

Child Care Enrollment Application

Program Overview

Child Care:

The Yurok Tribe offers a Full Day Child Care program which serves all eligible Native American children* (federally recognized, California Roll, and/or direct descendant to a Yurok Tribal member), which can extend the Head Start program to a full day. The Child Care program is also federally funded, and has different eligibility requirements.

Subsidized Child Care – On Site Program:

The Yurok Tribe offers full time (9 hours) or part time (4.5 hours) child care at our Centers depending on space availability. Currently the south area Center in Eureka is able to serve children ages 2-5 years; the Ke'pel Center in the east area serves 3-5 years unless eligible to be dually enrolled in Early Head Start; and the Klamath Center currently serves 1-5 years depending on space available. Eligibility requires that your child be Native American* (federally recognized, California Roll, and/or direct descendant to a Yurok Tribal member), that the family meets income requirements based on gross monthly income and family size, and the parents/ guardians must be working or going to school.

Private Pay Child Care - On Site:

For those families over the income ceiling, child care is available on a sliding scale at our Centers depending on space availability.

Subsidized Child Care – Off Site Program:

This voucher program helps subsidize the cost of your child care if you are working or going to school. Eligibility and parent fees are calculated on a sliding scale based on gross monthly income and family size. This program serves eligible Native American children ages 1 year to 12 years. **Vouchers are very limited. Call for more information (707) 465-8305 ext. 1121**

Food Program

All Yurok Tribe Early Childhood Education Center programs offer the USDA "School Lunch" program to all participants. We serve breakfast, lunch and snack. Children enrolled in Child Care may participate in the "School Lunch" program; a fee may be applicable based on a sliding scale depending on family income.

Conditions under Which the Agreement May Be Terminated:

This agreement may be terminated by either party in the event that the family moves from the area, or that the program no longer meets the needs of the child. This agreement may be terminated by the program if the parent, guardian or representative fails to meet the program's expectations for the child's regular attendance at program classes and/or activities.

Parent Enrollment Checklist: Please include the following information with your application. You application cannot be scored/processed without these items.

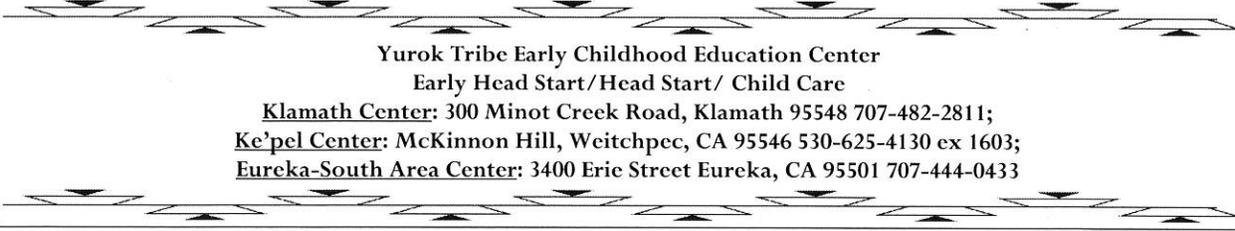
- 12 month income verification or current pay stub Employment / School Verification Immunization Record
- (*required for all household members)
- Certified Copy of Birth Certificate Tribal Enrollment Verification Social Security # Proof of Legal Guardianship

Parent/ Guardian Signature

Date

Early Childhood Education Center Representative Signature

Date



Yurok Tribe Early Childhood Education Center
Early Head Start/Head Start/ Child Care
Klamath Center: 300 Minot Creek Road, Klamath 95548 707-482-2811;
Ke'pel Center: McKinnon Hill, Weitchpec, CA 95546 530-625-4130 ex 1603;
Eureka-South Area Center: 3400 Erie Street Eureka, CA 95501 707-444-0433

Enrollment Application (Must complete this form for each enrolling child) Klamath Kep'el Eureka-South Area

Child's Name: _____
First Name MI Last Name

Date of Birth: _____ **Age:** _____ Boy Girl **Nickname:** _____

Guardian/Mother's Name: _____ **DOB:** _____
First MI Last

Guardian/Father's Name: _____ **DOB:** _____
First MI Last

Address (where child lives) _____
Street Apt. #

City State Zip

Mailing Address if different _____

Home Phone Number _____ **Mom's Cell** _____ **Dad's Cell** _____

Parent's Work Phone Numbers; Mom's Work _____ **Dad's Work** _____

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN AND / OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN & NUMBER	TELEPHONE

