INFORMATION FORM FOR LICENSED CHILD CARE PROVIDERS

PARENTS NAME:___________________________________ CASE NUMBER_________________

ADDRESS:____

PHONE (   )_______________ SOCIAL SECURITY NUMBER (OPTIONAL)______-_______-______

PROGRAM NAME:____

OWNER AND OPERATORS NAME:____

E-MAIL ADDRESS: ____

DATE OF BIRTH:___/___/______* (if interested in web submittal in CCTA)

SITE ADDRESS:____

MAILING ADDRESS (if different):____

PHONE (   )________________________ CCFS/License #:__________________________

**If provider is less than 18 years old, the Employment of Minors Form must be completed*

1. WHO IS IN NEED OF CARE?

Child Name	Date of Birth	Date you began/will begin care
A.		
B.		
C.		
D.		

☐ I agree that the amount I am charging the parent signing this form is NOT MORE THAN the amount I am charging for other children of the same age.

2. WHO WILL SUPPLY MEALS AND SNACKS?

Meals and snacks may be supplied either by the parent or by the provider.

If you would like information about how your child care program can get money to help pay for meals and snacks, call the Child and Adult Care Food Program (CACFP) at 1-800-942-3858.

A. **PROVIDER CERTIFICATIONS**:

-I will notify the Department of Social Services immediately if the hours of care or number of children in my care changes.
-I agree to collect the family share if instructed to do so by the Department of Social Services.
-I will immediately notify the Department of Social Services if the parent fails to pay the required family share.
-I agree to provide accurate attendance records as required by the Department of Social Services.

B. **PARENT CERTIFICATIONS**:

-I will notify the Department of Social Services if the hours that I need care or other circumstances related to my need or eligibility for care change.
-I agree to pay my family share as directed by the Department of Social Services.
-I agree to pay any difference in what my provider charges and what DSS pays.
-I certify that I have selected this provider to care for my child(ren).
-I understand that it is my responsibility to monitor the quality of care furnished to my child(ren).

C. **PARENT AND PROVIDER CERTIFICATIONS**:

We state to the best of our knowledge and belief all statements made on this form and any attachments are accurate and true. We understand that providing false or inaccurate information may result in the termination of payments and legal action by the Department of Social Services.
We state that the parent has specifically asked the provider if the provider, volunteers who are likely to have regular contact with children in care, or employees have been the subject of an indicated report or child abuse or maltreatment. The provider has asked all volunteers who are likely to have regular contact with children in care and all employees if they have been the subject of an indicated report of child abuse or maltreatment indications and is choosing this provider. The parent understands he/she has the right to select another provider.
If the provider is required to complete the Facility Safety Checklist, we state that we have completed it together. We understand that payment cannot be made until items marked “No” on the Facility Safety Checklist have been corrected. We agree to notify and provide documentation to the Department of Social Services when any item on the Checklist has been corrected or changed.

By signing this form, the parent and provider agree to the requirements listed above.

______________________________	______________________________
Parent Signature/Date	Provider Signature/Date

3. When is care needed?

For each day that care is needed, indicate what time the child(ren) will be dropped off and picked up. This information must be provided for all the children in care listed on page 1.

	DROP OFF TIME				PICK UP TIME			
	A	B	C	D	A	B	C	D
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								

Hours of Operation:

____

Hours of Operation after normal business hours (if applicable):

____

We confirm this information is accurate. If it changes, please notify the worker immediately.

____

Providers Signature/Date

____

Parent Signature/Date

PROVIDER FEE FORM

Please enter rates in each box below. If a box is left blank, we will assume you are not charging for that time period.

Rate/Age	Under 1 ½	1 ½ to 2	2 to 3	3 to 5	6 to 12
Part Day Rate	$	$	$	$	$
Daily Rate	$	$	$	$	$
Weekly Rate	$	$	$	$	$

AFTER HOURS RATES (IF APPLICABLE)

Rate/Age	Under 1 ½	1 ½ to 2	2 to 3	3 to 5	6 to 12
Part Day Rate	$	$	$	$	$
Daily Rate	$	$	$	$	$
Weekly Rate	$	$	$	$	$

Part Day Rate: Care is provided for at least 3 but less than 6 hours per day

Daily Rate: Care is provided for at least 6 but fewer than 12 hours per day.

Weekly Rate: Care provided for30 or more hours over the course of 5 or fewer days in a week.

________________________________ ______________________

Providers Signature Date

Please return completed form to: Montgomery County DSS, Child Care Unit
PO Box 745
Fonda, NY 12068-0745

Or Fax to: 518-853-5021 Attn: Child Care Unit