KAWERAK, INC.

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

CHILD CARE PROVIDER APPLICATION

TRIBALLY APPROVED PROVIDER

Welcome to Kawerak Child Care Services! We are happy that you're interested in applying to be a Tribally Approved Provider.

TRIBALLY APPROVED PROVIDER:

Provides child care services in their own private residence, or the child's residence. Tribally Approved Providers may care for no more than 4 children under 13 years of age, including the provider's own children. Providers may only receive payment for up to 4 children in care. No more than 3 of which may be under 30 months of age. If providing care in the child's residence, all children must be from one family and under 13 years of age. With parental permission, the provider may bring their own child, but no more than 4 children may be cared for in total.

Providers must be 18 years or older and pass a Tribally Approved Background Check. If care is provided outside the child's home and there are other adults 18 years or older in the residence they will also require a Tribally Approved Background Check.

Parents will pay the provider directly for any co-payment or additional fees the provider charges beyond Kawerak's child care rates.

CHECKLIST

In order to establish eligibility as a Tribally Approved Provider, please submit the following:

- ☐ Provider Application
- ☐ Authorization for the Release of Information for each adult 18 years or older as needed
- ☐ Clearance Form - Office of Children Services (Not needed for Relative Providers)
- ☐ Child Care Provider Responsibilities
- ☐ Health and Safety Assurances
- ☐ Vendor Payment Agreement
- ☐ W-9 Form
- ☐ Copy of current government issued photo identification

*This page is for personal use. Do not return with your application.

KAWERAK CHILD CARE SERVICES
TRIBALLY APPROVED PROVIDER
APPLICANT INFORMATION

Provider Name: _____
(First) (Middle) (Last) (Also known as/maiden name)

Social Security #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____
(P.O. Box #) (City) (State) (Zip Code)

Home #: _____ Work#: _____ Cell #: _____

Email Address: _____

Information About Care:

Type of care provided: Tribally Approved Relative Provider Tribally Approved Provider (license exempt)

Where will care be provided? ☐In Provider's Home ☐In Child(ren)'s Home]Provider resides w/children

Physical location care will take place: _____
(Street Address) (City) (State) (Zip Code)

Provider's Relation to Child: ☐Grandparent ☐Great-Grandparent ☐Aunt ☐Uncle
☐Sibling living in a separate household ☐Other

HOUSEHOLD MEMBERS: (Please list ALL household members in the home **where care will be provided**). Do not include children needing care.

First, Middle, Last Name	Relationship to Provider Applicant	Date of Birth

Have you identified the children you will be providing care for? ☐ YES ☐ NO

What age range will you provide care for? (Please list ALL that apply)

☐ 0-1 year ☐ 13 months – 47 months ☐ 4 years – 12 years

List all the children you will be providing care for, maximum of four children:

Children's First and Last Name:	Relationship to Provider Applicant	Date of Birth:

1st Parent receiving child care services:_____
(First) (Middle) (Last)

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

2nd Parent receiving child care services:_____
(First) (Middle) (Last)

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

I certify that I will comply with all the requirements set forth by Kawerak Child Care Services and the Child Care Development Fund (CCDF) program authorizing the approval of child care providers. I agree to accept Kawerak Tribally Approved Daily Rates. My answers to all the questions and statements I have made in this application are true and correct to the best of my knowledge.

I agree to notify Kawerak Child Care Services immediately if there is any change in household members, if care is provided in my own home.

Child Care Provider:

Print:_____ Signature:_____ Date:_____

Kawerak Child Care Services Staff or Representative:

Print:_____ Signature:_____ Date:_____

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Authorization for Release of Information

Providers must be 18 years and older and pass a tribally approved background check. Tribally Approved Providers and all other household members, 18 years and older, living in the residence where care is provided outside the child's home must complete this authorization for release of information every 12 months.

