ECONOMIC SUPPPORT SERVICES
P.O. Box 365
Oneida, WI 54155
Phone: 920-490-3939
Fax: 920-490-6803
2640 West Point Rd. Green Bay, WI 54304

ONEIDA

March 20, 2020

EMERGENCY RELATIVE CARE PROGRAM

Beginning March 22, Oneida Economic Support will accept applications for temporary Emergency Relative Care. The COVID-19/Corona Virus is a pandemic that has created challenges which includes the need for childcare. Due to this uncertain time, we are amending our internal policies to allow additional support to families for nontraditional childcare.

If you are a parent in need of child -care services, and are still mandated to report to work, do not have access to a licensed childcare facility, but have relatives who can provide childcare, you may qualify for this Emergency Relative Care Program.

Relative Care is a program to help support a family in need of child-care services. A relative is defined as a blood:

- Grandparent
- Great-grandparent
- Aunt
- Uncle
- Sibling

Relative care provider must be at least 18 years of age and reside in a separate residence.

Relative providers will receive payment to provide care for relative children ages 0-12 years old. Payment rates will vary dependent upon ages. A completed application must be received prior to payment.

Please refer to these websites for health and safety information:

Centers for Disease Control and Prevention https://www.cdc.gov/

https://www.cdc.gov/coronavirus/2019-ncov/index.html

The Oneida Nation COVID-19 Resource Page

https://oneida-nsn.gov/blog/2020/03/13/oneida-nation-covid-19-resource-page/

Wisconsin Department of Children and Families

https://dcf.wisconsin.gov/

Our agency doors are locked, and all business is being conducted over the phone, email, or postal mail. If you have any questions, please reach out to Melissa Staub at (920) 490-3768.

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Child Care Services Program

Child Care Developmental Fund Application (Emergency)

The Child Care Developmental Fund (CCDF) is a federal block grant that provides subsidy for working families who may not be eligible for Wisconsin Shares or families seeking child care for education. All child care programs are subject to funding availability.

Minimum Eligibility Criteria
The Parent/guardian must be in an approved activity (work, education/training, TANF activity, etc). Subsidy funding is based on income and household size according to state/federal guidelines. Families are required to pay a portion of childcare costs and are responsible for selecting their childcare provider. At least one household member must be enrolled in a federally recognized tribe and must live on the Oneida Nation Reservation or reside in Brown or Outagamie county.

If the application is incomplete or missing required verifications, you will receive notifications. Applications are valid for 30 calendar days from date received. If you fail to provide the required verifications within the 30 days, you will receive notification that your application has expired and must reapply. Please allow 10 business days for processing of applications.

Applications Requirements:

_____Tribal enrollment verification

_____All household income verification for the last 30 days (paystubs, award letters, etc.)

_____ Residency verification (mail postmarked within last 30 days, ex: utility bill, lease)

_____Current referrals/medical documentation (if applicable)

_____ Legal/temporary custody verification (if applicable)

_____ Social Security numbers for all household members

_____ Work/Education schedule

_____Application must be completed in full, signed and dated.

_____Parent Acknowledgement

_____Educational Plan (if applicable)

APPLICANT INFORMATION

CIF #

Last Name	First Name	M.I.	Soc. Sec. Number
Physical Address		On Reservation ☐ Yes ☐ No	How Many Years Living on Reservation?
City	State	Zip	County
Mailing Address (if different than above)			
City	State	Zip days,	
Phone Number (area code)	Message Number (area code)	Email Address	
Date of Birth	Tribe	Tribal Enrollment Number	Veteran: ☐ Yes ☐ No
☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

How are you related to the children on the application? ☐ Mother ☐ Father ☐ Caretaker/guardian or relative (court documents needed)

Are you a citizen of the United States? ☐ Yes ☐ No If no, are you authorized to work in the U.S. ☐ Yes ☐ No

Do any of these situations apply to you or your family? (check all that apply)
☐ Disability; list type _____ ☐ Medical Condition ☐ Domestic Violence ☐ Homeless ☐ Other _____

Are you currently receiving (check all that apply) ☐ FoodShare ☐ Badger Care ☐ TANF ☐ FSET ☐ Energy Assistance ☐ Other _____
If yes, Through what Tribe or County _____

CO-APPLICANT INFORMATION

CIF #

Last Name	First Name	M.I.	Soc. Sec. Number
Physical Address			
City	State	Zip	County
Mailing Address (if different than above)			
City	State	Zip	
Phone Number (area code)	Message Number (area code)	Email Address	
Date of Birth	Ethnicity/Tribe	Tribal Enrollment Number	Veteran: ☐ Yes ☐ No
☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

