick up your child(ren) from the Early Childhood Program. List below any others you wish to authorize for this purpose.

Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number

These people are <u>NOT</u> allowed to pick up my child.

Name	Relationship to Child
Name	Relationship to Child

For Operator Use Only:

The identification of this child has been verified. As proof of identification, the child's parent has produced:
☐ Copy of Child's Birth Certificate ☐ Child's Passport ☐ Other _____

Signature of Operator

UNITED TRIBES
TECHNICAL COLLEGE

3315 University Drive
Bismarck, North Dakota 58504

701.255.3285
www.uttc.edu

AUTHORIZATION OF FEDERAL STUDENT AID FUNDS AND/OR OTHER STUDENT AID PAYMENTS ALLOCATION

Initials

_____ I am authorizing United Tribes Technical College to apply any credit balance of FSA, Agency funding and/or scholarships to pay for prior year charges.

_____ I am authorizing United Tribes Technical College to apply any credit balance of FSA, Agency funding and/or scholarships to pay for childcare charges.

_____ I am authorizing United Tribes Technical College to apply any credit balance of FSA, Agency funding and/or scholarships to pay for miscellaneous charges. (ie. replacement key, replacement id, meal ticket)

_____ I am authorizing United Tribes Technical College to apply any credit balances of FSA, Agency funding and/or scholarships to pay for citation charges.

_____ I am authorizing United Tribes Technical College to apply any credit balances of FSA, Agency funding and/or scholarships to pay for overages of services.

I have the right to refuse authorization of any item on this statement. I am aware that I am able to cancel or modify this contract at any time. Any cancellation or modification will be in effect on the day it is received at the UTTC Business Office.

_____ _____
Please print name ID #

_____ _____
Student Signature Date

INFORMATION FOR THE RECIPIENT OF THE CHILD CARE ASSISTANCE PROGRAM

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SFN 598 (2-2018)

APPLICATION - PART 1

PURPOSE OF PROGRAM

Provide help with child care costs for families with low income while they are participating in work, job search or allowable education or training or other allowable activities.

APPLICATION

- Read application carefully and answer each question completely. The more information you give us the easier it will be to process your application.
- Assistance will begin the first day of the month the application is received in the County Social Service Office if all factors of eligibility are met. Eligibility can be determined for the month prior to the application month, if there is a need for assistance in that month and if all other factors of eligibility are met.

ELIGIBILITY REQUIREMENTS

- An applicant must verify **ALL** earned, unearned and self-employment income for **ALL** members of the household.
- Each person attending postsecondary education must complete and submit a Postsecondary Education Information (SFN 113) form. Each person attending postsecondary education or training must provide a copy of their class schedule.
- Provide verification of the applicant's identity and verification of the applicant's relationship/association to each child for whom Child Care Assistance Program benefits are being requested.
- Provide verification of age for each child for whom Child Care Assistance Program benefits are being requested.
- If you or another adult member of your household make court-ordered child support or court order spousal support payments, attach verification of the monthly amount.
- To be considered for the program, you must be a resident of the state of North Dakota.
- You must have a qualified child care provider.

PROVIDER INFORMATION

- Your provider must be at least 18 years of age.
- Your provider must be licensed, self-declaration, tribal registered, or an approved relative. The approved relative must be specifically approved for your child(ren).
- Your provider must complete a W-9 Request for Taxpayer Identification Number and Certification which must be submitted to the Child Care Assistance Program state office before payment can be made to either provider or parent.
- If your provider moves or changes provider type, a new W-9 Request for Taxpayer Identification Number and Certification must be completed and sent to the Child Care Assistance Program state office.
- Your provider may choose to receive the payment or have the payment sent to you. The provider must submit a signed and dated Provider's Request to Pay Parent Directly (SFN 848) form to the County Social Service Office if the payment is to be paid to you.

