



Child Care Services Program  
P.O. Box 948  
Nome, AK 99762  
[www.kawerak.org](http://www.kawerak.org)  
Email: [intake@kawerak.org](mailto:intake@kawerak.org)  
1-800-450-4341 or (907) 443-4358  
Fax (907) 443-4485 for eFax (907) 802-6183

## KAWERAK CHILD CARE ASSISTANCE APPLICATION

Dear Parents and Guardians,

The goal of Kawerak Child Care Service is to increase the availability, affordability, and quality of child care for families. Please see the Checklist and State Child Care Assistance Income Requirements here for information on how to fill out the Child Care Assistance Application. You may use the contact information above to return the completed application.

### **Checklist: All documents are required before application will be processed**

1. Complete and sign the Kawerak Child Care Services Application.
2. Complete the Kawerak Education, Employment, and Supportive Services Intake Form.
3. Submit a copy of your government issued photo identification.
4. Submit verification of tribal enrollment and Bering Strait residency for each child you are requesting child care services for.
5. Submit proof of all income (1 full month of pay stubs) received by the parent/legal guardian on the application. If newly employed or volunteering, an employee verification form. If self-employed, submit a 1040 income tax statement.  
(If State eligible, you will need to submit 2 months worth of pay stubs.)
6. Priority is given to families experiencing one or more of the following: homelessness, drug or alcohol rehabilitation, kinship care, teenage parent, disability, or domestic violence. Submit written documentation if you believe you qualify for a priority determination.
7. For licensed care, if income eligible, submit a complete State of Alaska Child Care Assistance Application.
8. For licensed care, if your income qualifies for State Child Care subsidy, an acceptance or denial letter will need to be acquired from Alaska Family Services once your State application is reviewed.
9. If applicable, submit proof of child custody, this can be a court order, affidavit, or statement.
10. If applicable, submit proof of any child support you are legally obligated to pay and are paying.
11. If applicable, submit a copy of your current or future school schedule including the school name and classes you are registered to attend / if attending high school, include the school name and hours.
12. If you are seeking Tribally Approved Relative Provider care and your child is enrolled with Nome Eskimo Community please contact the tribe directly for services as available.

Kawerak Child Care Assistance is available to families needing child care services for any American Indian/Alaska Native child under the age of 13, or under 19 if a documented disability. Parents must be working, enrolled in an education or job training program, engaged in job search or subsistence activities for a minimum of 20 hours per week. Children receiving protective services are eligible to apply. Priority is given to families experiencing one or more of the following: low income, homelessness, drug or alcohol rehabilitation, kinship care, teenage parent, disability, or domestic violence.

## CHILD CARE ASSISTANCE REQUIREMENT

**Tribally Approved Provider (Relative or License Exempt) Care do not require State Child Care Assistance. All other families seeking Licensed Child Care may be eligible for State Child Care Assistance: The following table lists the monthly income guidelines to determine State subsidy eligibility.**

Family Size	2	3	4	5	6	7	8
Max. Income	\$5,012	\$6,192	\$7,372	\$8,551	\$9,731	\$9,952	\$10,173

For licensed care, if your gross/pre-tax income falls below the maximum income for your family size as listed above, you will need to apply for Child Care Assistance with the State of Alaska through the Coastal Child Care Assistance Program. Please find an application online at [kawerak.org](http://kawerak.org), go to <https://dhss.alaska.gov>, or request an application from Kawerak Child Care Services.



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For Office Use Only: Received by: _____ Date: _____
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## KAWERAK CHILD CARE ASSISTANCE APPLICATION

**I am requesting assistance for the following service:**

- EHS/CCP     
  UPLC     
  State Licensed Care  
 Tribally Approved Provider (license exempt)   
  Tribally Approved Relative Provider

Please check all boxes that best describe your situation regarding a need for child care:

- Work  
  School/Job Training  
  Subsistence  
  Foster Parent  
  Job Search  
  Protective Services  
 Disability  
  Other

Contact Information				
Name:			Email:	
Street Address:	P.O. Box:	City:	State:	Zip:
Home Phone:		Cell:		Work:

