

CHILDCARE BLOCK GRANT PROGRAM REQUIREMENTS & REMEDIES

(KEEP THESE FOR FUTURE REFERENCE)

Program Application Eligibility Requirements:

This program assists low-income families **(which include all adult household members)** working, in school, or enrolled in formal training programs. This program will also provide families with 10 hours of childcare assistance per week for a minimum of 3 months while they are job searching. Updated Applications must be resubmitted yearly for services.

All persons 18 years and older:

- Family size & income are the main criteria. All earned income in the household is counted (boyfriend, girlfriend, common law husband/wife, brother, sister, cousin, parent, etc.) In the event of a projected funding shortage, priority will be given to the lowest-income families with enrolled members of a Federally Recognized Tribe.

Applications must include for all household members:

- Tribal Enrollment verification, Birth Certificate, Social Security Card, Residency (proof of where you live), and current immunization records for children (*your application will be denied if immunization records are not provided or if shots are overdue; copies are accepted*). Release of Information (all adults).

General Updates:

- Any change in hourly wage rates (up or down), work hours, work schedules, household size, etc., must be reported within 10 days, or you may be declared ineligible for assistance and your case will be closed. These updates can be made by requesting an "Update Application" and must be submitted to the CCBG Program Coordinator. *Applicants who are enrolled in college or a formal training program are required to submit their class schedule & financial aid award letters each quarter.*

HOW FAST ARE APPLICATIONS PROCESSED?

- Every effort will be made to process your application within 7-10 working days. If there is information lacking, your application WILL NOT BE ACCEPTED until all missing documents are submitted and *your application is complete*. If you are placed on a waiting list, you will be notified.
- It's imperative that you pay close attention to the "MONTHS AUTHORIZED FOR" dates, as you will be held responsible for any childcare expenses that fall outside of these dates. *Therefore, it is in your best interest to keep track of these dates and ensure that your application is up-to-date and that your case remains active with the CCBG Office.*

WHAT HAPPENS IF THERE IS A FUNDING SHORTAGE?

- In the event of a projected Child Care Block Grant funding shortage, priority goes to the lowest-income persons who are enrolled members of a Federally Recognized Tribe (children). Every effort will be made to provide at least thirty days' notice of funding unavailability. If the federal government discontinues or reduces funding, it may affect funding availability.

Childcare Provider Requirements:

- It is essential to select your childcare provider carefully and formally declare them in writing. You are not authorized to change providers without notifying the CCBG Program and declaring your new provider. *You must call and obtain approval before taking the child to a new provider.* This approval is crucial to ensure that your child and associated expenses are covered. If you choose a provider who is not on our CCBG provider list, provide a copy of their state license when applying for assistance. If your provider is not state licensed, they (and all persons over 18 in the home) must complete and pass a background check through DHRD (this process can take up to 3 months to be approved and CCBG will not pay any costs that may have incurred in the 3 months as we do not back pay) Family/Relative caregivers: A caregiver cannot live in the same home as the child(ren) they are providing care for. For family members who do not reside in the same household, there is a limit of 3 *children* in the home, with no more than two children under the age of 2. This count also includes their own child(ren). CCBG does not retro-pay any provider for services outside the authorized months.

Other requirements:

- *Parents are required to sign their child's sign-in sheet(s) DAILY. You are certifying the amount of time requested by the caregiver. Please review the sheet carefully before signing. The CCBG Coordinator will conduct periodic checks with your provider to ensure compliance. Failure to sign out will result in immediate disqualification from the program.*

Foster children and/or relative children:

- If you are applying for assistance for a child who resides with you but is not your natural or adopted child, you must present a legal document ensuring that you have proper and legal custody of the child.

Childcare Provider Co-payments:

- All parents will be required to pay a monthly co-payment directly to the childcare provider. Be sure to pay the co-payment amount monthly, as your provider cannot bill the program until your co-payments are paid and up to date. In a worst-case scenario, if you do not pay your co-payment, you will be responsible for paying the entire bill. The CCBG Program pays bills and re-obligates funds on a monthly basis. Therefore, the provider must bill the program on a timely basis, monthly. *Please be mindful that childcare providers rely on your promptness to maintain their business.*

Childcare Improvement Trainings:

- We offer providers monthly workshops. These trainings are designed to enhance the quality of childcare at local childcare facilities. Therefore, we strongly encourage childcare providers to attend regularly.
- Where can I apply for childcare if I am eliminated or ineligible for the Tribes Program? You may apply for childcare at the Nurturing Center in Kalispell – 1 (800)-204-0644 or (406)756-1414.

WHERE MAY I REQUEST A TRIBAL CCBG APPLICATION?

