

Quartz Valley Indian Reservation Child Care and Development Program (CCDF)

Recipient's Check List

The following documents should be submitted during enrollment process to the QVIR CCDF Department Staff. Information listed as mandatory is required before any subsidy payments by the tribe can be authorized. Please understand this means payment will not begin until everything listed is complete. We do not make retroactive payments.

1. Application (Mandatory) - all forms within the application must be filled out completely and signed depending on Exempt of License Status.
2. Immunization Record (Mandatory) – a copy of the child’s current immunization record must be submitted.
3. Trustline Registry Application (Mandatory) – Finger printing and Background Check must be submitted by all Providers, through the Siskiyou Child Care Council located in Weed, CA. This application is accessible through the Quartz Valley Indian Reservation CCDF Department.
4. Signatures (Mandatory) – All signatures request on the CCDF Application must be signed by the Provider and Recipient in order for your application to be processed.
5. Income Verification (Mandatory) – Must be submitted from both guardians if living in the same household as child.
6. Schedule Documentation (Mandatory) – documentation showing the need for child care; this includes work schedules, school schedules, and/or letter from QVIR ICWA Department stating the reasons for special needs services.
7. Facility Safety Review (Mandatory) – a walk through must be performed by both the Provider and Recipient. Signatures are required.
8. W9 Form (Mandatory) - A current W9 Form must be filled out, completed, and submitted to the QVIR CCDF Department Staff.
9. Transportation (Optional) – If you choose to have your provider transport your child on occasion it is recommended you give permission to your provider.
10. Physical Examination (Mandatory) – All providers must submit a TB Shot clearance. All Exempt Providers have the option of writing a letter to the QVIR CCDF Staff stating they are free of all communicable diseases and the relationship to the child in care. All other Providers must receive a Physical Examination and submit the paperwork to the QVIR CCDF Staff.
11. Providers Information Sheet (Mandatory) – All Providers must fill out and complete a Providers Information Sheet, this form was developed to ensure all needed information is collected at the time of enrollment.
12. CPR & First Aid Certification – All providers must submit certification of CPR & First Aid.
 - a. Completed: Yes No

Quartz Valley Indian Reservation



QUARTZ VALLEY INDIAN RESERVATION CHILD CARE & DEVELOPMENT PROGRAM

**CC ADMINISTRATOR
FRIEDA BENNETT**

Last updated: April 21, 2015

INTRODUCTION

Application #:2018-_____

PROGRAM DESCRIPTION:

The Child Care & Development Program (CCD) subsidizes Pre-School child care services, and Before & After School services for children (age 12 and under). Low and medium income parents who are working; receiving education; authorized tribal business; approved respite care or participating in a certified job-training program are eligible for the program if they are Tribal member or the child is a Tribal member. Parents choose their own private child care provider and if all program requirements are met, the Quartz Valley Indian Reservation will subsidize part or all of the cost. The amount of the tribal subsidy depends on the family income; family size and the cost of the child care services. The Tribe wills the subsidy directly to the provider on the monthly or semi-monthly basis. The parent is required to pay the child care provider for the remaining portion of the cost of Child Care.

The Quartz Valley Indian Reservation operates what is called a "Voucher" program. This gives the parent maximum flexibility when choosing who will take care of their children. Parents may choose who will care for their children; they may choose an unlicensed provider for In-Home and Family-Home care, and have the option of immediate family being the provider this includes: adult siblings (not living in same household), aunts, uncles, or grandparents. NOTE: Unlicensed providers shall be required to "register with Quartz Valley Indian Reservation, and meet the tribe's health and safety requirements.

CONFIDENTIALITY:

All information collected as part of this program will be considered confidential, and access will be limited to persons connected with the administration of the program. No other use of this information is allowed without the express written consent of the parent or legal guardian.

QUALIFICATION PROCEDURE:

The Parent will be asked to submit certain types of documentation and to supply certain information. Without this documentation and information the enrollment process cannot be completed and the family will not receive services. There are two different category of payment for providers: (1) Full payment and (2) Share of cost, both are determined by family income and family size.

