



Child Care Services Program  
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## KAWERAK TRIBALLY APPROVED RELATIVE PROVIDER RESPONSIBILITIES

**Please initial each sentence below on the line:**

\_\_\_\_\_ I understand that in order to get approved as a Kawerak Relative 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 Relative 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 the home whenever their children are 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 assurances for providing child care services.

\_\_\_\_\_ 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 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 will select my tax withholding amount and will be responsible for any tax liability I may have regarding the wages received.

\_\_\_\_\_ I will respect and maintain the confidentiality of parents participating in the program.

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

\_\_\_\_\_  
Provider Name (printed)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date