Household Information						
Last Name	First Name	Sex	DOB	Relationship to Applicant	Tribal Affiliation	Child Care Needed
				Self / Parent		
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Child Care Facility / Provider(s)			
Name:			
Phone Number:			
Street Address:	City:	State:	ZIP Code:

Parent #1	
Place of Employment / Training/Job Search / Subsistence/ Other:	Phone Number:

**Parent #2**

Place of Employment / Training/Job Search / Subsistence/ Other:	Phone Number:
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**Parent/Guardian(s) Employment/Training Schedule**

Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<i>Example</i>	8:00-4:30	8:00-4:30	8:00-4:30	8:00-4:30	8:00-4:30	<i>Off</i>	<i>Off</i>

**Income Sources**

Source of Income	Monthly Gross Amount
What is the total of your household's monthly wage or salary? <b>(please provide your last two paystubs)</b>	\$
How often are parents/guardians paid?	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice per month <input type="checkbox"/> Other
What are the total of your household's Self Employment Wages? <b>(please provide a copy of your most recent Tax Return)</b>	\$
Does anyone in your home receive the following? <input type="checkbox"/> Social Security Benefits <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Rental Income <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> TANF/SSP/SSI <input type="checkbox"/> Pension and Annuities <b>(If so, please provide documentation of income received.)</b>	
Are you currently receiving Child Care Subsidies from the State or another Tribe? <b>If so, please identify from where:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
If applying based on self-employment or subsistence activity, I attest to completing a minimum of 20 hours per week and submitting the Activity Assurance Log by the 1 <sup>st</sup> of each month.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If applying based on job search activity, I intend to job search part-time (up to 5 hours) or full time (up to 8 hours) per day and submit the Activity Assurance Log every two weeks.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Statement of Truth**

Under penalty of perjury or unsworn falsification, I certify that the statements made on this application and during my interview for assistance are true and correct to the best of my knowledge. I have read Kawerak's Child Care Assistance Parent Handbook or requirements. I agree to hold Kawerak, Inc. harmless from any liability, claims, or damages that may result from the child care provider of its obligations under the terms of this agreement. I attest that no one residing in the household, 18 years or older, has assets exceeding \$1 million dollars. I understand that, with the exception of Tribally Approved Provider Care both the State of Alaska and the Kawerak Child Care Application must be completed. All supporting documents must be received to begin processing within a period of 30 days or the application may be closed. By signing, I agree to comply with the requirements for participation in this program.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Signature of Other Adult Applicant \_\_\_\_\_ Date \_\_\_\_\_

# Kawerak, Inc. Education, Employment & Supportive Service Division

HE DE SS VT STRT SYP ABE GED ESL CNA AVTEC

**Mailing Address:** P.O. Box 948 Nome, AK 99762 ~ **Email:** intake@kawerak.org ~ **Phone:** (907)443-4358 **Toll Free:** (800)450-4341 ~ **Fax:** (907)443-4485

## Initial Intake & Short Education or Employment Development Plan

Name: \_\_\_\_\_ Current Age \_\_\_\_\_  
 (First) (Middle) (Last) (Also Known As - or Maiden name)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Present Mailing Address: \_\_\_\_\_  
 (Street Address or P.O. Box) (City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Work / Cell: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Tribally enrolled at:** Brevig Mission - Council - Diomed - Elim - Gambell - Golovin - King Island - Koyuk - Mary's Igloo - Nome Eskimo Community - St. Michael - Savoonga - Shaktoolik - Shishmaref - Solomon - Stebbins - Teller - Unalakleet - Wales - White Mountain - Other?