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

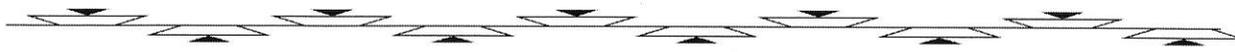
CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

TO BE COMPLETED BY FACILITY DIRECTOR / ADMINISTRATOR / LICENSEE

DATE OF ADMISSION _____ **DATE LEFT** _____

Child Care Early Head Start Head Start Center Voucher Home Base (EHS Only)

LIC 700 (CONFIDENTIAL)



Emergency Contacts / Persons Authorized to Pick Up Child

Mother/Guardian Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Father/Guardian Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Emergency Contact Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Emergency Contact Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Emergency Contact Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Emergency Contact Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Other Adult Full Name: _____

Cell phone: _____

Home Address: _____

Home phone: _____

Work Place: _____

Work phone: _____

Original = Site File

Copies = Teacher/ Emergency Binder / Bus Driver (if child rides bus)

LIC 700 (CONFIDENTIAL)



Emergency Contacts / Persons Authorized to Pick Up Child (CONTINUED)

Other Adult Full Name: _____ Cell phone: _____
Home Address: _____ Home phone: _____
Work Place: _____ Work phone: _____

Other Adult Full Name: _____ Cell phone: _____
Home Address: _____ Home phone: _____
Work Place: _____ Work phone: _____

Other Adult Full Name: _____ Cell phone: _____
Home Address: _____ Home phone: _____
Work Place: _____ Work phone: _____

Other Adult Full Name: _____ Cell phone: _____
Home Address: _____ Home phone: _____
Work Place: _____ Work phone: _____

Only persons listed on this form "Emergency Contacts / Persons Authorized to Pick Up Child (LIC 700)" are permitted to pick up your child from the Center or from the bus (if child rides bus). If the person is unknown to us, picture I.D.'s will be required.

The release of my child to any person under the age of 18 will be my responsibility and left to my discretion.

This consent is valid while my child is enrolled in the Yurok Tribe Early Childhood Education Center. The purpose of this consent form has been explained to me.

Signature Relationship Date

Signature Relationship Date

Original = Site File
Copies = Teacher/ Emergency Binder / Bus Driver (if child rides bus)

LIC 700 (CONFIDENTIAL)



Pre- Admission Health History

Child's Name: _____

Date of Birth _____

M F
SEX

Parents Report

Date of last physical /medical examination: _____

Does Father live in home with child? Yes No

Does Mother live in home with child? Yes No

Is / has child been under regular supervision of physician? _____

Is child presently under a Doctor's care? Yes No If yes, Name of Doctor: _____

Does child use any special devices? Yes No If yes, what kind? _____

Does child take any prescribed medication(s)? Yes No If yes, what kind and any side effects: _____

Does your child use any special device(s)? Yes No If yes, what kind? _____

Does your child use any special device(s) at home? Yes No If yes, what kind? _____

Does child have frequent colds? Yes No How many in the last year? _____

List any allergies the staff should be aware of: _____

Parent's evaluation of child's health: _____

Parent's evaluation of child's personality: _____

How does child get along with parents, siblings, and other children? _____

Has child had group play experiences? _____

Does child have any special problems/fears/needs? (Explain) _____

What is the plan for care when the child is ill? _____

Reason for requesting child care: _____



Pre- Admission Health History (CONTINUED)

Child's Name: _____

Developmental History

Started walking: _____ months Began talking: _____ months Toilet training started at: _____ months

Past Illnesses- Check illnesses that child has had and specify approximant dates of illnesses:

Illness	Approximate date:	Illness	Approximate date:	Illness	Approximate date:
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

Specify any other serious or severe illnesses, accidents, or hospitalizations: _____

Daily Routines

What time does your child get up?		What time does child go to bed?		Does child sleep well?	
Does child sleep during the day?		When?		How long?	
DIET PATTERN (What does child usually eat for these meals?)	Breakfast:			What are usual eating hours?	Breakfast:
	Lunch:				Lunch:
	Dinner:				Dinner:
Any food dislikes?			Any eating problems?		
Is child toilet trained? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, at what stage?		Are bowel movements regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is usual time?	
Word used for "bowel movement"			Word used for urination		

Is there anything else you would like us to know about your child? _____

Parent / Guardian Signature _____ Date _____

Parent / Guardian Signature _____ Date _____



Native American Verification

Please provide documentation that child(ren) are enrolled tribal members or descendants. (BIA letter, California Judgment Roll number, Tribal Card, and/or letter of descendant from a federally recognized tribe.) Please attach a copy of this documentation.