REQUIRED DOCUMENTS INCLUDE:

1. a) Verification of all income. Documentation may include wage check stubs; SSI/SSP award letter; any General Assistance verification from the County Welfare Department or Tribal TANF program; Social Security award letter; unemployment award letter or a signed statement of earnings from a parent who is self-employed. Monthly-adjusted family income shall be verified by observing the statement of earnings, which accompanies payment from the employer. A record showing the date of the payroll check, the period of payment and adjusted earning shall be entered in the certification. Where income is received as cash a written statement from the employer shall verify the amount.

b) If not employed, the parent(s) must provide documented proof that the parent(s) is enrolled in school or is a certified vocational education or job-training program.
2. If applicable, AFDC status and verification of Grants.
3. If applicable, MediCal Numbers.
4. Complete and up-to-date immunization records for each child are required. Immunizations are available at Anav Tribal Health Clinic. Following are the immunization requirements.

CHILD'S AGE	IMMUNIZATION RECORDS SHOULD SHOW
0-6 WEEKS	NONE
6 WEEKS – 4 MONTHS	Diphtheria/Tetanus (DPT) First immunization. Polio (OPV)
4-6 Months	DPT/OPV : First and second immunization.
6-15 Months	DPT: First, second, and their immunization OPV: First and second immunization Measles, Mumps, Rubella: available as a single injection (MMR) MMR (one shot is effective for a lifetime)
18 Months/Over	DPT: First, second, third, and forth immunizations. OPV: First, second, immunization MMR: First
24 Months/Over	The Previous immunizations plus a vaccination for hemophilic influenza (H flu) is recommended for children over two years.

The following information will also be required during the interview in order to complete the enrollment process before the program can begin:

1. Family information which will include, but not limited to: Complete names of all family members, addresses, phone numbers, Tribal ID numbers, Social Security Numbers, Work Schedule, etc. This information **MUST** be filled in completely for your application to be processed.
2. The child's Pre-admission Health History- Parents Report. This information will include: date of last health examination, developmental history, illness, daily routine, immunization reports, etc. (ex. what time does the child get up; What time does the child go to bed; What are the child's dislikes; and identifying any of the child's special needs). This information **MUST** be filled in completely for your application to be processed.

RECIPIENT NAME

RECIPIENT'S SIGNATURE

DATE

FAIR HEARING

For all components, the Quartz Valley Indian Reservation agrees to provide a fair administrative hearing to individuals whose application for assistance has been denied or not acted upon within reasonable promptness, or whose assistance has been adjusted or terminated. If a member disagrees with the determination of the Child Care Administrator, the member may appeal the decision to the Business Manager. In the event, it cannot be resolved the hearing will be scheduled for the next Business Council meeting date, for which the Council has at least 72 hours' notice of the appeal. Members will have 15 days from the date of notice of denial to the request a hearing in writing.

RECIPIENT NAME (PLEASE PRINT)

RECIPIENT SIGNATURE

DATE

EMPLOYMENT UNDERSTANDING

For all components, the Quartz Valley Indian Reservation is not considered the Employer for the Recipients Child Care Provider. I, _____, understand I am considered the employer to Provider:

_____.

RECIPIENT NAME (PLEASE PRINT)

RECIPIENT SIGNATURE

DATE

PROVIDER NAME (PLEASE PRINT)

PROVIDER SIGNATURE

DATE

HEALTH AND SAFETY REQUIREMENTS

1. Providers must provide proof that the provider has passed the State of California’s “Trustline” system to prevent child abuse. Proof must be provided before any payments can be made to licensed third-party providers. All other Providers who are required to register must present proof within 3 months of approval as a child care provider. The tribe will advise the Provider to register under the system as soon as possible since there may be a lengthy period after the “Trustline” until results are received.
2. Provider must provide proof that the provider is free of tuberculosis, as demonstrated by a TB test within the last 12 months. Proof of testing must be submitted before any payments can be made to the provider.
3. Provider must certify that the procedures have been established for the prevention and control of infectious diseases, including: safe food preparation, separation of sick children from other children, clean bathroom facilities and adequate bathroom cleaning materials, and that water and sewer systems meet the minimum county standards.
4. Parents are required to present proof that their child meets the tribal immunization standards before tribe will start paying for child care for that child at any licensed provider facility. These standards are provided to the parent in the tribe’s program materials, and free immunizations can be received through the local health clinic.
5. All licensed and non-licensed homes must have a fire extinguisher or smoke alarm. For licensed providers, proof of fire clearance is required if 7 or more children are in the home, or any non-ambulatory children are in attendance.
6. All licensed facilities and non-license homes must have a telephone, clearly displayed emergency numbers near telephone, and easy to find parent/guardian contact information.
7. The Tribe will inspect the location of any non-licensed care facility for a variety of other possible health and safety problems. The health and safety checklist for licensed provider is attached separately.
8. The parent/guardian will inspect the location of any licensed or non-licensed home provider for a variety of other possible health and safety problems. The health and safety checklist for non-licensed providers is attached separately.