Relative Provider review will include the State of Alaska Sex Offender Registry and the State of Alaska Court View Registry. Tribally Approved License Exempt Provider review will include the State of Alaska Child Abuse Registry, State of Alaska Sex Offender Registry, State of Alaska Court View Registry, out of state background checks for providers who have resided in another state within the past five years and the National Sex Offender Public Website check for any adults 18 years of age and older.

I hereby authorize Kawerak Child Care Services to conduct a Tribal Approved Background Check initially and annually thereafter. I understand this exchange of information will be done solely to benefit the provision of services I am requesting, and all information will be kept confidential. Copies of this release will be considered valid as the original and will be in effect for one year.

Full Printed Name First, Middle, Last	Date of Birth	Relationship to Child	Signature	Date

Alaska Department of Family and Community Services
Office of Children's Services

Not Needed for Tribally Approved Relative Providers

CLEARANCE FORM

CONFIDENTIAL

Worker_____
Field Office or
Private Agency _____

Instructions: Complete a separate form for *EACH* foster care applicant, unlicensed relative caregiver, adoptive applicant or guardian, household member age 16 years and older, and adult with direct access to children in the home.

_____ _____
Name (Last, First, Middle) **Household Name**

_____ _____
Aliases (Maiden Name, Previous Married Name(s)) **Social Security #** **Gender:** ◯ Male ◯ Female

_____ _____
Date of Birth **Place of Birth** (City, State, Country)

_____ _____ _____ _____
Driver License Number **State of Issuance** **Home Phone Number** **Alternate Phone Number**

_____
Physical Address (City, State, Zip)

_____
Mailing Address (City, State, Zip)

Residency: Alaska _____Yrs _____Mo's Physically here _____Yrs _____ Mo's

Please list your previous residence for the last five(5) years. Attach additional page(s) if necessary.

From (MM/YY)	**To** (MM/YY)	**City**	**State**	**Country**

Have you been previously licensed to care for children or adults?
NO ◯ YES ◯ If yes, indicate city, state, and type of care and dates of licensure:

Have you ever had a license to care for children or adults revoked, denied, or suspended in Alaska or any other state?
NO ◯ YES ◯ If yes, attach an explanation

Have you or any household members at any time ever been investigated for child abuse or neglect?
NO ◯ YES ◯ If yes, attach an explanation.

Do you have a physical, health, mental health, or behavioral problem that might pose a risk to the health, safety, or well-being of children? If you have a question regarding a problem, discuss it with your licensing worker.
NO ◯ YES ◯ If yes, attach an explanation.

Do you have a domestic violence problem or alcohol or other substance abuse problem that might pose a risk to the health, safety, or well-being of children?
NO ◯ YES ◯ If yes, attach an explanation.

Have you been convicted of a crime or charged with a criminal offense?
NO ◯ YES ◯ If yes, attach an explanation.

I authorize the department representative to review criminal justice (CJ), including, where applicable, juvenile criminal history, protective service, and licensing records and to share this information (except federal CJ records) with the applicant/licensee and if applicable, between the department and agency responsible for evaluating the facility. I agree and understand that I will be placed on the APSIN flag system. I certify that the contents of this form and information provided with it are true, accurate, and complete.

_____ _____
Signature Date

Authority: AS 47.05.310, AS 47.32
42 U.S.C. 671(a)(20)

(Office of Children's Services Staff Use Only)

Worker Name _____ Date_____

Required Background Checks

Child Protective Services History	○ No	○ Yes
Court View History	○ No	○ Yes
Sex Offender Registry History	○ No	○ Yes
Previous Licensing History	○ No	○ Yes
Criminal Justice JOMIS Check (must also be run on all youths age 12 and older)	○ No	○ Yes
Background Check Program Cleared	○ No	○ Yes

☐ Criminal Justice APSIN Check

☐ Other: _____

Comments:

Name of worker who did the checks _____ Date_____

Authority: AS 47.05.310, AS 47.32
42 U.S.C 671 (a)(20)

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KAWERAK TRIBALLY APPROVED PROVIDER RESPONSIBILITIES

Please initial each sentence below on the line:

_____ I understand that in order to get approved as a Kawerak Tribally Approved Provider my application and the Child Care Assistance Application of the parent(s) must be complete and approved prior to providing any child care services.

