Moapa Band of Paiutes Tribal Child Care

(702) 333-6565 info@mboptribalchildcare.org

Application for Child Care Assistance

Date: _____ **Tribal Affiliation:** _____

Parent/Guardian (applicant) Name:	**Relationship to Child(ren):**
Home Address:	**Mailing Address (if different):**
Applicant Date of Birth:	**Primary Phone#:** **Secondary Phone#:**
Email:	**Preferred contact method:**
Are you currently: ○ Working ○ In job training ○ In an educational program ○ Engaged in a job search activity ○ Vulnerable Population* (Choose one or more if applicable)	**Do YOU or ANYONE in your household have ANY of the following:** • Assets that exceed $1,000,000? **(Yes or No)** • Receive TANF benefits? **(Yes or No)** • Receive child care assistance from another agency? **(Yes or No)** If yes, please provide name of agency: _____ • Experiencing homelessness as defined in section 725 of subtitle VII-B of the McKinney-Vento Act (42 U.S.C 11434a;98.2)? **(Yes or No)** • Intellectual Disabilities? **(Yes or No)**
Co-Applicant (if applicable)	
Name:	**Relationship to Child(ren):**
Date of Birth:	**Telephone:** **Email:**
Are you currently: ○ Working ○ In job training ○ In an educational program ○ Engaged in a job search activity ○ Vulnerable Population* (Choose one or more if applicable)	Only requirement for application approval is 1 parent/guardian or 1 child be a member of a federally recognized tribe or can provide a letter of descendance. This will cover all children living in the "Indian Home". *Vulnerable populations include the economically disadvantaged, the uninsured, low-income children, the elderly, the homeless, those with human immunodeficiency virus, and those with other chronic health conditions; including severe mental illness, substance abuse, and alcoholism.

Revised: 1/20/2023

Provider/Child Care Information				
Provider Type: (Center or In-Home)				
Provider name:				
Provider Address:				
Telephone: **Email:**				
Additional Provider (if desired)**:**				

Household Information		
Total Family Size:	**Total Number of Adults:**	**Total Number of children:**

All Adults/Child Name(s) (other than applicants)	**Relationship to Applicant**	**Date of Birth**	**Gender**	**In need of child care? Y / N ?**

Please provide Tribal documentation for a minimum of 1 person listed on this application (applicant(s) and/or members of household). Within 5 business days, Tribal Child Care Staff will request additional documentation that will vary by each application, and/or depending on the information provided by the applicant(s). By signing this application, applicant(s) agrees that all information provided is true and accurate to the best of their ability. Any result to falsify information can result in denial of child care assistance, indefinitely. Tribal Child Care Staff has the right to verify if the information provided is accurate.

Applicant Signature: _____ **Date:** _____

Co-Applicant Signature: _____ **Date:** _____

OFFICIAL USE ONLY

Reviewed By:_____

Date: _____

Revised: 1/20/2023