The Front Desk at DHRD, Crystal Cadieux @ ext. 1382, crystal.cadieux@cskt.org, Joeline Matt @ ext. 1309, joelene.matt@cskt.org, or Traci Couture @ ext. 1324, traci.couture@cskt.org.

CHILD CARE BLOCK GRANT APPLICATION CHECKLIST

To be eligible for childcare assistance, please complete the following checklist to ensure that your application packet is complete before submitting it to our office. You must provide the following information; your application will not be processed if these items are not included. All items will be verified.

*****DO NOT LEAVE ANY BLANK SPACES*****

Name: _____

- _____ 1. Application
- _____ 2. Picture Identification for **ALL** adults
- _____ 3. Birth Certificates for **ALL** household members
- _____ 4. Social Security Cards for **ALL** household members
- _____ 5. Income Verification for **ALL persons 18yrs & older** (Recent check stub or other documents to verify All Household Members other income. Self-Employed will need to provide income tax return from previous year)
- _____ 6. If self-employed- A copy of the previous year's INCOME TAXES
- _____ 7. Work Verification for ALL persons 18yrs & older **(Supervisor signature required)**
- _____ 8. School/Training Verification **(Must attach class schedule and financial aid award letter, quarterly)**
- _____ 9. Tribal Affiliation Verification for **ALL** household members
- _____ 10. Proof of Residency: (Copy of Rental Agreement, electric bill)
- _____ 11. Current Immunization Records for **ALL** children
- _____ 12. Current Daycare Provider
Name: _____ Phone Number: _____
Mailing Address: _____
(Box # or Street) (City) (Zip)
Date started: _____
Physical Address: _____
- _____ 13. Is the current or proposed childcare provider related to you (applicant) or to the children in care? _____
If so, please describe: _____
Will there be other children cared for there? _____
If so, who and how many? _____
- _____ 14. When will care be provided? **(SUBMIT SCHEDULE VERIFIED BY EMPLOYER/SCHOOL)**

This application is for childcare services while the applicant(s) are working and/or attending a training program. Childcare services will be subsidized as long as the applicant(s) continuously work or attend training programs, provided that funds are available and family co-payments are up to date. By initialing below, I confirm that I have read and understand the attached CCBG Requirements & Remedies handout. INITIAL

DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT

CHILD CARE BLOCK GRANT FY27

P.O. BOX 278, PABLO, MT 59855

406-675-2700 Ext. 1382 or 1309

FAX # 406-675-2775

*****DO NOT LEAVE ANY BLANK SPACES*****

Applicant Name: _____ Telephone: _____ Email: _____
 Mailing Address: _____ City: _____ Social Security #: _____
 Physical Address: _____
 Employer: _____ Work Phone: _____
 How many hours per week will you be working: _____ Work Schedule: _____
 Spouse/Co-applicant: _____ Address/Phone: _____
 Spouse/Co-applicant Employer: _____ Work Phone: _____

***List all persons residing in your household including yourself: (circle children you are seeking assistance for)**

Names	DOB	Tribe	Tribal ID #	Relationship	M/F	Occupation

MONTHLY: (submit documentation)**APPLICANT**

Wages/Salary: _____
 Child Support: _____
 Social Security: _____
 Self-Employment: _____
 Public Assistance: _____
 (TANF, GA, etc.)
 Educ. Financial Aid: _____
 (Pell, Tribal BIA, HIS, other)
 Other – Describe: _____

SPOUSE/CO-APPLICANT

Wages/Salary: _____
 Child Support: _____
 Social Security: _____
 Self-Employment: _____
 Public Assistance: _____
 (TANF, GA, etc.)
 Educ. Financial Aid: _____
 (Pell, Tribal BIA, HIS, other)
 Other – Describe: _____

Total \$ _____ + Total \$ _____ = \$ _____
(Applicant) (Spouse) Total Monthly Income

Applicants: I hereby affirm that the statements included in this application are accurate, complete and true to the best of my knowledge. I understand that I must reapply and be determined eligible for childcare assistance as often as my status changes and/or as my authorization expires. I also understand that my co-payments must be current each month. I agree to notify the CCBG Program of any changes to my income and/or number of persons in the household and/or work/training status because these changes may affect my eligibility. I understand that because the CCBG is a federally funded program, the penalty for providing false information not to be more than \$10,000.00 and/or not more than five (5) years of imprisonment, and I will be terminated from the CCBG program immediately.

