KODIAK AREA NATIVE ASSOCIATION

KANA Child Care Assistance Program

Provider Registration Packet

Helping families afford safe and quality care for their children

Provider Name _____

Business Name _____

Mailing Address _____

Physical Address _____

City, State, Zip Code _____

City, State, Zip Code _____

Phone Number _____

Email Address _____

Please check provider type: ▢ Approved Provider ▢ Licensed Provider ▢ Military Provider

Do you charge a registration fee? ▢ Yes ▢ No

If yes, please list fee amount: $_____ ▢ One-Time Fee ▢ Annual Fee

Please list the days and hours you provide care: _____

Do you charge for holidays and/or closures? ▢ Yes ▢ No

If yes, please list amount(s) charge: $_____

Do you provide care for children with Special Needs? ▢ Yes ▢ No

Do you provide overnight care? ▢ Yes ▢ No

Please provide your rates in the chart below.

Age Range:	**Infant** (0 - 12 months)	**Toddler** (13 - 35 months)	**Preschool** (36 - 59 months)	**School Age** (5-13 years)
Full-time Enrollment:	$	$	$	$
Part-time: Enrollment:	$	$	$	$
Full-time Daily Rate:	$	$	$	$
Part-time Daily Rate:	$	$	$	$
Overnight Rate:	$	$	$	$

PROVIDER RESPONSIBILITIES

As a Child Care Provider participating in the KANA Child Care Assistance Program:

1. I understand I must complete all supplemental program paperwork in accordance with program requirements and timelines prior to receiving reimbursement.
2. I understand I must attend available training opportunities and events, to ensure compliance with program and State of Alaska annual training requirements.
3. I understand that as a provider I function as an independent contractor. I must complete a background check and comply with all applicable federal, state and local laws and regulations.
4. I understand that I will not receive payment for child care services if I do not have the required licenses or approval certification on file with the KANA Child Care Assistance Program. Should my license expire or be revoked I understand that the KANA Child Care Authorization will become null and void.
5. I understand Case Managers will visit providers on the following basis: initial visit, completed within 60 days of provider approval (within 90 days for remote village providers); annual visits, within one year of last visit; and "Drop in" visits as necessary.
6. I will provide proof of corrective action for areas of concern identified during health and safety visits.
7. I will submit complete Attendance and Billing Reports by the 20th of each month following care provided. Reports submitted after that date will be processed during the next billing cycle.
8. I understand that the parent(s) will be directly responsible for any portion over KANA's maximum allowable reimbursement rates in addition to the family's co-pay.
9. I will not discriminate against any parent or child. Additionally, I will not charge KANA parent(s) a different rate than what I charge non-subsidized parents for the same service.
10. I agree to submit any rate changes to the parent(s) and to the Child Care Assistance Program 30-calendar days before the effective date of change.

CERTIFICATION STATEMENT

As a Child Care Provider, I certify that I have read and understand the Provider Responsibilities under the KANA Child Care Assistance Program. I understand that non compliance with one or more of the Provider Responsibilities, falsification of information provided to the program, or violations of the Health and Safety Standards may result in the provider's removal from the KANA Child Care Assistance Program.

_____ _____

Provider Signature Date

KANA Approved Providers only - please complete the KANA Approved Provider Self- Certification Standards and Household Information.

KANA APPROVED PROVIDER SELF-CERTIFICATION STANDARDS

To become a KANA Approved Provider you must be at least 18 years of age and *are required to review and complete the following Health and Safety Standards:*

1. Background check within 30 days of the first day of care before reimbursements can begin for all individuals residing in the household 16 years or older who will be providing unsupervised care.
2. Health and Safety home visit and all Cardiopulmonary Resuscitation (CPR) required training within 60 days (Village providers have 90 days) following approval
3. Annual health and safety training on topics including, but not limited to: Sudden Infant Death Syndrome (SIDS), First Aid & CPR, recognition and reporting of child abuse, etc.,
4. Not provide care for more than four children under the age of 13 at any time.
5. Guarantee that the children will never be left unattended.
6. Notify parents if their child becomes ill while in care, and abide by terms stated in the Parent Provider Agreement.
7. Be in agreement with parents regarding medications.
8. Ensure that all medications, cleaners, and other harmful chemicals are inaccessible to children.
9. Practice proper hand washing habits before feeding children and anytime diapering or toileting.
10. Ensure that any firearms and/or ammunition is stored in an area that is inaccessible to children.
11. Not smoke nor allow others to smoke inside the home while children are in care.
12. Have an operative smoke detector on each level of the home.
13. Have at least one fully charged (dry chemical) fire extinguisher on each level of the home.
14. Not accumulate combustible materials around the home, flammable liquids are safely stored, and inaccessible to children.
15. Have heaters and heating elements equipped with protective devices (if such appliances present a hazard) and not in the exit ways or corridors.
16. Have at least two unobstructed exits out of the building. One exit should be ground level; a window may be considered an exit if an adult can fit through. An exit is required in the room that children use for sleeping/napping.
17. Have a first aid kit conveniently located and inaccessible to children.
18. Notify the Child Care Assistance Program if specific Health and Safety equipment is needed.

