COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

Registered Child Care Provider Information Form

THIS FORM AND FORM W-9 MUST BE COMPLETED BY EACH REGISTERED CHILD CARE PROVIDER. ALL REGISTERED PROVIDERS MUST BE AT LEAST EIGHTEEN (18) YEARS OF AGE AND MUST NOT LIVE IN THE CHILD'S HOME OR BE THE PARENT OF THE CHILD ELIGIBLE FOR CCAP BENEFITS.

Name:

_____
(Enter the name you use on tax returns or enter your name as it appears on your social security card)

Social Security Number (SSN): _____ **Date of Birth**: _____

Phone No. : (_____) _____ **Cell/Emergency Contact:** (_____) _____
(A land line or continuously operating cell phone is required in the home where care is provided)

Street Address: _____ **City/Town**: _____

Zip:_____ **County**:_____ **State:** _____

Mailing Address: _____

Email Address:_____

Location of Child Care: ☐ In Your Home ☐ In Child's Home

County Where Child Care is Provided: _____

Rate charged for child care:

TYPE OF CARE:	**(Birth – 12 mos) INFANT**	**(1 – 2nd Birthday) TODDLER**	**(2 – 3rd Birthday) TODDLER**
Part Day (PD) – *Less than five (5) hrs/day*	$ _____ per day	$ _____ per day	$ _____ per day
Full Day (FD) – *Five (5) or more hrs/day*	$ _____ per day	$ _____ per day	$ _____ per day

TYPE OF CARE:	**(3- 4th Birthday) PRESCHOOL**	**(4 –5th Birthday) PRESCHOOL**	**(5 – 6th Birthday) PRESCHOOL**
Part Day (PD) – *Less than five (5) hrs/day*	$ _____ per day	$ _____ per day	$ _____ per day
Full Day (FD) – *Five (5) or more hrs/day*	$ _____ per day	$ _____ per day	$ _____ per day

Provider Name_____
Provider ID _____

TYPE OF CARE:	(6 – 8th Birthday) SCHOOL AGE	(8 – 13th Birthday) SCHOOL AGE	(13 – 19th Birthday) SCHOOL AGE
Part Day (PD) – *Less than five (5) hrs/day*	$ _____ per day	$ _____ per day	$ _____ per day
Full Day (FD) – *Five (5) or more hrs/day*	$ _____ per day	$ _____ per day	$ _____ per day

Date Rates Listed Above Became Effective: _____/_____/_____***(Month / Day / Year)***

Please list hours of operation:

Monday through Friday	**Open:_____ am/pm**	**Close:_____ am/pm**
Saturday	**Open:_____ am/pm**	**Close:_____ am/pm**
Sunday	**Open:_____ am/pm**	**Close:_____ am/pm**

Provider Rights and Responsibilities

To receive payment under the CCAP, I understand and agree that I shall:

1. Meet all regulatory and statutory requirements related to child care registration.
2. Give permission to the Cabinet to verify any information necessary to approve or continue my child care registration.
3. Maintain information and records concerning children and families in a confidential manner, including information and records of children who do not receive CCAP benefits.
4. Not use any form of abusive language and/or corporal physical discipline, including spanking, shaking, hitting or paddling.
5. Report to the Cabinet an address change or a change in provider type (licensure, certification, or registration) within ten (10) days of the change.
6. Sign and return the DCC-94, Child Care Service Agreement and Certificate within ten (10) days of being issued. Payment will not be made until the signed Service Agreement has been received.
7. Charge the parents of children receiving CCAP benefits no more than the rate charged to parents of children who do not receive CCAP benefits.
8. Notify the Cabinet and the parents of children receiving CCAP benefits of any rate changes ten (10) days in advance of making the change.
9. Complete the monthly Provider Billing Form, DCC-97, accurately, promptly and according to instructions. I understand that if I give false information or withhold information, I may be subject to prosecution for fraud. CCAP staff will not make payments or accept adjustment requests more than ninety (90) days after the service month. After a monthly Provider Billing Form has been processed and paid, CCAP staff have the right to review and verify the accuracy of the form and the payment. CCAP payment(s) shall be adjusted if an overpayment or an underpayment has been identified. I will pay back any money I receive in error, even if the mistake is not my fault.
10. Not receive payment for any CCAP child who resides in the same home as I do.
11. Not receive payment for caring for my own children, and understand that my children are not eligible for CCAP benefits during the time I care for other children.
12. Agree not to care for more than three (3) unrelated children or up to six (6) children if they are a sibling group and related to me. I understand that the maximum number of children I may care for during the hours of operation is eight (8) which includes my own children, other related children, and unrelated children.
13. Not give any part of the CCAP payment to any employee of the Cabinet as wages, compensation, or gifts in exchange for acting as an officer, agency, employee, sub-contractor, or consultant to me.

Provider Name_____
Provider ID _____

14. Complete a Form W-9, Request for Taxpayer Identification Number and Certification, and submit it to the Cabinet. **I understand that I am not an employee or contractor of the Cabinet for Health and Family Services. I may be subject to federal, state, and local taxes and other requirements.** If I provide services in the child's home, federal law (the Fair Labor Standards Act (FLSA) (29 U.S.C. Section 206(a)) considers me to be a domestic service worker employed by the parent and therefore covered under minimum wage laws. **If I have questions regarding my status or the tax implication of any payments made to me on behalf of a parent by the Cabinet, I should contact a tax professional, the Kentucky State Revenue Cabinet, or the Internal Revenue Service.**
15. Submit a written evacuation plan as specified in regulation 922 KAR 2:180, agree to keep it on file, and follow the plan in the event of an emergency.

Reasons CCAP payments could stop:

1. I understand that CCAP payments may be withheld or terminated upon thirty (30) days notice due to a shortage or unavailability of funding.
2. I understand that CCAP payments may be withheld or terminated upon ten (10) days notice due to failure by the provider to properly fulfill the terms of this agreement or comply with applicable regulations or commitment of an an intentional fraudulent act or a violation by the provider of any provisions of this agreement.
3. Child care arrangements and all CCAP payments may be terminated immediately if the Cabinet initiates a Child Protective Services investigation involving me, or a member of my family, and the Cabinet determines that I have not satisfied the Cabinet's safety concerns by preventing further contact between the subject of the investigation and child(ren) served by me.

I understand and agree to all of the requirements included in this Provider Information form.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

In order to receive payment under the CCAP, you must complete, sign and return this form and Form W-9, Request for Taxpayer Identification Number and Certification to the address below. These forms must be updated and resubmitted to the Cabinet or its designated CCAP Staff if any changes occur. Keep a copy for your files.