The Klamath Tribes
Child Care Program

UPDATE/CHANGE REPORT

Official Use Only - Date Stamp Here

Time: _____ Initial: _____

Check which service the update/change is for:
_____ ECDC Ages 0-5
_____ ECDC Ages 6-12
_____ Family Home Care Provider (FHCP)
_____ State-Certified Center (CC)

Parent or Guardian Information			
Parent/Guardian 1 Name (first, last):			
Physical Address:	City:	State:	Zip:
Is this an updated address? Yes ____ No ____ If YES, please provide proof of residence (i.e. utility bill, parent's identification)			
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Lives with Child? Yes____ No ____	
Relationship to child: ___ Biological ___Legal ___ Authorized ___ Other		Tribal Affiliation:	
(IF APPLICABLE) Parent/Guardian 2 Name (first, last):			
Physical Address:	City:	State:	Zip:
Is this an updated address? Yes ____ No ____ If YES, please provide proof of residence (i.e. utility bill, parent's identification)			
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Lives with Child? Yes____ No ____	
Relationship to child: ___ Biological ___Legal ___ Authorized ___ Other		Tribal Affiliation:	

Please list ALL members of your household (copy page if additional space is needed) **Household Size: _____**

First & Last Name	Relation to Applicant	Date of Birth	Needs Child Care?	If Yes, Please Circle One
			Yes No	ECDC 0-5 ECDC 6-12 FHCP CC
			Yes No	ECDC 0-5 ECDC 6-12 FHCP CC
			Yes No	ECDC 0-5 ECDC 6-12 FHCP CC
			Yes No	ECDC 0-5 ECDC 6-12 FHCP CC
			Yes No	ECDC 0-5 ECDC 6-12 FHCP CC

General Information Questions

1. Do you or anyone in your household owe money to any other child care? Yes ____ No ____

If YES, explain:

2. Have you or anyone in your household ever committed fraud in a Federal assistance program? Yes ____ No ____

If YES, explain:

Change In Income

If you are completing an annual update or if your household income has changed, please complete the following:

Did income stop, start, or change? (Please provide documentation) Yes ____ No ____

Please list ALL income for household members who provide primary financial suppport for children receiving child care subsidy or ECDC services. Wages/salaries, self-employment, interest/dividends/real property, social security, unemployment, pension disability, worker's comp, unemployment, welfare, alimony, child support, per capita. (Provide documentation).
If you have nominal or no income, please complete the *Nominal/No Income Form.*

Household Income (copy page if additional space is needed)

Source	Household Member	Employer	Rate of Pay	Hours per Check	How Often Paid

Change in Child Care Provider (FHCP or CC only)

If you receive a subsidy for a family home care provider or certified center, please complete below:

Would you like to change your provider? Yes ____ No _____

If YES, explain:

Please provide the following information on the new provider below:

Name: Telephone number:

Physical Address:

Mailing Address (if different):

Is your new provider a relative? Yes ____ No ____ Is your new provider State certified? Yes ___ No ____

Relationship to child: No Relation _____ Grandparent _____ Great-Grandparent _____
Aunt/Uncle _____ Sibling (not sharing the same residence as the child) _____ Relation Not Listed _____

Any new provider must be approved by the Klamath Tribes before providing any care to your child(ren).

Disclaimer

By signing this form, I affirm under penalty of perjury I have given true and complete information. I realize that making false statements or hiding information may subject me to dismissal from the Child Care Program. I also understand that all changes in family members or household income must be reported to the ECDC in writing within 14 days of change. I have read this form and understand it. This is legally binding.

Parent/Guardian Signature: Date:

Parent/Guardian Signature: Date:

"This institution is an equal opportunity provider."