CERTIFICATE

- When eligibility for the Child Care Assistance Program has been approved, a certificate will be issued for a prescribed number of months.
- A copy of the certificate will be mailed to you and to each provider.
- The certificate will state the Family Monthly Co-pay to be paid by you, the State Rate, the allowable activity you are approved for, children who are approved for child care, the period of time the certificate is effective and the mandatory reportable changes.
- The caretaker is responsible for any amount over the allowable maximum charge per child and any other costs not covered by the Child Care Assistance Program.

CHILD CARE REQUEST FOR PAYMENT (SFN 616)

- This form must be used by child care providers to report hours of child care provided and the amount billed each calendar month.
- It is the provider's responsibility to complete the form each month with the actual hours of care provided and the amount billed.
- After the care has been provided for the month, the completed form must be signed and dated by both you and your provider.
- Submit the Child Care Request for Payment form to the County Social Service Office by the 5th of each month.

CHILD CARE ASSISTANCE PROGRAM APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

SFN 598 (2-2018)

FOR OFFICE USE ONLY
Date Received:

APPLICATION - PART 2

Please print or type your answers. Read application carefully, answer each question completely. Attach another sheet if you need more space to answer questions. Make sure to submit all the required verifications. Failure to answer each question and provide required verifications may delay processing of your application. Make sure to date and sign the application. Applications that are not signed and dated will be returned. Return completed application to your local County Social Service Office. If you have any questions about completing this application, contact your local County Social Service Office.

Tell us about you

First Name	Middle Initial	Last Name	
Residential Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
Telephone Number	Cell Phone Number	Work Telephone Number	
If you do not speak English, what is your preferred spoken or written language?			
Have you ever received or applied for Child Care Assistance? ☐ Yes ☐ No	If yes, when?		
Which city?	County	State	What name did you use?
Do you need child care assistance for last month? ☐ Yes ☐ No			

Tell us about the people in your home - List all persons in your household starting with you.

Household Members (Enter Legal Name) (First, Middle Initial, Last)	Social Security Number (optional)*	Birth Date	Relationship/ Association to You	US Citizen Yes or No	Sex	Marital Status (use codes below)	Race (use codes below)
			SELF				

Marital Status Codes: **MA**-Married **DI**-Divorced **NM**-Never Married **WI**-Widow

Race Codes: **AI**-American Indian/Alaska Native **AP**-Asian **BL**-Black **HP**-Native Hawaiian/Pacific Island **WH**-White

*The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Tell us about the people in your home (continued)

List household members of Hispanic or Latino ethnicity (optional):

List other names used by household members (maiden name, prior married name or nickname):

Is any household member temporarily out of the home? ☐ Yes ☐ No

Name of Absent Person	Relationship to Children Receiving Child Care

Reason for Absence	Date Expected to Return

Are both parents in the home? ☐ Yes ☐ No

Is a parent currently active duty in the U.S. Military? ☐ Yes ☐ No

Is a parent currently a member of the National Guard or a military unit? ☐ Yes ☐ No

Is your household currently experiencing homelessness? ☐ Yes ☐ No

Tell us about your household's assets

Total Estimated Value of Your Household's Assets

Tell us about your household's earned income

Complete the next section for each person that is employed. List information about full-time, part-time, seasonal, or temporary employment for all household members.

Household Member's Name	Employer	Gross Amount for Application Month	Hours Worked Per Week	Salary/ Hourly Wage	Amount of Tips/ Commission	How Often Paid	Day(s) of Week/Month Paid	Date of Next Paycheck

Has anyone's employment stopped? ☐ Yes ☐ No — If yes, who?

Last Day Worked — Date of Last Check

Do you or anyone in your household anticipate a change in earned income this month or next month? ☐ Yes ☐ No — If yes, who?

Explain the Change (provide verification of the anticipated change.)

You must attach proof of income

- Paystubs received in the month of application up to the date the application is submitted.
- All income for the month prior to the application month.
- Employer statement for all new jobs or any changes in anticipated income.
- If anyone in the household is self-employed, a complete copy of the most recent income tax return, including all schedules (if current tax return is not available, provide income and expense ledgers).