How are you related to the children on the application? ☐ Mother ☐ Father ☐ Caretaker/guardian or relative (court documents needed)

Are you a citizen of the United States? ☐ Yes ☐ No If no, are you authorized to work in the U.S. ☐ Yes ☐ No

Do any of these situations apply to you or your family? (check all that apply)
☐ Disability; list type _____ ☐ Medical Condition ☐ Domestic Violence ☐ Homeless ☐ Other _____

Are you currently receiving (check all that apply) ☐ FoodShare ☐ Badger Care ☐ TANF ☐ FSET ☐ Energy Assistance ☐ Other _____
If yes, Through what Tribe or County _____

ADDITIONAL HOUSEHOLD INFORMATION
List EVERYONE living in the household i.e. children, other relatives, friends

CHILD INFORMATION			
(1) Name	DOB	☐ Female ☐ Male	CIF #
Relationship to Applicant	What school child attends, describe any special needs (if applicable)		
Soc. Sec. Number	Tribal Enrollment Number	Ethnicity/Tribe	Is this child in shared Placement? ☐ Yes ☐ No

(2) Name	DOB	☐ Female ☐ Male	CIF #
Relationship to Applicant	What school child attends, describe any special needs (if applicable)		
Soc. Sec. Number	Tribal Enrollment Number	Ethnicity/Tribe	Is this child in shared Placement? ☐ Yes ☐ No

(3) Name	DOB	☐ Female ☐ Male	CIF #
Relationship to Applicant	What school child attends, describe any special needs (if applicable)		
Soc. Sec. Number	Tribal Enrollment Number	Ethnicity/Tribe	Is this child in shared Placement? ☐ Yes ☐ No

(4) Name	DOB	☐ Female ☐ Male	CIF #
Relationship to Applicant	What school child attends, describe any special needs (if applicable)		
Soc. Sec. Number	Tribal Enrollment Number	Ethnicity/Tribe	Is this child in shared Placement? ☐ Yes ☐ No

(5) Name	DOB	☐ Female ☐ Male	CIF #
Relationship to Applicant	What school child attends, describe any special needs (if applicable)		
Soc. Sec. Number	Tribal Enrollment Number	Ethnicity/Tribe	Is this child in shared Placement? ☐ Yes ☐ No

(6) Name	DOB	☐ Female ☐ Male	CIF #
Relationship to Applicant	What school child attends, describe any special needs (if applicable)		
Soc. Sec. Number	Tribal Enrollment Number	Ethnicity/Tribe	Is this child in shared Placement? ☐ Yes ☐ No

Absent Parent Information	
Name	DOB

Please check the types of assistance/income you or members of your household are receiving, include the monthly amount for each item checked. Copies of paystubs, award letters, etc. for the last 30 days are required.

INCOME INFORMATION – MONTHLY AMOUNT

____Gross Employment (applicant)	$_____	____Child Support	$_____
____Gross Employment (co-applicant)	$_____	____VA/Military Benefits	$_____
____Unemployment	$_____	____Per Capita	$_____
____SSI	$_____	____Worker's Comp	$_____
____ Social Security	$_____	____Other_____	$_____
____Retirement	$_____	____Educational Aid	$_____
		TOTAL INCOME	$_____

Is the total value of household liquid assets less than $1,000,000? ☐ **Yes** ☐ **No**

Please list your current employment and/or college

APPLICANT & CO-APPLICANTS EMPLOYMENT & COLLEGE INFOMATION

Name	Employee/College Name	Employer Phone Number	Start Date	Travel Time from Provider to Approved Activity

Please list information for child care provider you will be using

CHILD CARE PROVIDER INFORMATION

Provider Name	Address/City	Phone Number	Name Child/ren Attending

CONSENT TO RELEASE/DISCLOSE & SIGNATURE

I consent to release any and all information necessary for the determination of benefits on my behalf, to the Oneida Economic Support Agency and Community Support. I understand this release may include, but not limited to, any information regarding income, salary, benefits and disability. I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application or interview may result in denial of benefits.

Applicant Signature _____ Date _____

Co-Applicant Signature Date

Parent Acknowledgement

1. **You may be responsible for child care costs that are not paid by the Oneida Child Care Services Program, including**

   A. Unauthorized child care hours
   B. Costs not included in the Oneida Child Care Services Program payment, such as, transportation, meals, field trips, diapers, outside services, etc.
   C. Your parent payment as stated by your child care provider

2. **You must contact the Oneida Childcare Services Program immediately if there is a change in your childcare needs, including, but not limited to:**

   A. Changes in the number of work or training/school hours that change your child care needs.
   B. Children no longer attending the child care provider as listed on the authorization.
   C. Changes in child care provider during the authorization period will result in parent being responsible for childcare costs to a new provider.