RECIPIENT NAME (PLEASE PRINT)

RECIPIENT’S SIGNATURE

DATE

COMPLAINTS ABOUT CHILD CARE PROVIDERS

THE QUARTZ VALLEY INDIAN RESERVATION KEEPS AN OPEN PUBLIC RECORD OF ALL WRITTEN COMPLAINTS ABOUT PROVIDERS OR CHILDCARE. THIS PUBLIC RECORD IS AVAILABE FOR REVIEW BY MEMBERS OF THE TRIBE AT THE TRIBAL OFFICE DURING NORMAL OPERATING HOURS.

FOR ALL COMPLAINTS RECEIVED, A COPY SHALL BE SENT TO THE PROVIDER IN QUESTION. THE PROVIDER MAY REQUEST A HEARING WITH THE BUSINESS MANAGER. IF UNRESOLVED, HEARING WILL BE SCHEDULED WITH THE BUSINESS COUNCIL AT A REGULARLY SCHEDULED MEETING TO DEFEND AGAINST ANY CHARGES, PROVIDED THAT THE ACCUSER AND THE BUSINESS COUNCIL HAVE AT LEAST ONE WEEK’S NOTICE IN WRITING.

I UNDERSTAND MY RIGHT TO A FAIR HEARING AND I UNDERSTAND I WILL HAVE AN OPEN COMPLAINT RECORD IF FOUND GUILTY.

PROVIDER’S NAME (PLEASE PRINT) SIGNATURE OF PROVIDER DATE

I certify that my home or place of business meets all applicable health and safety requirements and do attest that I have never been accused of child abuse or neglect. I authorize the Quartz Valley Indian Reservation Child Care and Development Program to verify any or all information I provide.

PROVIDER’S NAME (PLEASE PRINT) SIGNATURE OF PROVIDER DATE

The provider further agrees that the program may investigate any complaints regarding child care and this registration may be revoked upon failure to comply with state regulations.

PROVIDER’S NAME (PLEASE PRINT) SIGNATURE OF PROVIDER DATE

ENROLLMENT FORM

Parent #1/Legal Guarding Name:			Date of Birth:
SSN:	Tribal ID#	Age:	Email Address:
Home Phone:	Cell Phone:		Message Phone:
Physical Address			
Mailing Address:			
Reason for Subsidy: Employment: <input type="checkbox"/> Job Training: <input type="checkbox"/> Student: <input type="checkbox"/>			
Employers Name:			N/A <input type="checkbox"/>
Employers Address:			Employers Telephone #:
Days: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Hours: Am/Pm _____ to Am/Pm _____
School's Name:			N/A <input type="checkbox"/>
School's Address:			School's Telephone #:
Days: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Hours: Am/Pm _____ to Am/Pm _____
If seeking employment the necessary forms MUST be completed and authorization MUST be approved prior to action.			
Parent #2			Date of Birth:
SSN:	Tribal ID#	Age:	Email Address:
Home Phone	Cell Phone:		Message Phone:
Physical Address:			
Mailing Address:			
Reason for Subsidy: Employment: <input type="checkbox"/> Job Training: <input type="checkbox"/> Student: <input type="checkbox"/>			
Employer's Name:			N/A <input type="checkbox"/>
Employer's Address:			Employer's Telephone #:
Days: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Hours: Am/Pm _____ to Am/Pm _____
School's Name:			N/A <input type="checkbox"/>
School's Address:			School's Telephone #:
Days: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Hours: Am/Pm _____ to Am/Pm _____
If seeking employment the necessary forms MUST be completed and authorization MUST be approved prior to action.			