Tell us about your household's earned income (continued)

Is any household member self-employed? ☐ Yes ☐ No	If Yes, Name of Business
Type of Business	
Does anyone in the household expect a change in self-employment income? ☐ Yes ☐ No	
If yes, what change is expected?	

Tell us about your household's unearned income

This section must be completed for each household person including all children. Check each item yes or no. If yes, show the amount received, who received it, date received and provide proof of the income.

Income	Yes	No	Amount	Date Received	Who Receives
Alaska Dividend					
BIA/Tribal General Assistance					
Child Support					
Contract or Contracts for Deed					
CRP (Conservation Reserve Payment)					
Dividends or Interest					
Fund Raising Received Directly by Family					
Income from Roomer/Boarder					
Individual Indian Monies Account					
Insurance/Lawsuit Settlement					
Private Insurance or Disability Income					
Mineral Lease					
Money from Friends, Relatives, or Others					
Oil/Mineral Rights/Royalties					
Railroad Benefits					
Rental Income					
Social Security Benefits					
Spousal Support					
SSI (Supplemental Security Income)					
Tribal Gaming Distribution					
Tribal Spirit Lake Social Impact Payment					
Trust Income					
Unemployment Benefits					
Veteran's Benefits					
Workforce Safety Insurance					
Other					

Do you or anyone in your household anticipate a change in unearned income this month or next month? ☐ Yes ☐ No

If Yes, Who?	Explain the Change (provide verification of the anticipated change)

Tell us about Court-Ordered Child Support and Court-Ordered Spousal Support

Do you or anyone in your household pay court-ordered child support and/or court-ordered spousal support? ☐ Yes ☐ No		
If Yes, Who?	Court-Ordered Amount	Amount Paid Monthly
Do you or anyone in your household anticipate a change in court-ordered child support and/or court ordered spousal support this month or next month? ☐ Yes ☐ No		
If Yes, Who?	Explain the Change (provide verification of the anticipated change)	

You must attach proof of the court-ordered child support and court-ordered spousal support.

- Verification of amount paid in the month of application up to the date the application is submitted.
- Verification of the amount paid in the month prior to the application month.

Tell us about your Postsecondary Education/Training

What is your highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree	Date Completed
If there is a second parent/caretaker in your household, what is their highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree	Date Completed
Do you need help paying for child care in order for any household member to attend postsecondary school or training? ☐ Yes ☐ No	

You must complete a Postsecondary Education Information form (SFN 113) for each adult family member attending postsecondary education and submit an official school schedule for each person attending postsecondary education or training.

Student's Name	Course of Education/ Anticipated Degree	Credit Hours	Start Date	End Date

Tell us about your child care needs

ACTIVITY SCHEDULE

Name of Parent/Caretaker Participating in Activity

Allowable Activity

☐ Employment ☐ High School/GED ☐ Applied/Receiving Diversion
☐ Applied/Receiving Crossroads ☐ Education or Training ☐ Applied/Receiving TANF
☐ Other - Specify: _____

Provide a schedule of when you participate in each activity - if additional space is needed, attach a separate sheet

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider (use codes below)
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

ACTIVITY SCHEDULE - complete this section if participating in more than one activity or for a second parent/caretaker if both parents are in the home)

Name of Parent/Caretaker Participating in Activity

Allowable Activity

☐ Employment ☐ High School/GED ☐ Applied/Receiving Diversion
☐ Applied/Receiving Crossroads ☐ Education or Training ☐ Applied/Receiving TANF
☐ Other - Specify: _____

Provide a schedule of when you participate in each activity - if additional space is needed, attach a separate sheet

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider (use codes below)
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

RIGHT AND RESPONSIBILITIES

Please read each bullet and sign at the bottom of the page.