CERTIFICATION STATEMENT:

As a KANA Approved Provider I certify that I have read and understand the KANA Approved Provider Health and Safety Standards. I understand that non compliance or violations of the Health and Safety Standards may result in the provider's removal from the KANA Child Care Assistance Program.

_____ _____

Provider Signature Date

APPROVED PROVIDER HOUSEHOLD INFORMATION

List all individuals that reside in your household.

Full Name:	**Date of Birth:**	**Relationship:**

KODIAK AREA NATIVE ASSOCIATION

ACH PAYMENT AUTHORIZATION FORM

(PLEASE PRINT OR TYPE ALL INFORMATION)

---------- **AUTHORIZED AGREEMENT** ----------

I hereby authorize Kodiak Area Native Association to automatically deposit payment to the account listed below. I certify that I am authorized to enter into this agreement on behalf of the account holder. I verify that the information provided on this form is correct.

Further, I agree not to hold Kodiak Area Native Association responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Kodiak Area Native Association receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Finance Department.

Company/Payee Name _____

Address _____

City/State/Zip _____

Remittance Advice to be emailed to _____

---------- **ACCOUNT INFORMATION** ----------

Financial Institution _____

ABA/Routing Number (9 digits) _____

Account Number _____ Type: Checking ☐ Savings ☐

---------- **SIGNATURE** ----------

Print Name _____

Authorized Signature _____ Date _____

PLEASE INCLUDE A CURRENT W-9 FORM & VOIDED CHECK

Please complete this form and return via email to : AccountsPayable@kodiakhealthcare.org.
If you have additional questions regarding ACH process, feel free to contact our Accounts Payable at 907-486-9862

Accounts Payable Use (initial):
_____ W9 Received
_____ Vendor ID

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

STATE OF ALASKA
DEPARTMENT OF PUBLIC SAFETY
REQUEST FOR CRIMINAL JUSTICE INFORMATION
From the Alaska Criminal History Record Repository

Original forms must be submitted to:

Criminal Records and Identification Bureau
5700 E. Tudor Road, Anchorage, AK 99507
Telephone: (907) 269-5767 Fax: (907) 269-5091 (RSAs only)
Include fee: $20 single copy, $5 each additional copy
Check or money order must be made payable to 'State of Alaska'

Type of information being requested **(from other than the record subject): (Choose ONE)**

☐ 1. Criminal Justice Information available to **ANY PERSON for ANY PURPOSE**
- This report includes current/open criminal charges and charges that resulted in conviction, excluding sealed records.

☑ 2. Criminal Justice Information available to an **INTERESTED PERSON**
- This report includes all criminal charges and dispositions, excluding sealed records

2.A. If you checked item 2, the requester must provide the following information:
I request this report for the purpose of determining whether to grant the record subject supervisory or disciplinary power over (check all that apply):
☑ Minor(s)
☐ Dependent adult(s)
Title or brief description of the position under consideration: **child care provider**

☐ 3. Criminal Justice Information needed for another purpose authorized by federal or state law.
Client Number: _____
If you check this box, you **must** provide the client number assigned by the DPS Records and Identification Bureau.
To obtain a client number, you must provide the applicable state or federal statute to this office for review and approval prior to submitting this request.

*A check or money order payable to the State of Alaska in the amount of $20 **must** accompany this request. Additional copies, if requested at the time of this request, may be obtained for an additional $5 per copy. State agencies with a Reimbursable Services Agreement (RSA) in place may fax the appropriate forms. All other requests must be submitted via U.S. Postal Service or in person.*

Subject Name: _____

Maiden/Alias name(s): _____

Mailing Address: _____

City/State/Zip: _____

Alaska Drivers License #: _____

Date of Birth:_____

Sex: ☐-Male ☐Female Soc Sec No. _____

Telephone: _____Msg: _____

To be completed by the record subject: *"I authorize the release of my criminal justice information record, (described above) to the named requester."*

Signature of subject:_____

Date Signed: _____

Requester Name: _____

Title: _____

Business/Agency: _____

Mailing Address: _____

City/State/Zip: _____

Date of Birth: _____Telephone: _____

Sex: ☐ -Male ☐ - Female Soc Sec No. _____

The requested record will be mailed to the above named individual at the listed address. If you would like the record faxed, check the box below:

☐ Fax Number: _____

Signature of requester: _____

Date Signed: _____

Unsworn Falsification Statement (Your request will not be processed if you do not sign this statement.)
I certify under penalty of unsworn falsification (AS 11.56.210) that the information I am supplying on and with this form is true and correct.

Record Subject's Signature **Date**