Before **or** **After** **School Services** **Both :**

Family Income

Funding	Parent # 1	Parent # 2
Employment Income	\$ _____	\$ _____
Alimony	\$ _____	\$ _____
Unemployment Insurance	\$ _____	\$ _____
SSI	\$ _____	\$ _____
Child Support	\$ _____	\$ _____
TANF/General Assistance	\$ _____	\$ _____
Other specify: Per-Capita	\$ _____	\$ _____
MONTHLY INCOME TOTALS	\$ _____	\$ _____

(PARENT# 1 TOTAL) + (PARENT #2 TOTAL) = (TOTAL MONTHLY INCOME)

\$ _____ + \$ _____ = \$ _____

Total Household Members: _____ Please list all Household Members and Ages:

INITIAL TO SHOW UNDERSTANDING:

A change in Family income and employment status **MUST** be reported within 10 working days. _____ (INITIAL)
 I understand a change in income may directly affect my share of cost for subsidy payment. _____ (INITIAL)
 Self-employed recipient's **MUST** provide the Quartz Valley Indian Reservation Child Care and Development program with their total income verification every 3 months to determine eligibility. _____ (INITIAL)
 All information **MUST** be filled in and clearly readable for this application to be processed! _____ (INITIAL)
 I understand the QVIR CCDF Staff re-determines eligibility annually; this may affect Share-of-Cost. _____ (INITIAL)
 I understand the Enrollment Form **MUST** be filled out completely for my application to be processed.

 RECIPIENT NAME (PLEASE PRINT) RECIPIENT'S SIGNATURE DATE

 CCDF Rep. Initials Date

Office Only		
Total Household Income	Household Size	Determined Co-Payment
CCDF Rep: _____ Date: _____		

PRE-ADMISSION HEALTH HISTORY-PARENT'S REPORT
FAMILY INFORMATION

Child's Name:		Date:
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	D.O.B.	SSN:
Tribal Affiliation:		Tribal #:
Father's Name:	Age:	D.O.B.
In Home with Child: Yes <input type="checkbox"/> No <input type="checkbox"/>	SSN:	Tribal #:
Mother's Name:	Age:	D.O.B.
In Home with Child: Yes <input type="checkbox"/> No <input type="checkbox"/>	SSN:	Tribal #:
PHYSICIAN INFORMATION		
Has the child been under regular supervision of a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of physician:	Telephone #:	
Address:	Last Examination:	
DEVELOPMENTAL HISTORY		
Walked at: _____ months	Began Talking at: _____ months	Toilet Training at: _____ months
ILLNESS		
Chicken Pox	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approximate Date:
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approximate Date:
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approximate Date:
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approximate Date:
ALLERGIES		
1.	2.	
3.	4.	
SHOTS		
An Immunization Report is attached: Yes <input type="checkbox"/> No <input type="checkbox"/>		
SPECIAL NEEDS		
Please describe any Special Needs for this child:		

DAILY ROUTINES

Usual Eating Schedule:	
Food child likes:	Food child dislikes:
Elimination Process (toileting/diapering):	
Things that comfort child:	
Cultural habits/home issues that may affect the child's behavior:	
Who is authorized to pick up this child from child care:	
Who will care for child when he/she is sick: <small>(Complete the Child Care Emergency Contact Information Form)</small>	
Legal Guardian's Signature:	Date:
Enrollment Date:	

I understand that a Pre-Admission Health History Form **MUST** be filled completely out for each child in care.

RECIPIENT NAME (PLEASE PRINT)

RECIPIENT'S SIGNATURE

DATE

CCDF Rep. Initials

Date

CHILD CARE EMERGENCY INFORMATION

Child's Name: _____ Birth Date: _____

Legal Guardian #1: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

Legal Guardian #2: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

EMERGENCY CONTACTS (to whom child may be released if legal guardian is unavailable)

Name #1: _____

Address: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

Name #2: _____

Address: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

CHILD'S USUAL SOURCE OF MEDICAL CARE CHILD'S USUAL SOURCE OF DENTAL CARE

Name: _____ Name: _____

Address: _____ Address: _____

Telephone Number: _____ Telephone Number: _____

CHILD'S HEALTH INSURANCE

Name of Insurance Plan: _____

Subscriber's Name (on insurance card): _____ ID #: _____

SPECIAL CONDITIONS, DISIBALITIES, ALLERGIES, OR MEDICAL INFORMATION FOR EMERGENCY SITUATIONS: _____

TRANSPORT ARRANGEMENT IN AN EMERGENCY SITUATION:

