



Department of Community & Cultural Affairs
CHILD CARE & DEVELOPMENT FUND

Caller Box 10007, Ascencion Court
 Bldg. 1347 Capitol Hill, Saipan MP 96950
 Tel.: (670) 664-2575/76 Fax: (670) 664-2547

APPLICATION CHECKLIST

For Subsidy Waitlist Application



PLEASE READ BEFORE APPLYING:

PARENTS ELIGIBILITY:

- *Must be working at least 30 hours per week or is scheduled to start work in 2 weeks
- *In Job training, at least 10 hours per week
- *Attending education on a full-time basis (12 credits for college students/ 5 classes for HS students)
- *Has a monthly gross income that does not exceed Federal Poverty Income Guideline for a family of the same size
- *Must be residing in the CNMI

CHILD'S ELIGIBILITY:

- *Resides with the parent who is in an approved activity (work, school, training)
- *Be under the age of 13
- *Must be a US citizen or qualified alien as defined in PRWORA
- *Must be residing in the CNMI

LIST OF REQUIREMENTS- (REVIEW LIST CAREFULLY, INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED)

- CCDF Application Form
- Valid Photo ID for each parent or legal guardian
- Map to residence (CCDF FORM)
- Developmental Screening Statement *for families w/ children ages 6 Weeks to 5 Years old only (CCDF FORM)*
- Statement of Assets (CCDF FORM)
- Affidavit of Living Arrangement or Court Documents for single parents (does not need to be notarized)
- Valid CWI, CW Receipt, Employment Authorization Document (EAD), or Green Card if applicable
- Court documents relating to guardianship or custody, if applicable
- Foster Care documentation, if applicable
- Letter of referral from DYS, Karidat, Family Court, Nonprofit organization (Related to homelessness)
- Child support statement, if applicable
- Child/ren Birth Certificate (All children under 18)
- Child's Individual Family Service Plan (IFSP) or Individualized Educational Plan (IEP) not older than one year, if applicable
- Social Security Income (SSI) Statement, if applicable
- Other documents pertaining to income

WORKING PARENTS:

- Three (3) most recent check stubs for each parent or legal guardian (*check stubs must indicate name of company, name of applicant hours worked and hourly rate*)
- CCDF Employment Verification (CCDF FORM)
- CCDF Front Liner Certification, if applicable (CCDF FORM)
- Most recent 1040 tax form for each parent or legal guardian, if filed separately
- If Self Employed: Business must be open for at least 3 months
- Copy of valid Business License, most recent 6 months BGR T, TAX FORM SCHEDULE C (Statement of Profit and Loss)
- Notarized Affidavit for self-employed parents (CCDF FORM)

EDUCATION OR TRAINING:

- Job Training documents such as class schedule and / or Letter of Acceptance from Institute (must indicate hours needed)
- Student class schedule (Acceptance letter for new students only)
 - (a) Certification from school for JR/High School students (b) Online class schedule (distance learning requirements must be met)

Please be advised that it may take 4 to 6 weeks to complete the application process before subsidized child care services can begin.

FOR CCDF USE ONLY		
<i>Applicants Name (s):</i>	<i>Reason for Child Care:</i> <small>Work: ___ School: ___ Training: ___</small>	<i>Number of Children being applied for:</i>
New ___ Re-Applying ___ Additional Child ___		CASE ID #: DCCA
Priority Criteria: ___ Front Liner ___ Special Needs ___ Homeless ___ Low Income		
<i>Household Income: \$</i> <i>Monthly Co-Payment: \$</i>	<i>Accepted by:</i> <small>Print & Sign</small>	<i>Date & Time Rec'd:</i> <i>Completed:</i>
REGULAR FUNDING ___ FRONTLINER REGULAR ___ FRONTLINER COVID FUNDING ___		