FOR OFFICE USE:

Date Received: _____ Date Approved: _____

Priority #: 98-P- _____ F- _____ Income Level: \$ _____ %

Co-Pay: \$ _____ Program CCDF _____ TANF _____

Months Authorized for: _____ Update Needed: _____

COMMENTS/CASE NOTES: _____

Applicant Signature _____ Date _____

Application Received By (DHRD Staff) _____ Date _____

DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT

CHILD CARE BLOCK GRANT FY27

P.O. BOX 278

PABLO, MT 59855

406-675-2700 ext. 1382 or 1309

FAX # 406-675-2775

WORK VERIFICATION

ALL PERSONS 18 YEARS & OLDER MUST COMPLETE A FORM

*****DO NOT LEAVE ANY BLANK SPACES*****

EMPLOYER: The information requested on this form is needed to determine eligibility for childcare services. Please provide the information requested. Thank you for your cooperation. Self-employed persons need to provide a copy of their last income tax return.

EMPLOYEE NAME: _____

1. What date did/does employment start? _____ Hourly Rate: _____
Month Day Year
2. What is this employee's **GROSS** salary or wages per pay month? _____
3. Does this employee have any company paid flexible daycare benefits that could be taken in cash?
_____ Yes _____ No Explain: _____, If yes, please
give amount \$_____ per month
4. Does this employee receive tips? _____ Yes _____ No
If yes, please give approximate \$_____ per month
5. Does this employee work overtime? _____ Yes _____ No
If yes, what is the monthly rate? _____ Per month
6. Does this employee receive non-cash or cash benefits as part of their pay; for example a housing allowance or apartment? If yes, please indicate the monthly cash value: \$_____

7. Please complete the following work schedule:

	<u>SUN</u>	<u>MON</u>	<u>TUES</u>	<u>WED</u>	<u>THURS</u>	<u>FRI</u>	<u>SAT</u>
Start Time:	_____	_____	_____	_____	_____	_____	_____
End Time:	_____	_____	_____	_____	_____	_____	_____

If schedule varies, what is the average number of hours per week? _____

PLEASE READ AND SIGN: I declare by signing this statement line that the information on this form is **TRUE** and **CORRECT** to the best of MY knowledge, and that I have the authority to make such verification on behalf of this organization.

I understand that because the Childcare Block Grant is a Federally funded program, the penalty for providing false information shall not be more than \$10,000.00 &/or not more than five (5) years imprisonment.

I certify that this information is true and correct to the best of my knowledge and that I have the authority to make such verification on behalf of this organization.

Supervisor Signature: _____ Date: _____

Title: _____ Phone Number: _____

Employer: _____ Address: _____

NO-INCOME DECLARATION

For all household members 18 years or older, declaring no income:

I/we, do hereby declare that I/we have not received any Income for the Month(s) of:

1. _____ 2. _____ 3. _____

The reason that I/we have had no income for the months listed above is as follows:

I/we have been meeting my/our basic living needs for rent, mortgage, food, child care, utilities, other, in the following way:

Rent or mortgage: _____

Food: _____

Child Care: _____

Utilities: _____

Other: _____

I/We declare by signing this statement line that the information provided on this form is true and correct to the best of my/our knowledge. I/We understand that because the Childcare Block Grant (CCBG) is a Federally funded program, the **penalty for providing false information shall not be more than \$10,000.00 &/or not more than five (5) years imprisonment.**

Date: _____ Signature of above Person declaring no income: _____

Date: _____ Head of Household Signature: _____

CONFEDERATED SALISH & KOOTENAI TRIBES
CONSENT FOR RELEASE OF INFORMATION

I/We, the undersigned are seeking services from the Department of Human Resources Development (DHRD) which includes, but is not limited to the following programs: 477 Programs including Child Care Block Grant, TFAP Cash Assistance, Commodities, Dire Need, WIOA, SYEP, LIHEAP, NEW, General Assistance, FEMA, Indian Elderly Program, Vocational Rehabilitation Program, Warming Center, Anchor Way and Pablo Small Home Transitional Housing, Tribal Social Services, and other emergency housing resources.

I/We, authorize the above-named programs to share, exchange, give, and receive information about my application and contents therein, in an effort to serve me, my family and my children (as declared on my application/applications for assistance).

In addition, I/We authorize the following programs/agencies to release and share information to the DHRD Program in an effort to provide and facilitate assistance to my/our children and myself/ourselves. Those programs and agencies include but are not limited to the following: **INITIAL EACH DEPT. YOU AUTHORIZE TO RELEASE INFORMATION.**