Ambulance service: _____ Child will be taken to: _____

(Parents/guardians are responsible for all emergency transportation charges)

PARENT/LEGAL GUARDIAN CONSENT AND AGREEMENT FOR EMERGENCIES

As Parent/legal guardian, I give consent to have my child receive first aid by provider if so instructed by emergency medical service personnel, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: _____ Parent/Legal Guardian's Signature #1: _____

FACILITY SAFETY REVIEW SHEET
FOR NON-LICENSED PROVIDERS

Provider's Name:		Provider's Birth Date:	
Street Address:		Email Address:	
Mailing Address:			
Facility Telephone Number:		Providers Social Security #:	
Mobile Telephone:		Vendor ID: (Format: Initials-year-CC)	
Name of Reviewer : (Please Print Clearly)		Date of Review:	

SAFETY ISSUES REVIEWED	MET	NOT MET	N/A	Reviewer's Initials
Inspection by QVIR CCDF Representative, Parent, Guardian (Date:)				
Provider is at least 18 years of age				
Adult is continuously present while children are in care				
Nobody smokes or has lighted cigarettes, matches, or lighters around children at any time while children are in care.				
Home is properly heated, lighted and ventilated for the comfort of child				
Home has Telephone services				
Home contains an Emergency Information Card for each child in care				
A well-stocked first aid kit is accessible to all caregivers				
Home contains an approved fire extinguisher and a working smoke alarm				
Fireplaces or open-faced heaters/furnaces are properly screened				
Safety Covers are on all electrical outlets with children under the age of 5				
Poisons, Medicines, and other hazardous substances are inaccessible to children. <u>Kitchen:</u> All Sharp utensils and cutlery, cleaning supplies, medicines, drawers and cabinets with liquor, plastic bags, and sharp things or small things children can swallow, etc. <u>Bathroom:</u> shampoo, mouthwash, toothpaste, medicines, perfumes/lotions/cosmetics, solvents, etc. <u>Garage or Outdoors:</u> Solvents, gasoline, oil, turpentine, paint, sharp tools, lawn mower, power tools, gardening tools, poisonous plants, abandoned machinery, old refrigerators/freezers, old vehicles, etc.				
Doors to places that children can enter, such as bathrooms, can be easily opened from the outside by child or by an adult				
Home <u>does not</u> have a Body of water at facility site <input type="checkbox"/> Or Home <u>does</u> have a _____ covered or fenced. The fence is at least 5 feet high with a self-latching gate that opens away from the pool of body of water. If using a cover, it must support the weight of an adult and shall be locked when pool is not in use.				
Outdoor play area is fenced or barricaded if any child in care is under the age of 5 the provider must be in direct supervision at all times; if not fenced or barricaded the plan for supervision is:				

Rooms that are not meant for care must be locked at all times				
Stairs are fenced or barricaded if any child in care is under the age of 5				
Firearms, projectile toys, darts, and cap pistols are not kept in the child care setting or are locked and inaccessible to children in care; Ammunition is stored and locked away separately from firearms.				
Poisonous plants are not present either indoors or outdoors in the child care areas				
Doorways to unsupervised or unsafe areas are closed and locked unless the doors are used for emergency exits				
Current T.B. Clearance for all Child Care Providers and any adult living in home				
Fingerprint (Trustline) Clearance for Providers and adults living in home.				
Provider's Understanding	Understand	Don't Understand	Reviewer's Initials	
I understand I must be at least 18 years of age				
If someone living in my home has been convicted of or has a charge pending for, a crime against children I must report to QVIR CCDF prior to subsidy approval				
All visitors and members of my household shall be in physical and mental health that will not bring harm to the health and well being of the children in my care				
Each floor used for child care has at least one unblocked exit and a smoke detector				
Children are never left alone in infant seats on tables or other high surfaces				
Children are not permitted to play with any type of plastic bag, balloon or latex vinyl gloves				
Toys must be too large to fit completely into a child's mouth and have no small, detachable parts to cause choking. No coins, safety pins, or marbles for children under 4 years of age.				
Outdoor area is clear of hazardous materials and obstacles				
Home has safe toys, play equipment and materials. Play equipment is securely anchored according to manufacturer directions.				
Pets are free from diseases and are maintained in a sanitary manner				
Trash is covered at all times and is stored away from heaters or other heat sources				
Infants and toddlers are not permitted to eat small objects and foods that may easily cause choking, such as hot dogs, hard candy, seeds, nuts, popcorn, and uncut rounds foods such as whole grapes and olives				
Babies are always put to bed on their backs				
Cribs, playpens, and highchairs are used properly and according to the manufacturer's recommendations for age and weight. Cribs have no corner posts.				
Handrails are attached to walls preferably to the walls on both right and left sides				
Stairway gates are locked in place when infants or toddlers are nearby. Gates should have openings small enough to prevent a child's head from fitting through. No accordion-type gates are used.				
Current T.B. Clearance for all Child Care Providers and any adult living in home				
Current Immunizations records for children in care must be available at all times				
Fingerprint (Trustline) Clearance for Providers and adults living in home.				

