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

Licensed or Certified Provider Agreement Form

THIS FORM AND FORM W-9 MUST BE COMPLETED BY EACH CHILD CARE PROVIDER THAT RECEIVES PAYMENT UNDER THE CHILD CARE ASSISTANCE PROGRAM (CCAP).

NOTE: IF CHILD CARE IS PROVIDED AT MORE THAN ONE (1) LOCATION, THE PROVIDER MUST COMPLETE A SEPARATE INFORMATION FORM, PROVIDER'S STATEMENT OF RATES, AND FORM W-9 FOR EACH SITE.

Licensed or Certified Provider Name: _____
(If you operate a licensed child care center or a certified family child care home, enter the name listed on your license or certificate to operate. The name recorded on the license or certificate must match the name used on tax returns or name as it appears on your social security card.)

Indicate the Tax Status for Your Business:

☐A. Individual ☐B. Sole Proprietorship ☐C. Partnership ☐D. Limited Liability Company
☐E. Corporation ☐F. Public Service Corporation (PSC) ☐G. Government/Non-Profit

If your tax status is:

- **Individual -** Enter your SSN as shown on your Social Security card.
- **Sole Proprietorship -** Enter your SSN or FEIN, followed by your name and "doing business as (DBA)." After DBA, enter your business name.
- **Partnership -** Enter your FEIN or the SSN for you or one of your partners. If a SSN is entered, also enter the name of the owner of the SSN as shown on the Social Security card.
- **Limited Liability Company -** Enter your FEIN
- **Corporation, Public Service Corporation, Government/Non-Profit -** Enter your FEIN.

(FEIN) or (SSN): _____
(Enter the Federal Employer Identification Number (FEIN) or Social Security Number (SSN) you use on tax returns)

All providers are responsible for obtaining correct taxpayer identification numbers (TIN) for the W-9. For individuals, this is your SSN. Providers are further responsible for properly maintaining records in case of an IRS inquiry and for the purpose of assuring correct 1099 reporting.

License or Certification Number _____ Expiration Date_____ Phone No. (____)_____

Location Address_____ City/Town _____ Zip _____

County _____ State _____

Mailing Address _____

Director/Owner _____

Licensee or Certified Provider's Maiden Name _____

Licensee or Certified Provider's Date of Birth _____

Provider Name_____
CLR Number _____

Rate Charged for Child Care:

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

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

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

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

Special Needs children served: ☐**Yes** ☐**No**

Is this site accredited? ☐**Yes** ☐**No**
If yes, name of accrediting organization_____

Do you charge an enrollment fee? ☐**Yes** ☐ **No**
If yes, how often is the fee charged? ☐ **Annually** ☐ **One Time** ☐ **Summer Session**
What is the amount of the enrollment fee? $_____
Is fee: ☐ **Per Family** ☐ **Per Child**

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**

Check Applicable Provider Type:
☐Center (Licensed Type I) ☐ Group Home (Licensed Type II) ☐ Certified Family Child Care Home

Provider Name_____
CLR Number _____

Provider Rights and Responsibilities

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

1. Meet all regulatory and statutory requirements related to my child care provider type (Licensed or Certified) as listed below, which can be found at http://lrc.ky.gov/kar/title922.htm:
   - 922 KAR 2: 020 Child care assistance program (CCAP) improper payments, claims, and penalties
   - 922 KAR 2: 090 Child care center licensure
   - 922 KAR 2: 100 Certification of family child care homes
   - 922 KAR 2: 110 Child-care center provider requirements
   - 922 KAR 2: 120 Child-care center health and safety standards
   - 922 KAR 2: 160 Child Care Assistance Program
2. Give permission to the cabinet or the CCAP staff to verify any information necessary.
3. Maintain capacity to no more than the number approved by Fire Marshal, which includes both children and adults, at any given moment of the day.
4. Maintain information and records concerning children and families in a confidential manner, including information and records of children who do not receive CCAP benefits.
5. Not use any form of abusive language and/or corporal physical discipline, including spanking, shaking, hitting or paddling.
6. Report to the CCAP staff the opening of a new site, an address change, a change of ownership, a negative action, or a change in provider type (licensure, certification, or registration) within five (5) days of the change.
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 CCAP staff and the parents of children receiving CCAP benefits of any rate changes ten (10) days in advance of making the change.
9. Not charge the parents of children receiving CCAP benefits for any days the facility is closed if the provider does not bill parents of children who do not receive CCAP benefits.
10. Collect daily family co-payment fees regularly. If the co-payment is not paid on time, I will contact the client to set up a payment plan to get the co-pay current.
11. Not permit an employee receiving CCAP benefits to provide direct care for the employee's own child.