DCCA-CCDF Subsidy Waitlist Application

CALLER BOX 10007 SAIPAN MP, 96950 ASCENSION COURT, BLDG. 1347 TEL.: 664-2575/6 FAX: 664-2547



PARENT/LEGAL GUARDIAN INFORMATION

Applicant: _____
Last, First, M.I

Date of Birth _____ Sex: Male Female:

Ethnicity: _____

Citizenship: U.S. Non-U.S. Other: _____

Mailing Address: _____

Physical Address: _____

Contact Information:

(Home) _____ (Cell) _____ (Work) _____

Email Address: _____

Check all that applies Work _____ School _____ Training _____

Other (Medical) _____
(Attach Doctor's Certification)

Employer: _____

Detailed to (if applicable) : _____

Educational/Training Institute: _____

Applicant: _____
Last, First, M.I

Date of Birth _____ Sex: Male Female:

Ethnicity: _____

Citizenship: U.S. Non-U.S. Other: _____

Mailing Address: _____

Physical Address: _____

Contact Information:

(Home) _____ (Cell) _____ (Work) _____

Email Address: _____

Check all that applies Work _____ School _____ Training _____

Other (Medical) _____
(Attach Doctor's Certification)

Employer: _____

Detailed to (if applicable) : _____

Educational/Training Institute: _____

SOURCES OF INCOME
(Copies Needed)

Child Support \$ _____ Mo.

Social Security \$ _____ Mo.

Alimony \$ _____ Mo.

Rental Income \$ _____ Mo.

Other Sources of Income \$ _____

SOCIAL SERVICES (check all that applies)

WIC NAP

NMHC MEDICAID

MARITAL STATUS:

Single (Affidavit)

Married

Common-Law

Separated (Affidavit)

Divorced (Court Documents)

Widowed (Death Certificate)

RACE:

Native American/Alaska Native

Native Hawaiian/ Pacific Islander

Asian American

White

African American

Other: _____

*Applications may be submitted in the CCDF drop box before, during or after working hours or in person from Monday to Friday from 8:30am to 3:30pm or Emailed to Eligibility Specialists: GEN GUERRERO at dccaiguerrero@gmail.com or JOELLA ROSARIO at ccdf.jrosario@gmail.com.

*Please be advised That it may take 4 to 6 weeks to complete the application process before subsidized child care services can begin.

*The Child Care and Development Fund Program is a Federally Funded program that has priority and criteria requirements. Submission of your application does not guarantee automatic approval.

*******IMPORTANT NOTICE*******
TEMPORARY CEASING OF CCDF SUBSIDY WAITLIST APPLICATIONS (CCDF REGULAR & FRONTLINERS)

The DCCA Child Care and Development Fund Program (CCDF) will temporarily cease acceptance of NEW applications effective May 09, 2022 and will resume accepting applications on September 01, 2022.

CHILD/FAMILY INFORMATION

Child Care Services Needed for: <small>Mark YES or NO</small>	List all children in Household below 18 years of age (oldest to youngest) <small>Last, First, M.I.</small>	D.O.B	Son/ Dtr	Ethnicity	Grade	School	Does the child have special needs (disability)? <small>If so, Attach updated IEP/IFSP or Doctors Certification</small>
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:

1.) All children declared in this application are physically living in my household.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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CHILD CARE AGREEMENT

By signing below, I have read and understand all requirements in this application and confirm that all information provided is correct.

I authorize the DCCA Child Care and Development Fund Program to investigate all statements and information contained in this application to verify that I am eligible for assistance . I agree to provide necessary documents to verify the statements in this application. If documents are not available, I/we agree to give the name of person(s) or organization(s) such as Doctors, Employers, State or Federal Agencies, and give consent for the program to contact the person or organization for information about me and or members of my household that may be needed to show that we are eligible for assistance.