- I declare under the penalties of perjury that the information on this application is true and correct.
- I understand that is my responsibility to provide proof of income and other requested information needed to determine eligibility for this program and that failure to do so can result in my application being denied.
- I understand that it is my responsibility to notify my County Social Service Office of changes within 10 days from the date the event occurred.
- I understand that I am responsible for payment of any child care expenses not covered by the Child Care Assistance Program.
- I understand that if I receive assistance to which I am not entitled as a result of providing false information, I must repay the costs of that assistance.
- I understand that I have the right to appeal any decision made by the Child Care Assistance Program and that the request must be made within 30 days of the print date of my denial or benefit notices.
- I understand I have the right to confidentiality concerning my circumstances except as they may relate directly to the administration of this program.
- I understand that I have the right to file a written complaint if I believe that I or members of my family have been unlawfully discriminated against by reason of race, color, religion, sex, national origin, age, political beliefs, handicap, or status with respect to marriage or public assistance. I understand that I can contact my local County Social Service Office or the state office to file the complaint.

I understand that the amount of Child Care Assistance I receive will be based on the information I have provided on this form. I also understand that the amount of Child Care Assistance may be changed without advance notice. I understand that the County Social Service Office will verify the information I have provided, and that federal and state laws provide for fines or imprisonment of any person who fraudulently receives, or attempts to receive public assistance to which he or she is not entitled. I understand that I must report all mandatory reportable changes. I understand that I am responsible for paying my Family Monthly Co-pay and any additional costs over the allowable maximum not covered by the program.

Please read and sign the authorization to furnish or release information for verification of wages, student status and child care costs. This authorization must be signed and dated in order to process your application.

TO WHOM IT MAY CONCERN:

I hereby authorize any person, agency or institution to supply information, other than protected health information, concerning me or my family requested by County Social Service Office and to allow inspection and reproduction of records in their possession by any duly authorized representative of county social services. I further authorize County Social Service Office to release such information, other than protected health information, to cooperating state or federal agencies. I authorize County Social Service Office to inform my provider(s) of my eligibility or ineligibility of payment for child care. I/We authorize Child Support to release any records of child support payments I/we have made or received.

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

This authorization is given only in connection with its use by county social service office in its administration of the Child Care Assistance Program and for no other purpose.

Parent/Caretaker Signature	Date
Other Signature (spouse, other parent/caretaker, or other adult)	Date

UNITED TRIBES TECHNICAL COLLEGE

UTTC Child Care Billing Contract

3315 University Drive
Bismarck, ND 58504
Education Building
Phone: (701) 255-3285

This contract is made between the parent(s)/guardian(s) of:
(Please Print)

Child's Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Female ☐ Male Child's Social Security Number: _____

Permanent Address: _____ City: _____ State/Zip: _____

Parent(s)/Guardian(s) Name: _____ and _____

Student's Name: _____

Local Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Parent(s)/Guardian(s) Social Security Number: _____ and _____

The following documents must be provided prior to services being rendered:

- ☐ Provide 2 copies of my Student Identification Card.
- ☐ Provide 2 copies of my current class schedule. If changes are made to my schedule, it is my responsibility to provide 2 revised/final copies within 5 days of the changes.
- ☐ Complete the Child Care Assistance Application (SFN 598) which can be picked up at your local Social Services office.
- ☐ Submit any additional documentation required by Burleigh County Social Services within 5 days of their request. If there is circumstances that will prevent the information from getting submitted within the allotted time, I will immediately notify the CDC Billing Technician.

UTTC Childcare Billing Office responsibility:

- Assist student/guardian with questions related to childcare billing statements or childcare reimbursement.
- Deliver signed childcare billing statements to Burleigh County Social Services by the mandated deadlines.
- If a signed statement has not been received by the stated deadlines, it will not be submitted to Burleigh County Social Services for reimbursement.
- **Notification of an unsigned billing statement or nonpayment will be sent to the CDC on the 9th of each month** or the previous Friday, if the 9th falls on a weekend.