1. _____ Tribal Personnel Office: (Drug Test results), etc.
2. _____ Early Childhood Services – ECS – Participation in services (CHIP information, Address, Household Composition)
3. _____ Tribal Health and Human Services - THHS (Mental Health, Family Support, Alternate Resource), etc.
4. _____ Tribal Education Department – TED (educational awards, grades, referrals), etc.
5. _____ Salish Kootenai College/ALC/ABE Programs – (Schedule, Test results, Student verification of attendance, Credit Loan, Grants), etc.
6. _____ Montana State Offices of Public Assistance – (Flathead, Lake, Missoula, Sanders County)
7. _____ Salish Kootenai Housing Authority – SKHA (eligibility, rent amount, bad debts, household compositions, lease compliance, residency), etc.
8. _____ S&K Holding – Welfare to work issues
9. _____ Public Schools – (verify attendance of minor children in general school and at IEP sessions)
10. _____ Tribal Police – (CPS referrals and outstanding warrants.), etc.
11. _____ Probation Adult/Juvenile – (Truancy, Community services and other requirements)
12. _____ Tribal Court – Community Services and Court Orders, Healing Court, etc.
13. _____ Tribal Lands Department (TLD) – (verify Land Lease), etc.
14. _____ Tribal Prosecutors / Tribal Defenders (CPS, Court Orders, Truancy, Families at Risk Staffing), etc.
15. _____ MT Children's Health Insurance Program (CHIP) – Eligibility Status & Employee Health Insurance Information
16. _____ Tribal Enrollment – verify enrollment enrolled tribe _____
17. _____ Social Security Administration, MT Disability Bureau, Veteran's Administration – Verify income
18. _____ Workman's Compensation Programs (income verification, medical coverage)
19. _____ MT STATE SNAPP PROGRAM/TRIBAL FOOD DISTRIBUTION PROGRAM **Case Number** _____
20. _____ CSKT Tribal Credit
21. _____ CSKT Tribal Council
22. _____ Homelessness Task Force Coordinator/Tribal Member Services Director/Anchor Way Case Manager
23. _____ NARSS Recovery Program
24. _____ Potential employers found by DHRD 477 programs. _____

I/We understand that the information received by the DHRD Programs will be kept confidential, used for professional purposes only in terms of facilitating services received by me and my/our family, and will not be released to other outside programs/agencies, unless prior authorization by me, in writing, is obtained. I/We understand the I/We may cancel this Consent for Release of Information, in writing at any time.

Print Name - Applicant/Parent or Guardian	Date	Sign Name	Date
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Witness

Date

THIS CONSENT FOR RELEASE OF INFORMATION IS VALID FROM _____ TO _____

THIS RELEASE OR REQUEST OF INFORMATION HAS BEEN REVOKED BY:

Applicant/Parent or Guardian Signature
DHRD Form – 1-16-02 – Consent for Release of Information

Date
revised 10-16-25 CC/TW/NK

Revised 8/25/2025

CONFEDERATED SALISH & KOOTENAI TRIBES
Individual Self-Sufficiency Plan (ISP)

CASE NAME: _____ **DATE:** _____

AS A PARTICIPANT of the CSKT 477 PROGRAM, I AGREE TO CONTINUE WITH THE FOLLOWING:

- I will accept and maintain employment as it becomes available, including a pre-employment drug test. Advancement to higher and more responsible work is encouraged. If I refuse, quit or are terminated from employment, my family will serve a 90 Day penalty period (during this 90 days there will be no cash grant or eligibility for GA). The penalty period begins from the date of re-application. Failing a drug test is equal to refusing quitting and or terminating from employment.

YES ☐ NO ☐ REASON/EXPLAIN _____

- I will/can participate in the inclusion of cultural and tribal activities, as verified by the Tribal Culture Committees.

YES ☐ NO ☐ Total hours allowed _____

- I will establish, with my Case Manager, and attend any and all ISP renewal appointments scheduled. **Next Appointment Date:** _____

- I will participate in any and all trainings and receive and review any and all information provided to me on the Individual Self-Sufficiency Plan (ISP).

YES ☐ NO ☐ EXEMPTION ☐ TIME PERIOD _____

- I will cooperate with DHRD to ensure services are issued accurately and effectively.

YES ☐ NO ☐

- I will sign a DHRD Consent for Release of Information Form.

Date Signed: _____

- I will apply for LIHEAP, LIWAP, and General Assistance (GA) through DHRD. Need to provide proof. Date Applied _____

- I will apply for Vocational Rehabilitation through DHRD. Need to provide proof.

Date Applied _____

- I will apply for SSI/SSDI within 30 days. Need to provide proof.

Date Applied _____

- I will review and sign the DHRD Intake Form. Date Signed: _____
- I will obtain my HiSET. Date to complete is _____
- I will be required to obtain my Driver's License. Date Signed _____
- I will participate in the 6 week Mentoring classes that are offered by the DHRD. Reason/Explain. _____

- Date Signed _____
- I understand that if I do not comply with all the above-mentioned activities I will be sanctioned for 90 days with the possibility of eviction from the 477 program for noncompliance.

I have been informed of and understand my rights, responsibilities, and other information as listed above. My signature also indicates receipt of a copy of this Individual Self-Sufficiency Plan (ISP).

PARTICIPANT SIGNATURE

DATE

CASE MANAGER/DESIGNEE of DHRD

DATE

Case Notes:

