Fort McDowell Yavapai Nation

'Hmañ 'shawa Early Childhood Development Center
P.O. Box 17779, Fountain Hills, AZ 85269
Phone (480)789-7227 Fax (480)789-7289

Child Care Assistance Application

The application must be complete with the documentation listed below:

Child's Documents (for all children needing childcare)	Parent/Guardian Documents (for each parent in household)
☐ Birth certificate	☐ Work/School Schedules
☐ Child's Immunization Record	☐ Paystub, or other income verification
☐ Tribal Enrollment Documentation	☐ Proof of Guardianship/Custody Orders, or any other legal documents that are currently in place, if applicable.
☐ Infant Feeding Schedule (if applicable)	☐ Social Security, Child Support, or any additional income
	☐ Proof of ID (copy of license)

Applicant Information

Child #1 Name	Child's Birthdate and Age
☐ Male ☐ Female	Tribal Affiliation and Enrollment Number
Residential Address	
Does your child have any diagnosed health or behavioral disabilities that require special care? ☐ Yes ☐ No If yes, does your child have an IEP or IFSP? ☐ Yes ☐ No	
Is child currently in protective custody/foster care? ☐ Yes ☐ No (if yes, please provide case worker contact information and documentation)	

Child #2 Name	Child's Birthdate and Age
☐ Male ☐ Female	Tribal Affiliation and Enrollment Number
Residential Address	
Does your child have any diagnosed health or behavioral disabilities that require special care? ☐ Yes ☐ No If yes, does your child have an IEP or IFSP? ☐ Yes ☐ No	
Is child currently in protective custody/foster care? ☐ Yes ☐ No (if yes, please provide case worker contact information and documentation)	

Child #3 Name	Child's Birthdate and Age
☐ Male ☐ Female	Tribal Affiliation and Enrollment Number
Residential Address	
Does your child have any diagnosed health or behavioral disabilities that require special care? ☐ Yes ☐ No If yes, does your child have an IEP or IFSP? ☐ Yes ☐ No	
Is child currently in protective custody/foster care? ☐ Yes ☐ No (if yes, please provide case worker contact information and documentation)	

Child #4 Name	Child's Birthdate and Age
☐ Male ☐ Female	Tribal Affiliation and Enrollment Number
Residential Address	
Does your child have any diagnosed health or behavioral disabilities that require special care? ☐ Yes ☐ No If yes, does your child have an IEP or IFSP? ☐ Yes ☐ No	
Is child currently in protective custody/foster care? ☐ Yes ☐ No (if yes, please provide case worker contact information and documentation)	

Child #5 Name	Child's Birthdate and Age
☐ Male ☐ Female	Tribal Affiliation and Enrollment Number
Residential Address	
Does your child have any diagnosed health or behavioral disabilities that require special care? ☐ Yes ☐ No If yes, does your child have an IEP or IFSP? ☐ Yes ☐ No	
Is child currently in protective custody/foster care? ☐ Yes ☐ No (if yes, please provide case worker contact information and documentation)	

Select Program Option:

- ☐ 'Hmañ 'shawa ECDC (Monday - Thursday, 7:00am-5:45pm)
- ☐ CCDF Certificate Program (any other State-licensed Child Care Provider)
- ☐ Home-Based Child Care Provider

Parent/Guardian Information		
Parent/Guardian #1 Name	Relationship to child	Lives with child? ☐ Yes ☐ No
Residential Address		
Home Number	Work Number	
Email Address	Tribal Affiliation and Enrollment Number	
School/Job Training ☐ Full Time ☐ Part Time ☐ No School	Employment ☐ Full Time ☐ Part Time ☐ Unemployed	
School Name	Employer Name	
School Address	Employer Address	
Family Status (check all that apply) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Teen Parent ☐ Legal Guardian		

Parent/Guardian #2 Name	Relationship to child	Lives with child? ☐ Yes ☐ No
Residential Address		
Home Number	Work Number	
Email Address	Tribal Affiliation and Enrollment Number	
School/Job Training ☐ Full Time ☐ Part Time ☐ No School	Employment ☐ Full Time ☐ Part Time ☐ Unemployed	
School Name	Employer Name	
School Address	Employer Address	
Family Status (check all that apply) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Teen Parent ☐ Legal Guardian		

Household Information (List all household members supported by parents/guardians' income)	
Name	Relationship to parent/guardian
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
Total number of family: _____ (parents/guardians, and all dependents listed above)	

Do you consider your family homeless?	☐ Yes ☐ No
Do your family assets exceed $1,000,000?	☐ Yes ☐ No
Does your child have a parent currently receiving residential treatment services?	☐ Yes ☐ No