Parent/Guardian's responsibility:

- Sign child in and out every day services are provided.
- Review and sign the final billing statement by the **5th of each month at Student Accounts.** If the 5th falls on a Saturday or Sunday, I have until 4:00 pm on Monday to submit my signed statement.
    - If I do not sign my billing statement by the 5th of each month, the CDC Billing office will attempt up to a maximum of 2 times to contact me (via telephone, mail, email, final bill, and/or notice from daycare center) for a final signature.
    - It is **my** responsibility to submit my final bill to Burleigh County Social Services if my signature is not received by the CDC Billing Office by the **8th day** of the month. If the 8th falls on a Saturday or Sunday, my final signed statement will need to be received by the Friday prior to the 8th day of the month.
    - CDC will **suspend** childcare services until my bill is signed and/or paid.
- **Payment for childcare services is *my responsibility***. I will be responsible for any and all amounts not covered by the Child Care Assistance Program or other available funds.
- I understand my childcare must be at a **zero balance each semester** in order to utilize the childcare facilities at the start of the next term; if it is not, I understand I will be denied services until it is paid.
- In the event that I do not complete all of the necessary requirements to Burleigh County Social Services for reimbursement consideration or I am denied, it is my responsibility to pay all outstanding charges by the 10th of each month.
- If I have questions or concerns regarding my billing statement, I will need to contact the CDC Billing Office within ten (10) days of receipt of the bill.
- To abide by the terms and conditions as stated in this contract. This authorization expires twelve (12) months after the signed date below.
- Child Care fee: $3/hour

By signing below, as the parent/guardian of the above stated child, I agree to the terms and conditions herein:

Parent's/Guardian Signature:_____Date:_____

Parent's/Guardian Signature:_____Date:_____

Witness by:

CDC Staff Signature:_____Date:_____

Tylenol Consent Form

(Infant Toddler Center ONLY)

This is a **Standing Order Form** granting UTTC-CDC permission to administer Tylenol.

This Standing Order is only to be used under the discretion of the **Director or other authorized staff** and under the conditions that the Child Development Center was unable to reach the parents.

Conditions for the Standing Order are:

* Fever of 101 or higher
* Obvious pain due to teething, earache, or injury
* Uncontrollable crying due to teething, earache, or injury

Dispersal of Tylenol: According to your child's weight.

Please answer the following questions:

1. Does your child have any allergies to medicines? Yes No

2. If yes, which medicines: _____

3. Is your child currently taking any medications? Yes No

4. If yes, Please list the medications: _____

Child's Name: _____

I _____ give my permission
(Name of Parent)

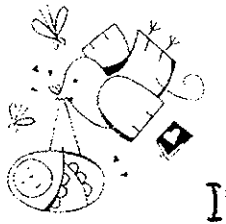
for the Child Development Center Director or Supervisor to administer my child Tylenol in the event that the center cannot contact me under the above conditions.

Date: _____

Medicine Record

Child's Name: _____

Name of Medicine	Date	Time	Dosage	Given By	Comments



Infant Toddler Center (Newborn – 36 Months) Registration Packet

Parents have 2 weeks to complete Registration Packet (Birth Certificate/Immunizations/Case Number ONLY) or childcare services will be denied

Type of Formula/Milk:_____ Nursery/Tap Water Center Provides: Enfamil

** ALL HIGHLIGHTED ITEMS MUST BE TURNED IN BY THE PARENT **

_____ Birth Certificate
_____ Class Schedule(s) ____Mom ____Dad
_____ Immunizations
_____ UTTC ID Card(s) ____Mom ____Dad

** ALL PAPERS LISTED BELOW MUST BE FILLED OUT BY THE PARENT **

_____ Authorization To Disclose Information
_____ Billing Contract
_____ Case Number from Social Services Free and Reduced Meals
_____ Child Enrollment Form/Infant Participation Form
_____ Child Information Sheet
_____ Contract for Childcare Services
_____ Developmental History
_____ Food Program Application
_____ Handbook Orientation Form
_____ Infant Sleep Permission Form (newborn-11 months ONLY)
_____ Registration Form
_____ Statement of Health of Child
_____ Tylenol Consent Form

Child's DOB: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

School Year: Fall Spring Summer 2019/2020

Dropped Date: _____

Added Date: _____

Dropped Date: _____

Billing Office

_____ Authorization To Disclose Information
_____ Billing Contract Form
_____ UTTC ID Card(s) ____Mom ____Dad

Start Date: _____