I am fully aware and understand that:

1. Submission of my complete packet to CCDF does not guarantee a slot in CCDF.
2. That my application will be assessed based on the time and date it was received as well as the place in the priority of eligibility for CCDF.
3. That if I fail under the COVID FUNDING I understand that should I be approved that my eligibility period is for twelve (12) months.
4. That it is my responsibility to update the CCDF office with any changes to the information I provided in this application.
5. That it is my responsibility to update my application packet at least 30 days prior to the first date of receipt of my application, failure to do so would mean my application will be null and void.
6. That is my responsibility to follow up with CCDF on the status of my application.
7. That it may take 4 to 6 weeks to complete the application process before subsidized services can begin.

I hereby certify that all the information provided is true and correct to the best of my knowledge. I understand I will be asked to verify information supplied on this application when and if I complete application for services.

Applicant Print Name and Sign	Date	Co-Applicant Name and Sign	Date	CCDF Staff Print/Initial & Date
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CHILD CARE PROGRAM
 Caller Box 10007, Ascension Court
 Bldg. 1347 Capital Hill, Saipan MP 96950
 Tel.: 670-664-2575/76 Fax: 670-664-2547



EMPLOYMENT VERIFICATION

• **NAME OF EMPLOYEE:** _____

• **JOB TITLE:** _____

COMPANY/EMPLOYER INFORMATION: (Information below is that of the EMPLOYER)

Name of Company/Employer: _____

Phone No.:	Fax No.:	Email:
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Postal Address:	Physical Address:
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- The individual named above is employed beginning:
 Month: _____ Day: _____ Year: _____
- The individual named above has had an increase in salary beginning:
 Month: _____ Day: _____ Year: _____

INCOME INFORMATION:

Hourly Rate: _____ Monthly Gross Salary: _____

Mode of Salary: Weekly Bi-Weekly Semi-Monthly (Twice a month) Monthly

Number of Max Hours (Based on Mode of Salary Payment) _____ (REQUIRED INFO)

Is this employee receiving any other compensation?

- No
- Yes (If yes, what type of compensation and how often?)

Work Schedule: Monday Tuesday Wednesday Thursday Friday Sat. Sunday

Name of person completing this form: _____
 HR/Immediate Supervisor, Print Name, Sign & Date

Contact # of person completing this form: _____



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FRONT LINER CERTIFICATION

Employee:	
Employer:	
Job Title:	Detailed To:
Assigned Immediate Supervisor:	Contact Number:
Assigned Job Title:	
Job description related to Covid-19: _____	

Note: Must attach (if applicable) documentation if employee is detailed elsewhere from his or her regular work site.

Completed by: _____ Date: _____
HR/Immediate Supervisor, Print Name & Sign

CCDF DEFINITION OF FRONTLINERS: (Updated August 5, 2021)

1. Front liners/workers assigned to working on Covid-19 activities
2. Law Enforcement, CNMI Homeland Security, Emergency Medical service employees
3. Retail cashiers, Gas attendants, financial services and lending institutes
4. All employees at child care centers/programs, employees in the educational sector such as the Public School System, Northern Marianas College, Northern Marianas Trade Inst.
5. Critical Social Service workers
6. Workers in the hotel industry
7. Field Workers from utility, water, and waste water companies
8. Legally operating transportation service workers
9. Public works employees, including parks and recreation, individuals who conduct field work and inspections
10. Communications and information technology workers
11. Sanitation and Hazardous material workers
12. Employees working at the airport and seaport
13. Restaurant workers, Food delivery services and those who work in the food industry.

*Must have direct face-to-face interactions with clients.



Department of Community & Cultural Affairs
CHILD CARE & DEVELOPMENT FUND



AFFIDAVIT OF SELF-EMPLOYMENT

(Must be Notarized)

I, _____ with mailing
address _____ and
physical address _____,
CNMI .

This letter is to confirm that I am the business owner of _____
located in the village of _____ (Saipan, Tinian, Rota).

