

IV-E Tribal Child Care Referral Child and Family Services Division

1. Complete a separate referral for each child.
2. FAX or mail completed referral to: IV-E Unit
P.O. Box 8005
Helena, MT 59604

Today's date: _____

Child's Name: _____ Birth Date: _____ Sex: M F

SS#: _____ *If known*, CCUBS Case #: _____

Child's address: _____ City: _____ State: _____ Zip: _____

Child's School Type: Not in school Preschool Kindergarten (part-day)
 Kindergarten (full day) Elementary Junior High

Child's Race: American Indian White Hawaiian or Pacific Islander Black or African Asian

Child's Tribal Affiliation: _____ Child's Enrollment #: _____

Is this child Hispanic or Latino: _____

Has this child received a TANF cash grant within the past 90 days: _____

Does this child have special needs (IEP/IFSP/Child Care Plan)? _____

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Child Care Arrangements:

Is this child currently in child care? ___ If yes, who is the child's provider? _____

If no, name(s) of preferred child care provider? _____

Does this child have siblings? ___ Do they need the same provider? ___ If siblings will be placed together, list names and ages to assist in locating a provider: _____

Child care is needed because: the foster parent is employed out of the home; or the child is not in school and the foster parent is unable to supervise the child due to the foster parent's work hours; or the foster parent is required to participate, without the child in attendance, at administrative or judicial reviews, case conferences, or foster parent training.

Child Care Begin Date: _____ End Date: _____ Total hours per week: _____

Daily Hours: M: _____ Tu : _____ W: _____ Th : _____ Fr: _____ Sa: _____ Su: _____

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Social Worker's Name: _____ Telephone: _____

Mailing Address: _____

Fax #: _____ **e-mail:** _____

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IV-E Verification:

_____ is currently eligible for IV-E day care payments to allow his/her parent to work or attend administrative or judicial reviews, case conferences, or foster parent training.

Signature of IV-E Worker