



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

RENEWAL APPLICATION CHECKLIST



FOR CCDF USE ONLY

APPLICANT/CO-APPLICANT: _____
CASE ID #: DCCA _____
CENTER NAME: _____
CO-PAYMENT: \$ _____

PLEASE UPDATE THE FOLLOWING DOCUMENTS APPLICABLE TO YOU

- ___ CDF Application Form
- ___ Map to residence (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), if applicable
- ___ Child support statement, if applicable
- ___ 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)
- ___ Valid Business License
- ___ Three (3) most recent BGRT
- ___ CCDF Affidavit of Self Employment (notarized)

EDUCATION OR TRAINING:

- ___ Student class schedule
- ___ Job Training documents such as class schedule and/or Letter of Acceptance from Institute (hours must be indicated)



DCCA-CCDF JUNE 2022 RENEWAL 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 apply)

___ WIC ___ NAP

___ NMHC ___ MEDICAID

MARITAL STATUS:

___ Single (Affidavit)

___ Married

___ Common-Law

___ Separated (Affidavit)

___ Divorced (Court Documents)

___ Widowed

COMPLETED APPLICATIONS MAY BE SUBMITTED IN THE CCDF DROP BOX BEFORE OR AFTER WORKING HOURS OR IN PERSON FROM MONDAY TO FRIDAY FROM 8:00AM TO 4:00PM OR YOU MAY EMAIL YOUR COMPLETED APPLICATIONS TO YOUR ASSIGNED CASE WORKER.

APPLICATION SUBMISSION WILL BEGIN WEDNESDAY, JUNE 1, 2022 AND CONTINUE UNTIL THURSDAY, JUNE 30, 2022.

ELIGIBILITY SPECIALIST CONTACT INFORMATION

GEN GUERRERO: (670) 664-2576/dccajguerrero@gmail.com JOELLA ROSARIO: (670) 664-2575/ccdfjrosario@gmail.com

CHILD/FAMILY INFORMATION

FOR CCDF USE ONLY	List all children in Household below 18 years of age (oldest to youngest) Last, First, M.I.	D.O.B	Son/ Dtr	Ethnicity	Grade	School	Does the child have special needs (disability)? If so, Attach updated IEP/IFSP or Doctors Certification
							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
							<input type="checkbox"/> Yes <input type="checkbox"/> No What type:
							<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
2.) Since your last determination, has any dependent under the age of 18 moved into your household? (attach birth certificate/court docs) Name: _____ Birthdate: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.) Since your last determination, has any dependent turned 18? Name: _____ Birthdate: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.) Since your last determination, has any parent permanently moved out of the household? Name: _____ Effective Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.) Since your last determination, has the absent parent moved in/out of your household? (Contact Eligibility Specialist for required documents) Name: _____ Effective Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In <input type="checkbox"/> Out

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 still 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 still eligible for assistance.

I am aware that acceptance of my application does not guarantee approval.

I am aware that it is my responsibility to follow up on the status of my application and schedule of the Mandatory Parent Renewal Orientation (during a declared disaster or emergency ; case to case basis this may not be needed)

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 renewal application when and if I complete application for services.

Applicant Print Name and Sign

Date

Co-Applicant Print Name and Sign

Date

CCDF Staff Print Name and Sign

Date



Department of Community & Cultural Affairs
CHILD CARE PROGRAM
Caller Box 10007, Ascencion 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: _____

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: _____



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: _____



Department of Community & Cultural Affairs
CHILD CARE & DEVELOPMENT FUND (CCDF) PROGRAM
Caller Box 10007, Ascencion Court
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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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1. Front liners/workers assigned to working on Covid-19 activities
2. Law Enforcement, CNMI Homeland Security, Emergency Medical service employees
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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
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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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



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.



Department of Community & Cultural Affairs

Child Care & Development Fund

Caller Box 10007 Saipan, MP 96950

Tel.: (670) 664-2575/76/89 Fax: (670) 664-2547



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: _____