Additional Examples of problems to watch for: rusty nails, broken glass, peeling paint; exposed electrical wires.

Signature Parent or Guardian

Date

Signature Non-Licensed Provider

Date

AGREEMENT FOR NON-LICENSED SERVICES

PARENT-PROVIDER-TRIBE

Quartz Valley Indian Reservation
Attn: Child Care and Development Program
13601 Quartz Valley Rd.
Fort Jones, CA 96032
education@sisqtel.net
fbennett@qvir.com

(530) 468-5907 Office
(530) 468-5908 Fax

Parent's Name: _____

Provider's Name: _____

Child's Name: _____

Birthday: _____

QVIR CCDF Representative: _____

1. The child care provider charges \$_____ per day/hour (circle one). The provider certifies that the fees indicated are the usual and customary charges for the same services provided to children of non-subsidized families.
2. The Quartz Valley Indian Reservation herein referred to as the "tribe," will pay a _____% subsidy of this fee. The Parent is responsible for directly paying the Provider for the remaining portion of the fee. The tribe may change or terminate its subsidy upon written notice to the other Parties at the sole discretion of the tribe.
3. It is understood that the Provider will be paid on a monthly/bi-weekly (circle one) basis by the tribe. Invoices are due, signed by the Parent as verification, by the fifth of the month following care. The tribe will reimburse the provider within 10 working days of receipt of invoice. The invoice must be received by the tribe by the fifteenth of the month following care, or the invoice may not be reimbursed at all. All reimbursement timelines are dependent on receipt of funds for funding sources.
4. The Provider certifies that child care services do not include religious instruction.
5. The Provider understands that money received from the tribe is for child care services for children who are members of the tribe or classified as an Indian child.
6. All Parties agree to remain in compliance with all policies and procedures pertinent to the tribe's Child Care and Development Program.
7. The Provider and the Parent agree to give all parties two weeks' notice of withdrawal from program
8. The Provider's services meet all health and safety requirements of the State of California
9. The Provider guarantees that the Parent(s) and the tribe will have unlimited access to their children and to the individual(s) caring for their children, during the normal hours of operation or whenever such children are in the care of the Provider.
10. All Parties concerned realize that this is a parental choice program and that the tribe has not inspected or warranted the condition of the Provider's facility or the degree or type of supervision. The tribe assumes no responsibility for injury or damage arising from the performance of this contract. The Provider and parent understand that the tribe is a federally recognized Indian tribe with sovereign immunity and cannot be held liable for harm arising from this program.
11. All Parties concerned realize that since this is a parental choice program that the tribe is not the employer of the Provider and that the Recipient is the employer of the provider.

12. Any other agreement signed between the Parent and Provider is solely between those two Parties. The tribe assumes no responsibility for such agreements.