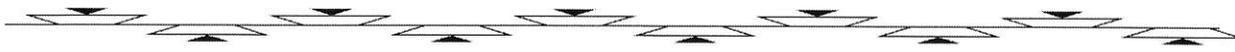
Person with Native American status or direct descendant

Relationship to enrolling child

Please attach copies of birth certificates that links your child with the person listed above.

PLEASE COMPLETE IF APPLYING FOR CHILD CARE. PLEASE LIST ALL MEMBERS OF THE HOUSEHOLD, INCLUDING ADULTS, AND/OR SIGNIFICANT OTHERS REGARDLESS OF MARITAL STATUS.

Name of Child / Household Member (in an adult additional information will be asked in another section)	Birth Date	Receives Services from another agency Yes/No If yes, please list:	Child Care needed? Yes/No Which cycle? Fall/Winter (Oct-March) Spring/Summer (April-Sept)	Hours per day (9hrs full time/4.5hrs part time and for school age except during school breaks)	Summer Break Care? (List number of days and hrs per day)	Enrolled Yurok Tribal Member Yes/No If yes, enrollment #	Social Security # (Only for child[ren] needing child care)



Yurok Tribe Employment/School Attendance Verification & Release of Information

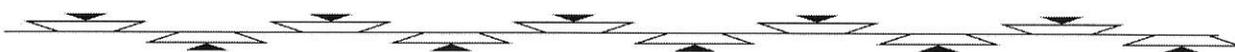
DIRECTIONS: Applicant, complete this portion then take the form to your school or employer for final processing. Your school or employer can return the completed form to you or mail it to:

The Yurok Tribe Child Care

Program: P.O. Box 1027 Klamath, CA 95548

I, _____ grant permission to the **YUROK TRIBE** to obtain all necessary verifications in order to process my child care application. I acknowledge that the information received will be used to determine either my initial eligibility or my continued eligibility for child care funding.

Applicant Signature _____ Date _____



REQUEST FOR TRAINING/SCHOOL VERIFICATION

School Official: The information requested is needed to determine eligibility for the Yurok Tribal Child Care Reimbursement Program. Please provide the information requested. Thank you for your cooperation. The above person is enrolled;

Part-time Full-time at _____
(Name of school/training program)

Please complete the following class/study lab time:

Schedule	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Start Time							
End Time							

School Official Signature

Title

Date



REQUEST FOR EMPLOYMENT VERIFICATION

The above person is employed Part-time Full-time at _____

Schedule	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Start Time							
End Time							

Employer / Supervisor Signature

Title

Date



Income

List income from all sources for the past 12 months OR Last calendar year (check time period used)

VERIFICATION MUST BE ATTACHED

*If child is in foster care or guardianship, list only the child's source of income and amount

<u>SOURCE</u>	<u>TOTAL AMOUNT RECEIVED</u>	<u>PERIOD RECEIVED</u>
Wages (Gross)	\$ _____	From _____ to _____
Social Security	\$ _____	From _____ to _____
Unemployment Benefits	\$ _____	From _____ to _____
Public Assistance (TANF)	\$ _____	From _____ to _____
Foster / Guardianship	\$ _____	From _____ to _____
Other _____	\$ _____	From _____ to _____

The Information on this form will help us to determine your child's eligibility for Child Care and help in prioritizing your application. All information will be held in the strictest of confidence.

I certify the information provided in support of this application is accurate and truthful to the best of my knowledge, and authorize the Yurok Tribe Early Childhood Education Center representative to contact my employer or social worker to verify my income and or school attendance.

1. I agree to call when my child will not be attending the Child Care Center and to abide by all Center policies.
2. I will notify the agency within 10 days when there is any change in my income, family size, or need for services.
3. I understand that I must renew my eligibility every six (6) month period.
4. In the event of the denial of the services I have the right to know the reason for denial; and I have the right to appeal the decision.

Parent/ Guardian Signature

Date

Parent/ Guardian Signature

Date