My business operation is open during the following days and my current business hours
are from: *(Please ✓ days and indicate hours)*

Monday	<input type="checkbox"/>	_____ to _____	Friday	<input type="checkbox"/>	_____ to _____
Tuesday	<input type="checkbox"/>	_____ to _____	Saturday	<input type="checkbox"/>	_____ to _____
Wednesday	<input type="checkbox"/>	_____ to _____	Sunday	<input type="checkbox"/>	_____ to _____
Thursday	<input type="checkbox"/>	_____ to _____			_____ to _____

I work a minimum of _____ hours per week and I perform the following duties/tasks
during the time specified above and declare that I am competent in the duties listed below:

I hereby declare under penalty of perjury that the information stated by me is true and
correct to the best of my knowledge. Done this _____ day of _____.

Applicant Print Name and Sign



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EMPLOYMENT VERIFICATION

- **NAME OF EMPLOYEE:** _____
- **JOB TITLE:** _____

COMPANY/EMPLOYER INFORMATION: (Information below is that of the EMPLOYER)

Name of Company/Employer: _____		
Phone No.: _____	Fax No.: _____	Email: _____
Postal Address: _____	Physical Address: _____	

- The individual named above is employed beginning:
Month: _____ Day: _____ Year: _____
- The individual named above has had an increase in salary beginning:
Month: _____ Day: _____ Year: _____

INCOME INFORMATION:

Hourly Rate: _____ Monthly Gross Salary: _____

Mode of Salary: Weekly Bi-Weekly Semi-Monthly (Twice a month) Monthly

Number of Max Hours (Based on Mode of Salary Payment) _____ (REQUIRED INFO)

Is this employee receiving any other compensation?

- No
- Yes (If yes, what type of compensation and how often?)

Work Schedule: Monday Tuesday Wednesday Thursday Friday Sat. Sunday

Name of person completing this form: _____
HR/Immediate Supervisor, Print Name, Sign & Date

Contact # of person completing this form: _____



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FRONT LINER CERTIFICATION

Employee:	
Employer:	
Job Title:	Detailed To:
Assigned Immediate Supervisor:	Contact Number:
Assigned Job Title:	
Job description related to Covid-19: _____	

Note: Must attach (if applicable) documentation if employee is detailed elsewhere from his or her regular work site.

Completed by: _____ Date: _____
 HR/Immediate Supervisor, Print Name & Sign

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5. Critical Social Service workers
6. Workers in the hotel industry
7. Field Workers from utility, water, and waste water companies
8. Legally operating transportation service workers
9. Public works employees, including parks and recreation, individuals who conduct field work and inspections
10. Communications and information technology workers
11. Sanitation and Hazardous material workers
12. Employees working at the airport and seaport
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I, _____ with mailing
address _____ and
physical address _____,
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This letter is to confirm that I am the business owner of _____
located in the village of _____ (Saipan, Tinian, Rota).

My business operation is open during the following days and my current business hours
are from: *(Please ✓ days and indicate hours)*

Monday	<input type="checkbox"/>	_____ to _____	Friday	<input type="checkbox"/>	_____ to _____
Tuesday	<input type="checkbox"/>	_____ to _____	Saturday	<input type="checkbox"/>	_____ to _____
Wednesday	<input type="checkbox"/>	_____ to _____	Sunday	<input type="checkbox"/>	_____ to _____
Thursday	<input type="checkbox"/>	_____ to _____			_____ to _____

I work a minimum of _____ hours per week and I perform the following duties/tasks
during the time specified above and declare that I am competent in the duties listed below:

I hereby declare under penalty of perjury that the information stated by me is true and
correct to the best of my knowledge. Done this _____ day of _____.

Applicant Print Name and Sign



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STATEMENT OF ASSETS

I/We, _____, & _____

with a physical address of _____, and

postal address of _____

due hereby declare that:

a. I/We certify that our family assets do not exceed \$1,000,000.00

Done on this _____ day of _____ 202__ on
(Saipan/ Tinian/ Rota), Commonwealth of the Northern Mariana
Islands.

