APPLICATION FOR APPROVAL FOR RELATIVE CHILD CARE PROVIDER

ND DEPARTMENT OF HUMAN SERVICES
OFFICE OF ECONOMIC ASSISTANCE
SFN 23 (1-2008)

Clear Fields

☐ New
☐ Renewal
☐ Additional Family

To be completed and signed by the Child Care Provider. Please Print.

PROVIDER INFORMATION

Provider Name:			
Social Security Number: (Mandatory) *	Date of Birth: (Provider must be 18 to quality for payment.)	Telephone Number:	
Street Address (Required):	Mailing Address: (If different from street address)		
City:	County:	State:	Zip Code:

ALL ADULT(S) IN PROVIDER'S HOUSEHOLD (Anyone 18 or Older):

ADULT NAME	AGE	ADULT NAME	AGE

The program only pays for care given in the provider's home.
Only under special circumstances can payment be made for care given in the child's home with prior approval by State Administrator.
If the provider, the parent, and the child(ren) reside in the same home, ONLY check in provider's home.

Where do you provide the care? ☐ In Provider's Home ☐ In Child's Home

Were you licensed, registered or a self-declared provider in the previous thirty-six months? ☐ Yes ☐ No Where? _____

Have you been denied approval or had the following revoked:

Self-declaration (self-certification) ☐ Yes ☐ No
Tribal Registration ☐ Yes ☐ No
Child Care License ☐ Yes ☐ No

If Yes:	When:	Where:	Why:

Has anyone in the household been subject to a court order removing a child from the individual's home, based on a determination of the individual's unfitness to care for a child? ☐ Yes ☐ No

If Yes:	Who:	When:

* The Privacy Act of 1974 (P.L. 93-579, Section 7) requires that the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

COMPLETE THE OTHER SIDE OF THE FORM

Return this form with the W-9 to:
Child Care Assistance Program, PA Division
ND Department of Human Services
600 E. Boulevard Ave. Dept. 325
Bismarck, ND 58505-0250

FOR STATE OFFICE USE	
Provider ID:	Date Approved:
Approved: ☐ Yes ☐ No	By:
Date Denied:	Expiration Date:

NOTE: If caring for children of more than one family on child care assistance, complete a Page 2 for each family

COMPLETE INFORMATION ON PARENT(S) APPLYING FOR CHILD CARE ASSISTANCE

Parent Name(s):		Telephone Number:	
Provider's Relationship to Either Parent: (include parent's name, if different from the parent name listed above)			
Street Address (Required):	Mailing Address: (If different from street address)		
City:	County:	State:	Zip Code:

List ALL children that are cared for in the provider's home(include provider's children and all other chilren living in the providers' home). State the PROVIDER'S relationship to each child listed. By federal law the relatives, who qualify for approval and must be related by marriage, blood relationship, or court decree, are: Grandparent, great grandparent, aunt, and uncle. Siblings, who are 18 or older and do not live in the same home as the children for whom care is being provided, may also qualify. NO other relationships qualify.

CHILD'S NAME	DATE OF BIRTH	PROVIDER'S RELATIONSHIP TO CHILD
Do you care for 4 or more infants (under 24 months of age)? If yes, you **must** be **licensed** according to state law and the approved relative status will be denied.	☐ Yes	☐ No
Do you care for 6 or more children over age 2 and under age 12 including your own children? If yes, you **must** be **licensed** according to state law and the approved relative status will be denied.	☐ Yes	☐ No

All applicants must complete a W-9 (Request for Taxpayer Identification Number and Certification) and send it with this application. The W-9 is required before payment can be made. I hereby certify that the information on this form is true and complete to the best of my information and knowledge.

Provider's Signature:	Date: