Child's Name: ____________________ Date Received: ____________ Received By: ____________

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Please turn in the following documents along with with application to be considered complete :

- ☐ Birth Certificate
- ☐ Enrollment Card
- ☐ Social Security Card
- ☐ Physical
- ☐ Shot Record
- ☐ Any Court Documents that you may have pertaining to your child

Your childs application will be date stamped upon completion. If the application is returned to our office incomplete, we will attempt to inform the parents/guardians listed to allow you to complete the application. Applicants will be added to the wait list. Spots in the program are first serve and candidates are selected through an interview process. Thank you for your interest in our program.

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*Please note that applications must be updates annually in order to maintain current and accurate information on file. Copies of Birth Cerificates, SS Cards and enrollment cards do not need to be updated, unless changes are made.

Application for Enrollment - form KA-001

Application Date: _____

Date of Enrollmetn: _____

APPLICATION FOR IMMERSION

Name of Child			Cherokee Name or Nickname
Last	First	MI	
D/O/B	SS# - -		Enrollment No. R-

Information about the family:

Mother/Guardian: _____

Address: _____ Zip Code: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

Father: _____

Address: _____ Zip Code: _____

Employer: _____ Work Phone: _____

Home Phone: Cell Phone:

Information about your child:

Does your child have any known allergies: Yes _____ No _____

Explain: _____

Please give any information concerning your child which will be helpful in his experience in a group setting (such as play, eating and sleeping habits, special likes or dislikes.

Emergency Information:

Name of Child's Doctor: _____ Office Phone: _____

Address: _____

Name of Child's Dentist: _____ Office Phone: _____

Address: _____

Hospital Preference: _____ Phone Number _____

Application for Enrollment - form KA-001

Emergency Contact:

If neither father or mother (or guardian) can be reached, call (please list relationship):

Name: _____ Home Phone: _____ Other: _____

Name: _____ Home Phone: _____ Other: _____

Name: _____ Home Phone: _____ Other: _____

Child's Pick Up List:

If you cannot come for your child, please give names of persons to whom the child can be released.

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

_____ _____

Signature of Operator Date

FORM-KA-001

DCD 0108
12/99

Children's Medical Report

Name of Child_____ Birthdate _____

Name of Parent or Guardian_____

Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what?_____

_____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason?_____

_____

3. Is the child on any continuous medication? No Yes If yes, what?_____

_____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?_____

_____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___ ; diabetes No___Yes___; convulsions No___ Yes___; heart trouble No___ Yes___; asthma No___ Yes___.
   If others, what/when?_____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:_____

_____

Any mental disabilities? No___ Yes___ If yes, please describe:_____

Signature of Parent or Guardian_____ **Date**_____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.
Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____Throat_____
Neck_____ Heart_____Chest_____Abd/GU_____Ext_____
Neurological System_____Skin_____Vision_____Hearing_____
Results of Tuberculin Test, if given: Type_____date_____ Normal___Abnormal_____followup_____

Developmental Evaluation: delayed_____age appropriate_____
If delay, note significance and special care needed;_____

_____

Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations:_____

_____

_____

Date of Examination_____

Signature of authorized examiner/title_____ **Phone #**_____

503.01 - Credit Policy

Tribal Programs providing billable goods and services to Tribal Members and the general public may extend credit to customers only after being authorized by the Revenue Department. Customers must submit a credit application to the Revenue Department prior to any delivery of goods or services. A database of customers deemed to be non creditworthy will be maintained by the Revenue Department for the use of the department and individual programs in determining which customers will or will not be extended credit.

Only those customers having no past due debt to the Eastern Band of Cherokee Indians will be authorized for credit. Customers having past due debt will not be authorized to incur additional debt for good and services until the original amount plus authorized fees and charges have been pain in full.

a. Customer must submit a credit application to the Revenue Department
b. Tribal Programs providing billable goods or services must verify the customer may be extended credit by consulting the database of non-creditworthy customers maintained by the Revenue Department
c. Programs may provide billable goods or services to creditworthy customers.
d. Programs generate an invoice document for billable goods and services, delivering copies of invoice documents to the Revenue Department on a monthly basis
e. Billing staff in the Revenue Department will generate a final invoice for the goods and services which will be delivered to the address provided on the credit application
f. Invoices may be paid by mail or the Revenue Department located at 88 Council House Loop Cherokee, North Carolina

EASTERN BAND OF CHEROKEE INDIANS

OFFICE OF THE TREASURER – REVENUE

TRIBAL SERVICES CERTIFICATION FORM

This form certifies only the information on file as of the date it is signed.

Applicant Name _____

1. Lien amount section (only applies to taxes)
   - ☐ (NO) There are no delinquent Tribal taxes or other fees, privileges, penalties and interest charges that may constitute a lien on interests to real property.
   - ☐ (YES) There are delinquent Tribal taxes or other fees, privileges, penalties and interest charges that may constitute a lien on interests to real property.

     Amount of Lien $_____

     _____ _____

     Signature of Authorized Revenue Representative Date

2. Tribal Debt amount section
   - ☐ (NO) There are no delinquent financial debts owed to the Tribe, entities or enterprises
   - ☐ (YES) There are delinquent financial debts owed to the Tribe, entities or enterprises

     Amount of Debt $_____ Program or Entity _____

     _____ _____

     Signature of Authorized Revenue Representative Date

3. Approval/Denial
   - ☐ (NO) The Revenue Office does not recommend providing services until payment of outstanding debt is made or payment agreement reached.
   - ☐ (NO) The Revenue Office cannot recommend providing services for a period of 36 months based upon the current Finance Write-Off Policy. This individual will not be approved for services until _____.
   - ☐ (YES) The Revenue Office recommends extending credit to this individual.

_____ _____

Customer Signature Date

_____ _____

Revenue Manager Signature Date