_____ I understand as a Tribally Approved Provider, I will be reimbursed for the days and times that the parent is determined eligible. Child care services provided outside the days and times of the Letter of Authorization are to be paid by the parent.

_____ I will notify Kawerak Child Care staff immediately if there are any changes to my household, if care is being provided in my home. This includes changes in any household members 18 years and older, temporary or permanent, who were not identified on my original application.

_____ I will give the parent(s) and Kawerak Child Care staff at least 14 days' notice of my intent to end child care services, or a shorter period may be agreed upon with mutual agreement between myself and parents.

_____ I agree that parent(s) will have unlimited access to their children while in care.

_____ I will never leave the children in my care unattended or with another person.

_____ I understand that I am a mandatory reporter of any suspected abuse or neglect of the children in my care and that I will notify the appropriate authorities.

_____ I agree to abide by the Health and Safety Standards and Assurances as required for providing child care services.

_____ I agree to hold Kawerak, Inc. harmless from any liability, claims, or damages that may result from providing care under the terms of this agreement.

_____ I will maintain written records that reflect the arrival and departure time of children in care. I will submit the original Certificate Time Sheets on the appropriate due dates.

_____ I understand that I may not misrepresent facts to receive child care subsidy payments. I understand that any benefits received in error must be repaid and may result in denial of further participation in the program.

___ I understand that I am responsible for any tax liability I may have regarding the wages received.

___ I will respect and maintain the confidentially of parents participating in the program.

___ I agree to complete the required orientation and training within 90 days of hire and annually thereafter.

I certify that I have read, understand and will comply with my responsibilities under the Kawerak Tribally Approved Provider Agreement.

_____ _____ _____

Provider Name (printed) Provider Signature Date

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HEALTH & SAFETY ASSURANCES
TRIBALLY APPROVED PROVIDER CARE

As a Tribally Approved Provider participating in Kawerak Child Care Services, please indicate by checking **Yes** or **No** on each line that you agree to implement the following best practices for Health and Safety. Any item checked **No** will initiate a follow up discussion with Kawerak Child Care staff to explore technical assistance being provided or other types of support for implementation.

	Yes	No
1. Space and equipment arrangements are adequate for the child(ren)'s safety and comfort.	☐	☐
2. Ventilation, temperature, and lighting are adequate for the child(ren)'s safety and comfort.	☐	☐
3. A safe play area is provided in both inside and outside areas.	☐	☐
4. Floors and walls are clean and maintained in a safe condition for the child(ren).	☐	☐
5. At least one smoke detector is installed at an appropriate location in the home or facility.	☐	☐
6. The home or facility has at least one fire extinguisher in the kitchen, which is maintained in an operable condition at all times.	☐	☐
7. Combustible and flammable materials are not stored in the water heater rooms, furnace rooms, or laundry rooms but stored in a safe place.	☐	☐
8. In case of a fire, my first responsibility, as a provider, is to evacuate the child(ren) to safety.	☐	☐
9. Toys and objects (including high chairs) are safe, durable, easy to clean, and non-toxic.	☐	☐
10. The home has a first aid kit which is inaccessible to the child(ren) and stored in a convenient location.	☐	☐

11. Diaper changing is not done in the food preparation area. ☐ ☐
12. Clean towels and wach cloths will be used. ☐ ☐
13. Firearms are unloaded and kept locked up; ammunition is stored in a separate location. ☐ ☐
14. Child(ren) in care will never be left alone or with someone else. ☐ ☐
15. Physical, verbal, or emotional punishment will not be used as a form of discipline. ☐ ☐
16. Use of alcohol, drugs, or tobacco will not be allowed during child care service hours. ☐ ☐
17. Medicines, cleaning substances, and dangerous materials will be kept in locked cabinets. ☐ ☐
18. The parents and Kawerak Child Care Services will be contacted for any injury to the child(ren) requiring medical treatment or for serious illness. ☐ ☐
19. Medicine will be given only with the parent's written instructions. ☐ ☐
20. I will wash hands before and after handling food, and after changing diapers and using the bathroom. ☐ ☐
21. The child(ren) will never be around a person or animal known to be dangerous. ☐ ☐
22. Food will be stored, refrigerated, and prepared properly. ☐ ☐

My signature indicates that I have answered the Health and Safety Assurances truthfully and agree to implement the health and safety assurance as stated above.

