

# Ben-no-tteh Wigwam



15380 K Road - Mayetta, KS - 66509  
 966-2707 - 966-2527 - 966-2475 Fax# 966-2514

|                  |  |
|------------------|--|
| Application Date | Official Use Only<br>Received DT:<br><br>Date of Review: |
| Start Date       |  |
| End Date         |  |

## Prairie Band Potawatomi Early Childhood Education Center Application of Enrollment

### Section I - Primary Adult (lives with child)

|                               |             |                     |  |
|-------------------------------|-------------|---------------------|--|
| Last Name:                    | First Name: | Middle IN:          | Preferred Name:  |
| Date of Birth:                | CDIB #:     | Tribal Affiliation: | <input type="checkbox"/> PBP Enrolled Tribal Member<br><input type="checkbox"/> PBP Tribal Descendent<br><input type="checkbox"/> Member of Another Tribe<br><input type="checkbox"/> Native American Descendent |
| Applicant currently pregnant: | Gender:     | Teen Parent:        |  |

### Contact Information for Primary Adult and Child

|                  |   |             |                |
|------------------|---|-------------|----------------|
| Living Address:  | Mailing Address: (if different from Living Address) |             |                |
| City, State, Zip | City, State, Zip                                    |             |                |
| Home Phone:      | Work Phone:   | Cell Phone: | Email Address: |

|   |  |  |
|---|--|--|
| Child's Relationship to Adult:<br><input type="checkbox"/> Child-Natural/Adopted/Step<br><input type="checkbox"/> Grandchild<br><input type="checkbox"/> Niece/Nephew<br><input type="checkbox"/> Foster<br><input type="checkbox"/> Other/Specify: | Education-Highest Grade Completed:<br><input type="checkbox"/> College/Advanced Training<br>year of degree: _____<br><input type="checkbox"/> Attending College<br><input type="checkbox"/> High School Graduate<br><input type="checkbox"/> GED<br><input type="checkbox"/> Specify Last Grade Attended | Employment/Training:<br><input type="checkbox"/> Full Time <input type="checkbox"/> Part Time<br><input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Seasonally Employed<br><input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed<br><input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time & Training<br>Employer:                                      Phone #:<br><br>School:    Phone #: |
|---|--|--|

### Information for Primary Adult

|   |                     |   |
|---|---------------------|---|
| Race (check all that apply)<br><input type="checkbox"/> Asian <input type="checkbox"/> Black<br><input type="checkbox"/> White <input type="checkbox"/> Hispanic<br><input type="checkbox"/> Native American <input type="checkbox"/> Other | Language(s) spoken: | Days of Employment/School: <b>Sun. Mon. Tues. Wed. Thurs. Fri. Sat.</b><br>Hours of Employment/School:<br>AM- 6:30 7:00 7:30 8:00 8:30 9:00 9:30 10:00 10:30 11:00 11:30<br>PM- 12:00 12:30 1:00 1:30 2:00 2:30 3:00 3:30 4:00 4:30 5:00 5:30 |
|---|---------------------|---|

### Section II - Secondary Adult (lives with child)

|                               |             |                     |  |
|-------------------------------|-------------|---------------------|--|
| Last Name:                    | First Name: | Middle IN:          | Preferred Name:  |
| Date of Birth:                | CDIB #:     | Tribal Affiliation: | <input type="checkbox"/> PBP Enrolled Tribal Member<br><input type="checkbox"/> PBP Tribal Descendent<br><input type="checkbox"/> Member of Another Tribe<br><input type="checkbox"/> Native American Descendent |
| Applicant currently pregnant: | Gender:     | Teen Parent:        |  |

### Contact Information for Secondary Adult

|                  |   |             |                |
|------------------|---|-------------|----------------|
| Living Address:  | Mailing Address: (if different from Living Address) |             |                |
| City, State, Zip | City, State, Zip                                    |             |                |
| Home Phone:      | Work Phone:   | Cell Phone: | Email Address: |



**Section V - Developmental Information**

Do you have any concerns about your child's developmental, physical, or emotional progress? Has your child ever been assessed for special needs? Does your child have an IEP or IFSP? If yes, please explain.

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**Section VI - Certification**

I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subjected to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency use Only

Income Verified by:  FCPM  CCS  EHSPM **Signature:** \_\_\_\_\_ Date \_\_\_\_\_

Type of Income:  Check Stub  Income Tax **Signature:** \_\_\_\_\_ Date \_\_\_\_\_  
 Other/Specify: \_\_\_\_\_ **Signature:** \_\_\_\_\_ Date \_\_\_\_\_

Income = 1 wk wages X 4.3 for a months wages **Signature:** \_\_\_\_\_ Date \_\_\_\_\_  
1 months wages X 12 = Annual Income

Formula for verifying income:  
Income = 2 wks wages X 2.15 = 1 months wages  
1 months wages X 12 = Annual Income

Income Eligible  Over Income

The following copies of child's documents are on file:

- Birth Certificate
- Certified Degree of Indian Blood (CDIB) Card
- Health Assessment
- Immunization Record

**Childcare Enrollment Agreement:**

Parent's Names: \_\_\_\_\_

Child (ren)'s Name(s): \_\_\_\_\_

\* I understand that childcare billing is charged monthly and will be completed at the first of each month for the current month of services. Services may be discontinued if billing is not paid.

\* I understand that PBP ECEC's hours of operation is Monday through Friday from 7 a.m. to 5:30 p.m. and I must be working or attending training/school for my child(ren) to remain in childcare. If I arrive a minute after 5:30 p.m., I understand that the Social Services will be called to pick up my child(ren). If SS cannot be reached we then will call PBP Tribal Police.

\* The PBP ECEC requires parents acknowledge and adhere to our **Health Care Policy** as it carefully outlines the expectations and limitations regarding any child's attendance vs. exclusion regarding illness.

\* I have received a copy of the PBP ECEC's Parent Handbook and I agree to adhere to the policies and procedures contained within. I also understand that if violated three (3) times, I will be discontinued from the childcare program. I have read the conditions of this enrollment/tuition agreement, and I understand and accept each policy as a condition of my enrollment at PBP ECEC.

\* I understand that the PBP ECEC will be closed on the following holidays; I understand monthly billing will remain the same each month regardless of any absences due to illness, vacations, school closure, Staff Training, and/or legal holidays.

\* I understand that if PBP Tribal operations close due to Administrative leave during normal business hours, I will be called to pick up my child. Advanced backup care is advised, please contact ERC for referral.

**New Years Eve/Day  
Martin Luther King Day  
President's Day  
Easter (Good Friday)  
Memorial Day  
Independence Day**

**Labor Day  
American Indian Day  
Employee Appreciation Day  
Veteran's Day  
Thanksgiving Day (2 days)  
Christmas Day**

***Week in August for Preservice  
(1) day of Inservice for the months of:  
November  
January  
(2) Days of Center wide Health Fair***

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Staff's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Release "To" Information

We require written permission by a parent or guardian prior to releasing any child from our facility, Please list three people we could call to be responsible for your child in the event of an illness, accident, or emergency when parents(s) cannot be reached:

| Name | Address | Relationship | Home/Work/Cell Phone |
|------|---------|--------------|----------------------|
| 1    |         |              |                      |
| 2    |         |              |                      |
| 3    |         |              |                      |

\*Please list responsible parties who will be transporting your child. Child will not be released to those under 16 yrs.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Legally Prohibited person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pick-up location: \_\_\_\_\_

Drop off: \_\_\_\_\_

Directions from the center to your home and/or pick-up/drop-off location: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Staff's Signature: \_\_\_\_\_ Date: \_\_\_\_\_