

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

**CHILD CARE ASSISTANCE
REINSTATEMENT FORM**

Applicant Name: _____

Has there been a change to your name, address or telephone number since your initial application was completed?

Yes No If yes, please complete the appropriate changes:

Name: _____

Mailing Address: _____

Physical Address: _____

Home Telephone: _____

Work Telephone: _____

Please list all eligible children requiring child care

Child's Name	Birth Date	Social Security #	Sex	Tribal #	Current Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have there been any changes to your household's employment or wages since the initial application was completed?

Yes No If yes, please complete the appropriate change. (If there has been a change in income, please include proof of income for the last 30 days)

	Name	Social Security #	Action: Explain Change	New Wage
1	_____	_____	_____	_____
2	_____	_____	_____	_____

Please briefly describe circumstances leading to the interruption in child care services:

Who provided your child care during your absence from the program? _____

Will you be using the same provider approved on your initial application? Yes No

I certify that all the answers given are true, complete and correct. I further understand and agree that the information provided will be used to determine continued eligibility for the LTBB Child Care Assistance Program. As agreed upon in my initial application, I attest that I have reported all changes in my household composition and/or household income within the required 10 day time frame. I understand that any false information or misrepresentation is considered fraud and is subject to prosecution and immediate termination from this program.

Applicant Signature

Date