Please keep this sheet as a reference guide

PLEASE REVIEW CAREFULLY

Block Grant Applicant criteria and approved by:

1. Dated Completed application
2. Child care balance must be paid in full by October 1, 2025

Documentation that is needed for your application to be considered complete:

1. Proof of income all working household adults:
   a. Four (4) current pay-stubs.
   b. Verification from employer, i.e. letter from HR or supervisor
   Failure to do so will deem application incomplete.
2. Proof of residency (only need one item):
   a. Utility bill.
   b. Driver's license.
   c. Pay stubs.
3. Tribal ID
   a. Tribal ID is required for person requesting services and child(ren) receiving services. (Federally recognized tribe)
   b. 1st -2nd descendent

Additional information:

- All areas of the application must be filled out to be considered complete. **Incomplete applications will not be reviewed for approval.**
- Anyone approved will receive a phone call and an approval follow up letter.
- Expected mothers:
  - Please write "unborn child" under the "child receiving care area".
  - You may not include them as a number in household until child is born.

Please contact Caitlin John (716)945-5035 x 3309
/Caitlin.john@sni.org with any
Question's you may have regarding your application.

SENECA NATION CHILDCARE & DEVELOPMENT FUND
APPLICATION (Oct. 2025 – Sept. 2026)

ALLEGANY SALC 25 Center St Salamanca, NY 14779

NAME (Last, First, MI) TELEPHONE NUMBER
SPOUSE/SIGNIFICANT OTHER(need to include income of spouse if you are married).
ADDRESS PHYSICAL & MAILING (if different) (Number & Street, City, State & Zip Code)

EMPLOYER NAME
EMPLOYER ADDRESS
EMPLOYER TELEPHONE NUMBER

Household number
Household Gross Annual Income
Applicant Tribal Affiliation
Child/Children Tribal Affiliation

_____HOUSEHOLD TYPE	_____EDUCATION	___SOURCE OF INCOME
F – Female/Single Parent	**A** – 1st – 8th grade complete	**E** – Employed
M – Male/Single Parent	**B** – 9th – 12th, non-graduate	**SS** – Social Security
T – Two Parent Household	**C** – Graduate/GED	**A** – AFDC
O – Other, Please Explain	**D** – 12+ years of education	**DC** – Disability
		SSI – Supplemental Security

HOUSEHOLD INFORMATION (Please list everyone in household)	
Name	DOB

Please list all of the children receiving care and what you are charged.		
NAME	**WEEKLY RATE**	
	Daycare Rate	Summer Rate

The weekly rate must be given and agreed upon between provider and parent; using own rates. Rates then, CANNOT be changed throughout the Block Grant service year.

PROVIDER INFORMATION	
NAME	TELEPHONE NUMBER
ADDRESS	
Is the child care provider a relative? ____yes ____no	
If yes, what relation to the CHILD?	
__Aunt __Uncle __Sister __Brother __Grandparent __Other	
Where is the child care provided?	
__In Center __In Child's Home __Relative's Home __Provider's Home	

Providers Signature Date

BLOCK GRANT

PARENT AGREEMENT AND SIGNATURE

I attest that I have been informed of all child care options available to me through the Child Care Development Fund (CCDF). I also agree to submit weekly timecards to the center, as I understand that CCD funds can only be used while I am at work.

I further attest that all information provided in this application is true and accurate. Due to Audit purposes our records may be challenged. By verifying your employment status, you are stating that all household income claims have been reported and are subject to an audit.

I agree to have the Block Grant Coordinator come into my home (only applicable if childcare is provided in home) three times per service year. The first and last visit will be scheduled, while the other will be unannounced. The home visits are to promote safety and quality in the provider's home.

I attest that I do not obtain assets that exceed $1,000,000.00.

Signature Date