_____	_____	_____
Provider Name (printed)	Provider Signature	Date

FOR KAWERAK CHILD CARE STAFF:

Include notes below on follow up items needed to implement Health and Safety Assurances. Please initial and date the resolution of any follow up items:

KAWERAK, INC.

REPRESENTING
Brevig Mission
Sitaisaq
Council
Diomede
Iŋaliq
Elim
Niviarcaurluq
Gambell
Sivuqaq
Golovin
Chinik
King Island
Ugiuvak
Koyuk
Kuuyuk
Mary's Igloo
Qawiaraq
Nome Eskimo
Sitnasuak Inuit
Savoonga
Sivungaq
Shaktoolik
Saktuliq
Shishmaref
Qikiqtaq
Solomon
Aŋuutaq
St. Michael
Taciq
Stebbins
Tapraq
Teller
Tala
Unalakleet
Uŋalaqłiq
Wales
Kiŋigin
White Mountain
Iġałuik /
Nutchirviq

Dear Kawerak Partner,

We are delighted that you are doing business with Kawerak. In order to establish or update your account in our accounting system, we need to collect some essential information from you.

To begin, we require a Kawerak Vendor Payment Agreement that provides your full name (company), mailing address (PO Box), phone number, email address and payment preference. This information is critical for us to contact you in case there is an issue with payment or to send you relevant documentation.

We also require your tax identification number (TIN) or Social Security number (SSN). For this purpose, we have included a W-9 form with this packet. Please complete both of these forms and return it to us as soon as possible.

Additionally, Kawerak's preferred payment method is electronic payment. We will need your banking information, including the name of your bank, routing number, and account number. This will enable us to make payments quickly and easily through Automated Clearing House (ACH). Kawerak strongly encourages paying our vendors via bank ACH or credit card without transaction fee to expedite payment processing and improve efficiency.

*****Should you choose physical check as a payment option, please be aware, Kawerak mails all physical checks from Nome, AK via US Postal Service. Physical mailing to and from rural Alaska locations can take up to 30 days. Please take this into consideration when choosing your preferred payment method. For this reason, we do not reissue payment for physical checks for 60 days from the date of issue.*****

If you have any questions or concerns about this vendor packet, please do not hesitate to contact Olga Downey in Accounts Payable 907-302-6958, her email is odowney@kawerak.org, you can also email finance@kawerak.org. We appreciate your cooperation and look forward to a successful partnership with you.

Sincerely,
Will Gemar
William Gemar
Controller Payables

KAWERAK, INC.
VENDOR PAYMENT AGREEMENT

AUTHORIZATION FOR VENDOR PAYMENT

VENDOR NAME : _____

MAILING ADDRESS: _____

VENDOR EMAIL: _____

VENDOR PHONE: _____

PAYMENT METHOD: (INITIAL)

☐ **- ACH TRANSFER**Please fill out Bank information and sign below**

☐ **- PHYSICAL CHECK **Please sign below, Kawerak we will not reissue physical payments for 60 days**

DEPOSITORY (bank) NAME: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Checking/Savings (CIRCLE ONE)

TRANSIT ROUTING#: _____

ACCOUNT #: _____

I (we) hereby authorize KAWERAK, Inc. to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to: Checking or Savings Account indicated above and the depository named above, called DEPOSITORY.

This authority is to remain in full force and effect until Kawerak, Inc. has received written notification from me of its termination.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

Attach voided check below line, if possible, before emailing to finance@kawerak.org

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*