PROVIDER REPRESENTATIVE'S SIGNATURE

DATE

VENDOR NUMBER

_____-_____-_____
SOCIAL SECURITY NUMBER

PARENT'S SIGNATURE

DATE

QVIR REPRESENTATIVE'S SIGNATURE

DATE

TITLE

LICENSED FACILITY SAFETY REVIEW SHEET

Facility Name:	Facility License Number:
Street Address:	
Mailing Address:	
Facility Telephone Number:	Providers Social Security #:
Name of Reviewer:	Date of Review:

SAFETY ISSUES	MET	NOT MET	N/A
1. License available for review in home			
2. Current T.B. clearance for all child care providers and any adults living in the home			
3. Fingerprint "Trustline" clearance for providers, and adults living in the home			
4. Operates within licensed capacity			
5. Fire clearance if 7 or more children present, or if any non-ambulatory children			
6. Licensee or substitute adult continuously present when children in care			
7. Home is clean and orderly, and properly heated and ventilated			
8. Home has telephone services			
9. Home has safe toys, play equipment, and materials			
10. Ill children evaluated and isolated if infectious			
11. Poisons, medicines, and other hazardous substances inaccessible to children			
12. Home contains an approved fire extinguisher or a smoke alarm			
13. Fireplaces or open-face heaters or furnaces are properly screened.			
14. Stairs are fenced or barricaded if any children under care are under 5 years of age			
15. Pools or water are properly fenced or made inaccessible			
16. Outdoor play area(s) are fenced or outdoor play is supervised			
17. Firearms and/or dangerous weapons are in locked cabinets			
18. Home contains an emergency information card for each child			
19. Inspection was permitted during business hours			
20. Accommodations, furnishing and equipment is safe, healthy and comfortable			
Examples of problems to watch for: matches, lighters or cigarettes in reach of children; rusty nails, broken glass or other sharp objects in yard; peeling paint on walls or furniture; power tools, lawn mowers, or garden tools within reach of children; bleach or other hazardous materials in reach of children; exposed electrical wire; fences that have holes or need repair.			

Provider's Signature

Date

Reviewer's Signature

Date

AGREEMENT FOR CENTER-BASED SERVICES

PARENT-PROVIDER-TRIBE

Quartz Valley Indian Reservation
Attn: Child Care and Development Program
13601 Quartz Valley Rd.
Fort Jones, CA 96032
education@sisqtel.net
fbennett@qvir.com

(530) 468-5907 Office
(530) 468-5908 Fax

Parent's Name: _____

Provider's Name: _____

Child's Name: _____

Name of Provider's Representative: _____

Birthday: _____

Title of Provider's Representative: _____

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13. The child care provider charges \$ _____ per day/hour (circle one). The provider certifies that the fees indicated are the usual and customary charges for the same services provided to children of non-subsidized families.
 14. The Quartz Valley Indian Reservation herein referred to as the "tribe," will pay a _____ % subsidy of this fee. The Parent is responsible for directly paying the Provider for the remaining portion of the fee. The tribe may change or terminate its subsidy upon written notice to the other Parties at the sole discretion of the tribe.
 15. It is understood that the Provider will be paid on a monthly/bi-weekly/weekly (circle one) basis by the tribe. Invoices are due, signed by the Parent as verification, by the fifth of the month following care. The tribe will reimburse the provider within 10 working days of receipt of invoice. The invoice must be received by the tribe by the fifteenth of the month following care, or the invoice may not be reimbursed at all. All reimbursement timelines are dependent on receipt of funds for funding sources.
 16. The Provider certifies that child care services do not include religious instruction.
 17. The Provider understands that money received from the tribe is for child care services for children who are members of the tribe or classified as an Indian child.
 18. All Parties agree to remain in compliance with all policies and procedures pertinent to the tribe's Child Care and Development Program.
 19. The Provider and the Parent agree to give all parties two weeks notice of withdrawal from program
 20. The Provider's services meet all health and safety requirements of the State of California
 21. The Provider guarantees that the Parent(s) and the tribe will have unlimited access to their children and to the individual(s) caring for their children, during the normal hours of operation or whenever such children are in the care of the Provider.
 22. All Parties concerned realize that this is a parental choice program and that the tribe has not inspected or warranted the condition of the Provider's facility or the degree or type of supervision. The tribe assumes no responsibility for injury or damage arising from the performance of this contract. The Provider and parent understand that the tribe is a federally recognized Indian tribe with sovereign immunity and cannot be held liable for harm arising from this program.

23. All Parties concerned realize that since this is a parental choice program that the tribe is not the employer of the Provider and that the Recipient is the employer of the provider.