3. **You must inform the Oneida Childcare Services program within 10 days from the date of:**
   A. Changes in your household income
   B. Change in your home address
   C. Change in marital status
   D. Change in shared placement for your child
   E. Change in number of people in your household
   F. Change in your approved activity

4. **Overpayment, Recoupment, and Sanctions**
   A. You could be referred for a fraud investigation and may be required to repay any overpayments if the information you provide is not accurate or if your changes are not reported in a timely manner.
   B. If you fail to report changes and it results in a childcare overpayment to your provider, you may be required to repay the overpayment to the Oneida Child Care Services Program.
   C. If you discontinue the approved activity for which you receive child care assistance but continue to utilize childcare, you may be required to pay back the Oneida Child Care Services program and could result in a referral for fraud investigation.
   D. If you use childcare for activities that are not approved, you are responsible to pay for those hours of child care on your own.
   E. You may be responsible to repay overpayment caused by Oneida Child Care Services Program error.

5. **Appeals**
   A. You have the right to request an appeal if you do not agree with the action taken on your case. You must submit the appeal request in writing to the Child Care Services Program Manager within 10 business days of the notice of negative action.

I have read and understand the above parent responsibilities as provided to me.

Applicant Signature _____ Date _____
Co-Applicant Signature _____ Date _____

FOR OFFICE USE ONLY		
Total Monthly Income	Income %	Family Size
Parent Payment		Effective Dates
Name of Provider		Provider Type ☐ Licensed ☐ Certified ☐ Provisional
Provider Weekly Rate		
Approved Activity ☐ Work ☐ Seeking work ☐ Education/training ☐ TANF activities ☐ Teen parent attending school		
Comments		
Oneida Representative Signature		Date

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Child Care Services Program
Educational Plan

APPLICANT INFORMATION		
Last Name	First Name	Social Security Number
College/University Attending	Academic Level ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior	Academic School Year 20_____ - 20_____
Declared Major/Program	Type of Degree you will earn (circle) Tech-Diploma AA/AS BA/BS	Expected Graduation Date

Complete this form prior to each semester/term or upon class registration

CHECK ONE TERM ONLY AND LIST ALL COURSES/INFORMATION FOR THAT SEMESTER/TERM.

CHECK ONE
☐ Fall Term ☐ Winter Term ☐ Spring Term ☐ Summer Term

Name of course	Check if On-Line	Credits	Start Date	End Date

***PLEASE ATTACH CLASS SCHEDULE**

Student Signature_____ Date_____

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Emergency Parent Relative Care Agreement Form

I understand that, _____ will be the caregiver providing temporary emergency relative care for my children _____ _____ _____ _____. I understand that due to the public health crisis that care is temporary, and all health and safety standards regularly mandated by Oneida CCDF are waived at this time. I understand that my decision for the temporary relative care provider takes full responsibility for my children's well-being during this emergency. I understand he/she must provide a safe, nurturing environment for the children while they are in care. I understand that payment made on the child's behalf will be for authorized hours and amount only.

_____ _____
Signature Date

_____
Print Name

EMERGENCY CARD

Child's Name: _____ Date of Birth_____

Child's Physician: _____

Clinic Address: : _____ Phone: _____

List Any Known Allergies: _____

Mother's Name: _____ Phone: _____

Home Address: _____

_____

Employer: _____ Phone: _____

Father's Name: _____ Phone: _____

Home Address: _____

_____

Employer: _____ Phone: _____

Over

EMERGENCY CARD

Child's Name: _____ Date of Birth_____

Child's Physician: _____

Clinic Address: : _____ Phone: _____

List Any Known Allergies: _____

Mother's Name: _____ Phone: _____

Home Address: _____

_____

Employer: _____ Phone: _____

Father's Name: _____ Phone: _____

Home Address: _____

_____

Employer: _____ Phone: _____

Over

EMERGENCY CARD

Child's Name: _____ Date of Birth_____

Child's Physician: _____

Clinic Address: : _____ Phone: _____

List Any Known Allergies: _____

Mother's Name: _____ Phone: _____

Home Address: _____

_____

Employer: _____ Phone: _____

Father's Name: _____ Phone: _____

Home Address: _____

_____

Employer: _____ Phone: _____

Over