Family Income Checklist (select all that apply)	
☐ Employment	☐ Per Capita (non-FMYN)
☐ Child Support	☐ Public Assistance (TANF/Cash Assistance)
☐ Supplemental Security Income or Death Benefits	☐ Unemployment
☐ Scholarships/Educational Grants	☐ Other, please specify:
☐ Self-Employed (a notarized self-employment form that includes hours worked and monthly wages earned must be submitted)	

Statements made on this form by me are true and correct to this best of my knowledge. I authorize the 'Hmañ 'shawa Early Childhood Development Center to verify any information through employers, school institutions, or other entities mentioned within the application. Any applicant who knowingly submits false information or knowingly conceals a material fact on the application will not be considered for selection and will be withdrawn. I understand that: my childcare services may be stopped if I fail to pay the designated co-payment to my childcare provider; that payment will not be made for childcare services if the provider has not been pre-authorized by 'Hmañ 'shawa Early Childhood Development Center; that I am responsible for any additional charges such as late fees, special activity fees; that I must cooperate with 'Hmañ 'shawa Early Childhood Development Center in order to initiate and maintain eligibility. Failure to cooperate with program requirements may result in loss of childcare services.

Parent/Guardian PRINTED name	SIGNED name	Date

Parent #1 Work/School Schedule

Today's Date _____

Parent Name _____

Name of Employer _____

Name of Manager or Supervisor _____

Employer Telephone _____

Requesting: Regular scheduled hours

Please complete table below or provide a copy of printed work schedule.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

_____
Parent Signature

_____
Manager/Supervisor Signature

Should you have any questions, please contact:
Andrea LeBeau
480-789-7250
alebeau@fmyn.org

Parent #2 Work/School Schedule

Today's Date _____

Parent Name _____

Name of Employer _____

Name of Manager or Supervisor _____

Employer Telephone _____

Requesting: Regular scheduled hours

Please complete table below or provide a copy of printed work schedule.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

_____
Parent Signature

_____
Manager/Supervisor Signature

Should you have any questions, please contact:
Andrea LeBeau
480-789-7250
alebeau@fmyn.org

Emergency and Medical Information

Child's Name	Child's Birthdate	☐ Male ☐ Female
Home Address	Home Phone	

Mother/Guardian Name	Home Address
Workplace and Work Phone	Cell/Home Phone

Father/Guardian Name	Home Address
Workplace and Work Phone	Cell/Home Phone

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (please list at least two contacts)

Name and relationship to child	Phone
Name and relationship to child	Phone
Name and relationship to child	Phone
Name and relationship to child	Phone

The following individual(s) may NOT remove my child from the facility:

Names:

If Medical care is necessary, call:

Health Care Provider	Name:	Phone:

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety.

In case of injury or sudden illness, I request that this individual be called first:	

Custody papers have been provided and are on file at the facility: ☐ Yes ☐ No ☐ N/A

Medical Information

Is child allergic to food or other substances? ☐ No ☐ Yes If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:
Is child usually susceptible to infections and if so, ☐ No ☐ Yes what precautions need to be taken?
Is child subject to convulsions/seizures and ☐ No ☐ Yes what should be our procedure if one occurs?
Is there any physical condition that we should be aware of and ☐ No ☐ Yes what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)?
Additional comments:
Other special instructions:

Be it known that in the event that I cannot be reached, I the undersigned parent or guardian of the child named above, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said child as, in the judgment of said doctor or hospital may be required on an emergency basis, in the event said child should be injured or stricken ill while participating in an activity sponsored by the childcare program.

It is hereby understood that the consent and authorization hereby given and granted are continuing and are intended by me to extend throughout their enrollment in the childcare program.

It is further understood that any expenses incurred will be paid for by the parent/legal guardian of the student and their insurance carrier. Payment of the expense is not the responsibility of the childcare program.

This Emergency and Medical Information form is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED name	SIGNED name	DATE

Screening Consent
(‘Hmañ ‘shawa ECDC only)

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. Additionally, social-emotional development within the first few years of life prepares your child to be confident, trusting, curious, and able to develop positive relationships with others. Your child’s positive social-emotional development forms a foundation for learning throughout life.

‘Hmañ ‘shawa Early Childhood Development Center will track your child’s development on a regular basis, including but not limited to: ASQ-3: Ages and Stages Questionnaire, ASQ:SE-2: Ages and Stages *Social-Emotional* Questionnaire, Teaching Strategies Gold Assessment, CDC Milestones checklists, PLS:5 speech/language screener, hearing and vision screening.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program. Some screenings may take place onsite with a caregiver, some screenings may be sent home with parents to complete at home.

- ☐ I wish to have my child participate in the screening/monitoring program.

- ☐ I do not wish to participate in the screening/monitoring program.

_____

Parent/guardian’s signature Date

Child’s name:_____
Child’s date of birth: _____
If child was born 3 or more weeks premature, # of weeks premature: _____