24. Any other agreement signed between the Parent and Provider is solely between those two Parties. The tribe assumes no responsibility for such agreements.

PROVIDER REPRESENTATIVE'S SIGNATURE

DATE

LICENSE NUMBER

_____-_____-_____
SOCIAL SECURITY NUMBER

PARENT'S SIGNATURE

DATE

QVIR REPRESENTATIVE'S SIGNATURE

DATE

TITLE

CHILD CARE LICENSED-PROVIDER RATE SHEET

PLEASE ATTACH A COPY OF THE FACILITY LICENSE

PROVIDER FEES

Infants: _____ month(s) to _____ year(s)

Part Time: _____ hours or less

Monthly: \$ _____ Daily: \$ _____ Hourly: \$ _____

Full Time: _____ hours or more

Monthly: \$ _____ Daily: \$ _____ Hourly: \$ _____

Pre-School: _____ year(s) to _____ year(s)

Part Time: _____ hours or less

Monthly: \$ _____ Daily: \$ _____ Hourly: \$ _____

Full Time: _____ hours or more

Monthly: \$ _____ Daily: \$ _____ Hourly: \$ _____

School Age: _____ year(s) to _____ year(s)

Part Time: _____ hours or less

Monthly: \$ _____ Daily: \$ _____ Hourly: \$ _____

Full Time: _____ hours or more

Monthly: \$ _____ Daily: \$ _____ Hourly: \$ _____

Registration Fee: \$ _____ per _____

Insurance Fee: \$ _____ per _____

Does your Facility charge or have other Fees: Yes or No
If yes, please explain:

Does your Facility offer Discounts for Siblings? Yes or No
If yes, please explain:

Does your Facility charge for absences due to Illnesses? Yes or No
Does your Facility charge for Holidays? Yes or No
Does your Facility charge for Vacations? Yes or No

Does your Facility have a Termination Policies? Yes or No

If yes, please explain:

Does your Facility expect pre-payment? Yes or No

Does your Facility issue reimbursement to the parent? Yes or No

I certify that parents/legal guardians have unlimited access to their children, including written records concerning their children, and to staff caring for their children, during normal hours of operation or while children are in my care. I certify that the rates listed above (or attached) represent the usual and customary rates charged for ALL CHILDREN for whom care is provided in the above-named child care/home center.

Provider Signature: _____ Date: _____

I understand that a Child Care Licensed Provider Rate Form MUST be filled out completely for application to be processed.

RECIPIENT NAME (PLEASE PRINT) RECIPIENT'S SIGNATURE DATE

CCDF REPRESENTATIVE SIGNATURE DATE

TRANSPORTING PERMISSION SLIP

DATE: _____

RE: _____

To Whom It May Concern:

SINCERELY,

X. _____

OTHER ADULTS RESIDING IN PLACE OF CARE-INFORMATION

UNDER THE CHILD CARE AND DEVELOPMENT PROGRAMS REGULATIONS, IT STATES THAT ALL ADULTS OVER THE AGE OF 18, LIVING IN THE PLACE OF CARE SHALL BE LISTED ON THIS APPLICATION. IT IS THE RESPONSIBILITY OF THE RECIPIENT TO LET THESE INDIVIDUALS KNOW THEY ARE SUBJECT TO A BACKGROUND CHECK, BY THE QUARTZ VALLEY INDIAN RESERVAATION. IT IS THE DUTY OF THE QUARTZ VALLEY INDIAN RESERVATIONS'S CCDF PROGRAM TO ENSURE SAFETY FOR CHILDREN WITHIN THIS PROGRAM.

- 1) **ADULT #1'S NAME:** _____
- 2) **Male or Female**
- 3) **Date of Birth:** _____
- 4) **SSN:** _____ - _____ - _____

-
- 1) **ADULT #2'S NAME:** _____
 - 2) **Male or Female**
 - 3) **Date of Birth:** _____
 - 4) **SSN:** _____ - _____ - _____

-
- 1) **ADULT #3'S NAME:** _____
 - 2) **Male or Female**
 - 3) **Date of Birth:** _____
 - 4) **SSN:** _____ - _____ - _____

-
- 1) **ADULT #4'S NAME:** _____
 - 2) **Male or Female**
 - 3) **Date of Birth:** _____
 - 4) **SSN:** _____ - _____ - _____