Kiowa Tribe

Indian Child Welfare

Promoting Safe and Stable Families or Title IV-B(1)

P. 580-654-2349 F. 405-247-4921

CHECKLIST

- Please notify worker if services have been provided through either of the Programs.
- Provide **CDIBs of all Kiowa enrolled children** in the home.
  (Ages: Birth to 17 years. 18 years if still in school.)
- Provide a signed **Letter of Request**. Must include what the request is for and go into detail of why you are unable to take care of it.
- Physical Examination of one enrolled Kiowa child *(6 years to 17 years)* **OR** Shot Record of the youngest enrolled Kiowa Child *(5 years and under)*.
- If applying for utility assistance, a copy of the bill must be submitted
- If applying for rent, the following must be provided:
  a. *Landlord's Name, Address, and Phone Number*
  b. *Address of Rental*
  c. *Statement of how much the rent or deposit is.*
  d. *W-9 Form filled out and signed by the Landlord.*
- Complete Application

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Children's information

Name	Age	Tribe & Roll #	SSN	Gender

Address _____

Family information

Marital Status	

Mother

Name		Tribe		SSN	
Address		Home Phone		Work Phone	

Father

Name		Tribe		SSN	
Address		Home Phone		Work Phone	

Guardian

Name		Tribe		SSN	
Address		Home Phone		Work Phone	

Other household members *(Over 18 years old)*	Age / DOB	Sex	SSN	Tribe	Relationship

Has child had a *(Check all that apply)*	☐ Physical ☐ Hearing Test ☐ Psychological Evaluation ☐ Education IEP ☐ Dental Checkup ☐ Medical Checkup

Has child been diagnosed as having a disability?	◯ Yes ◯ No
If so, what was the child diagnosed with? *(check all that apply)*	☐ Mental Retardation ☐ Visual or Hearing Impaired ☐ Emotionally Disturbed ☐ Physical Disability ☐ Other medically diagnosed condition requiring special care Please explain:

Financial Status

Are you currently employed?	◯ Yes ◯ No
If yes, where are you employed and how long have you been employed here?	
Please list the monthly income of all household members	
Wages, Salaries, and Support	
Social Security	
SSI or Disability	
TANF/Food Stamps	

Reason for request

CHILD HEALTH RECORD: PHYSICAL EXAMINATION/ASSESSMENT

Child's Name		Gender		DOB	
Address		Phone			
City		State		Zip	

_____

Parent/Guardian Signature

Screening Tests

(When recording results, enter at a minimum "N" for normal, "S" for suspect, or "A" for atypical/abnormal)

Present Age	Date		Results	
Height *(No shoes, to nearest 1/8th in.)*	Date		Results	
Weight (Light clothing to nearest ¼ lb.)	Date		Results	
Blood Pressure	Date		Results	
Hematocrit or Hemoglobin	Date		Results	
Hearing (Type or Test)	Date		Results	
Vision (Type or Test)	Date		Results	
Acuity, R/L	Date		Results	
Rescreening	Date		Results	
Strabismus	Date		Results	
Comments				
TB	Date		Results	
Sickle Cell	Date		Results	
Lead	Date		Results	
Ova & Parasites	Date		Results	
Urinalysis	Date		Results	
Other:	Date		Results	

PHYSICAL EXAMINATION/ASSESSMENT

General Appearance	
Posture, Gait	
Speech	
Head	
Skin	
Eyes External Aspects	
Optic Fundiscopic	
Cover Test	
Ears External & Canals	
Typanic Membrane	
Nose, Mouth, Pharynx	
Teeth	
Heart	
Lungs	
Abdomen (Includes hernia)	
Genitalia	
Bones, Joints, Muscles	
Neurological/Social Gross Motor	
Fine Motor	
Communication Skills	
Cognitive	
Self-Help Skills	
Social Skills	
Glands (Lymphatic/Thyroid)	
Muscular Coordination	
Other:	

General statement on child's physical status

Findings, treatments, and recommendations

Abnormal Findings/Diagnosis	
Treatment Plan	
Recommended Follow-up or Results *(Initial and date when complete)*	

Abnormal Findings/Diagnosis	
Treatment Plan	
Recommended Follow-up or Results *(Initial and date when complete)*	

Abnormal Findings/Diagnosis	
Treatment Plan	
Recommended Follow-up or Results *(Initial and date when complete)*	

**To be signed by a doctor*

_____

Signature & Title *Date*

_____

Address

_____

State *Zip Code*

_____

Phone Number