CCAP BILLING AND PAYMENT

12. Sign and return the DCC-94, Child Care Service Agreement and Certificate, within ten (10) days of it being issued. Payment will not be made until the signed Service Agreement has been received.
13. Complete a Form W-9, Request for Taxpayer Identification Number and Certification, and submit it to the CCAP staff. I understand that I am not an employee or contractor of the Cabinet for Health and Family Services or the CCAP agency. 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.
14. Be reimbursed by the Cabinet for State or Federal holidays for which the provider is closed only if the provider bills parents of children who do not receive CCAP benefits. Payment under CCAP will not be made to a licensed or certified provider for more than ten holidays per calendar year.
15. Not give any part of the CCAP payment to any employee of the cabinet or the CCAP staff as wages, compensation, or gifts in exchange for acting as an officer, agency, employee, sub-contractor, or consultant to me.
16. Not receive payment from CCAP for any child that I care for who resides in the same home as I do.
17. Understand that if I operate a child care business in my home, my child(ren) is not eligible for CCAP benefits during the time I care for (an)other child(ren).
18. Promptly pay back any child care payment received to which I was not entitled to receive.
19. Ensure that CCAP payments are made only to the center approved for care. When a center is closed, the center cannot move children to another center and expect payment.
20. Maintain payment records for a period of five (5) years. This includes the DCC-94E, Child Care Daily Attendance Record.
21. Not be paid for payment requests or adjustment requests ninety (90) or more days after the service month.
22. Not give false information or withhold information as I may be subject to CCAP disqualification or prosecution for fraud.

23. Be required to pay back any overpayment and the overpayment may be pursued as an intentional program violation in accordance with 922 KAR 2:020 if I or staff acting on the child-care center or home's behalf does not bill accurately in accordance with 922 KAR 2:160.
24. Be reviewed after a monthly DCC-97, Provider Billing Form, has been processed and paid. CCAP staff has 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.

DCC-94E, CHILD CARE DAILY ATTENDANCE RECORD

25. Maintain the DCC-94E, Child Care Daily Attendance Record, in which the daily arrival and departure times of each child is recorded. The child's name must be legible and must be written the same as it is given on the DCC-97, Provider Billing Form.
26. Sign the DCC-94E, or an employee acting on my behalf shall sign the DCC-94E, at the end of each week. I shall ensure that client or designated person does not sign the DCC-94E prior to the end of care for a given week.
27. Not receive a payment for days or weeks during which a child(ren) is not signed in or out on the DCC-94E. If I or a person acting on my center or home's behalf fails to secure the appropriate initials daily and the client's signature weekly, any payments received will be recouped.
28. Not be paid for any absences or holidays for a child who does not have attendance during a calendar month.
29. Submit the DCC-94E sheets upon request of the Cabinet or designee.
30. Complete the monthly DCC-97, Provider Billing Form, accurately, promptly, and according to instructions.
31. Complete the DCC-97, Provider Billing Form, as documented on the DCC-94E, Child Care Daily Attendance Record.
32. Complete the cabinet approved training on billing and the DCC-94E.

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;
   - Upon ten (10) days notice due to failure by the provider to comply with the terms of this agreement or by violating 922 KAR 2:020, 2:090, 2:100, 2:110, 2:120, 2:160, 2:180, or 2:190;
   - Upon notice of the Office of the Inspector General, Division of Regulated Child Care, that failure to comply with provisions of applicable administrative regulations has caused my license or certification to be suspended or revoked;
   - When not in good standing with the Cabinet; or

   While a disqualification is imposed due to fraud in accordance with 922 KAR 2:020.

2. 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 Agreement form. I also understand and agree that I will follow all of the requirements of 922 KAR 2:160.

_____**DATE**_____

Licensee or Certified Provider SIGNATURE

"Licensee", as defined by 922 KAR 2:090, is an owner and operator of a child care center to include sole proprietor, corporation, Limited Liability Company, partnership, association or organization.

PRINT NAME AND TITLE:_____

In order to receive payment under the CCAP, you must complete, sign, and return this form and Form W-9 to the address below. These forms must be updated annually and if any changes occur, they are to be resubmitted to the CCAP Staff. Keep a copy for your files.

CCAP Staff: _____

Address: _____Phone: (____)_____ FAX: (___)_____