Applicant Print & Sign

Co-Applicant Print & Sign

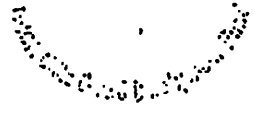


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Child Care & Development Fund

Caller Box 10007 Saipan, MP 96950

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MAP TO RESIDENCE

Name of Applicant: _____

Village: _____

Apartment Number (if any): _____

Street Name: _____

Obvious Landmarks Store, Church, etc.) _____

Parent/Legal Guardian: _____

(Print Name and Sign)

Date: _____



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AFFIDAVIT

If you are claiming to be a single parent, you must provide an Affidavit. This affidavit must contain the following information.

Affidavit's that do not contain the following information will **NOT** be accepted.

1. State your complete name and address (mailing address and physical address).
2. State the names and ages of ALL your children physically residing in your household.
3. State that you are a single parent and whether the father or mother of the child/ren does not stay in the same house as you do.
4. State whether you are residing with a common-law spouse who is not the biological parent of your child/ren.
5. State whether you are receiving any type of assistance from the father/mother of the children. (If receiving child support, you must indicate how much and how often you receive. If you are receiving monetary support that is not court mandated, you must indicate how much and how often. If you are receiving nonmonetary support, such as food items, pampers, etc. you must indicate it in this affidavit as well).
6. Affidavit must be signed by applicant.

EXAMPLE OF AFFIDAVIT

I, Jane D. Doe with a mailing address of P.O. Box 501234, Saipan MP 96950 and a physical address of Capitol Hill. My children are John Doe (4 years old), James Doe (3 years old), and Jamie Doe (2 years old). I am a single mother and the father of my children does not stay in the same as we do. I do not live with a common-law spouse who is not the biological father of my children. I do not receive any monetary support from the father of my children, but he does provide food and clothing for the children on a monthly basis.

Learn More about Your Child's Development:

Developmental Monitoring and Screening



Taking a first step, waving “bye-bye,” and pointing to something interesting are all developmental milestones, or things most children can do by a certain age. Children reach many milestones in how they play, learn, speak, act, and move. Developmental monitoring and screening are ways to look for your child’s developmental milestones.

Developmental Monitoring

WHO:	You — parents, grandparents, other caregivers
WHAT:	Look for developmental milestones
WHEN:	From birth to 5 years
WHY:	To help you: <ul style="list-style-type: none">▸ celebrate your child’s development▸ talk about your child’s progress with doctors and child care providers▸ learn what to expect next▸ identify any concerns early
HOW:	With easy, free checklists — get yours at www.cdc.gov/Milestones

Developmental Screening

WHO:	Healthcare provider, early childhood teacher, or other trained provider
WHAT:	Look for developmental milestones
WHEN:	At 9, 18, and 24 or 30 months, or whenever there is a concern
WHY:	To find out: <ul style="list-style-type: none">▸ if your child needs more help with development, because it is not always obvious to doctors, child care providers, or parents▸ if a developmental evaluation is recommended
HOW:	With a formal, validated screening tool — learn more at www.hhs.gov/WatchMeThrive

- All young children need both developmental monitoring and developmental screening.
- The best person to track your child’s development is you! Use free [milestone checklists](#) and go over them with the doctor at every well-child visit. To see *Milestones in Action* visit www.cdc.gov/Milestones.
- What if your child is not reaching milestones as expected? You know your child best. If you are concerned about your child’s development, talk with your child’s doctor about your concerns and ask about developmental screening. For more information, go to www.cdc.gov/Concerned. Don’t wait! Acting early can make a real difference.

Your child’s development is a journey.
Monitoring and screening show you the way.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)



Learn the Signs. Act Early.



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DEVELOPMENTAL SCREENING ACKNOWLEDGEMENT

I/We, _____, & _____ have read/been informed regarding Developmental Screenings. I understand that my child/children will have a Developmental Screening completed at my provider of choice within 45 calendar days after enrollment.

Done on this _____ day of _____ 202__ on (Saipan/ Tinian/ Rota), Commonwealth of the Northern Mariana Islands.

Applicant Print & Sign

Co-Applicant Print & Sign