**Veteran?**  Yes  No - Date of Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Registered with Selective Service?**  Yes  No

**Educational Status:**  High School Diploma - Year Graduated: \_\_\_\_  GED - Year obtained \_\_\_\_ OR Highest Grade Completed: \_\_\_\_  
 College/Vocational Graduate - Type of Degree:  Certificate  AA/AAS  BA/BS  MA/MS  Other: \_\_\_\_\_ Year \_\_\_\_

Most Kawerak EESS programs and/or jobs are subject to drug testing. **Are you willing to take a drug test?**  Yes  No

Applicant Ethnicity:	Applicant Primary Goal: (check one)	Education/Employment Service Needs List:
(check all that Apply)  <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Other (specify): _____  <b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single/Separated <input type="checkbox"/> Living with Partner <input type="checkbox"/> Divorced/Widowed	<input type="checkbox"/> Obtain or Improve a Job <input type="checkbox"/> Retain Current Job <input type="checkbox"/> Self-employment <input type="checkbox"/> Earn a High School Diploma or GED <input type="checkbox"/> Enter Postsecondary Education or Job Training <input type="checkbox"/> Educational Gain <input type="checkbox"/> Obtain Driver's License <input type="checkbox"/> Commercial Driver's License <input type="checkbox"/> Subsistence Activities (carving, beading, sewing, etc.) <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Relocation Assistance for Employment <input type="checkbox"/> Housing Assistance <input type="checkbox"/> Transportation To/From Training or Job <input type="checkbox"/> Enter Postsecondary Education or Job Training <input type="checkbox"/> Child Care <input type="checkbox"/> Training Fees or Tuition <input type="checkbox"/> Work Attire or On The Job Clothing <input type="checkbox"/> Other (Specify): _____

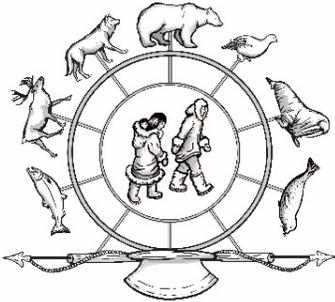
### Applicant Status and Program Enrollment

Applicant Primary Status	Barriers to Education/Employment	Institutional Programs
(Check All That Apply) <input type="checkbox"/> Disabled <input type="checkbox"/> Employed <input type="checkbox"/> Worked 90 days or more - this calendar year <input type="checkbox"/> Unemployed → <input type="checkbox"/> Collecting Unemployment <input type="checkbox"/> Not in the Labor Force <input type="checkbox"/> On Public Assistance ← (ATAP, TANF, food stamps, tribal welfare assistance)	(Must Complete)  <b>Last or Current hourly wage:</b> \$ _____  <b>Unemployed since:</b> ____/____/____  (currently on or received in last six months)	(Check All That Apply) <input type="checkbox"/> In Correctional Facilities (AMCC, Seaside, etc.)  Release date _____  <input type="checkbox"/> In Other Institutional Settings (A.P.I., Substance Treatment, etc.) Release date _____  <input type="checkbox"/> None of the above

I certify that the information given on this application is true to the best of my knowledge. By signing my name, I agree to allow information from this form to be used for statistical and follow-up purposes. I understand that my name will never be used in any report and that all data will be kept strictly confidential.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**KAWERAK, INC.**

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**AUTHORIZATION OF RELEASE OF INFORMATION**

(Valid for no less than 24 Months)

I hereby authorize the release of any and all information needed by Kawerak, Inc. for the use and determination of eligibility for financial assistance through the Education, Employment, and Supportive Services Division and for exchange of information for the Education or Employment Development Plan and career guidance services.

Persons or organizations that may be contacted include, but are not limited to: State of Alaska: Department of Labor and Workforce Development; Office of Children's Services; Department of Health and Human Services, Department of Public Assistance; Social Security Administration; Local Governments; City Councils; Village Councils; Native Corporations; State, Federal, and Private Educational organizations; Financial Institutions; Landlords, Employers, School Districts; Businesses and Private individuals.

I hereby authorize the use or disclosure of my personal and protected information described below but may not be all inclusive.

Birth Certification     Social Security Card     Verification of Tribal Enrollment     Employment Pay Stubs

Verification of Selective Service     Verification of Employment     Verification of Residency

Verification of Public Assistance or Unemployment from the State of Alaska

Verification of Education Diploma, Degree, or Certificate     Other: \_\_\_\_\_

I understand that this authorization is voluntary. I understand that my records may contain sensitive information. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization. This authorization expires 2 years from the date of signature.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
**IF UNDER 17 Years of Age:** Signature of Parent or Guardian

\_\_\_\_\_  
Date

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