

<Client First MI Last Name >
<Care of (c/o)>
<To Street Address Line1>
<To Street Address Line 2>
<To City, State, Zip>

Child Care Service Agreement and Certificate

FAMILY INFORMATION

RECIPIENT NAME:		RECIPIENT DOB: / /	
HOME ADDRESS:			
CITY:	STATE:	ZIP: -	
HOME PHONE: () -		CASE NUMBER:	

PROVIDER INFORMATION

PROVIDER NAME:		CLR#:	PHONE NUMBER: () -	
STREET ADDRESS:		MAILING ADDRESS:		
CITY:	STATE:	ZIP: -	CITY:	STATE: ZIP: -

ENROLLMENT INFORMATION

FD = FULL DAY, PD = PART DAY, FS = FLEX SCHEDULE

CHILD NAME: DOB: / / INDIVIDUAL ID: SPECIAL NEEDS: NON-TRADITIONAL HRS:

START DATE	END DATE	CARE LEVEL **	RATE		DAILY CO-PAY	DAILY CHFS PAYMENT	
			FD	PD		FD	PD

SCHEDULED DAYS

START DATE	END DATE	MON	TUE	WED	THU	FRI	SAT	SUN	SCHOOL OPEN	SCHOOL CLOSED	FS UP TO

MONDAY THROUGH FRIDAY RATE WHEN SCHOOL IS IN SESSION IS DISPLAYED IN THE 'SCHOOL OPEN' BOX AND THE RATE WHEN SCHOOL IS NOT IN SESSION IS DISPLAYED IN THE 'SCHOOL CLOSED' BOX

SCHEDULE NOTES:

You must either send the signed document to the address or fax number mentioned below or return this in person to any Department for Community Based Services office, or upload it on the KICCS Provider Portal.

NOTE: Please ensure signatures are provided on page 2 and 3 before returning the entire form.

DCBS
<Mail Room Address Line 1>
<Mail Room Address Line 2>

<Mail Room City, State, Zip>

Fax: <Mail Room Fax Number>

If you have questions or need help collecting these things, please call <Call Center Number>.

CONDITIONS OF ACCEPTANCE

The Cabinet for Health and Family Services agrees to reimburse the child care provider on behalf of the recipient at the rate agreed upon for child care services rendered to the children identified on this form upon timely receipt of properly completed prescribed billing forms. The cabinet agrees to pay the provider for the number of days/hours of care as specified in this agreement. This agreement between the cabinet, parent, and provider shall remain in effect subject to continued eligibility of the provider, family and child and the need for services. Eligibility and need for services shall be determined every twelve months, when changes are reported, or upon termination of an authorization. This agreement is subject to the continued availability of state and federal funds.



RECIPIENT NAME: _____

As recipient of child care assistance on behalf of the named children, I have chosen to send my children to the named child care provider as agreed by the cabinet or its designee, the child care provider and me. I agree to pay the assessed family co-pays according to the prearranged plan for such payments to the child care provider. I understand and agree that I will be responsible for any amount exceeding the total daily payment (overage charges) and for days the children are absent from care which are not payable by the cabinet according to the provisions of 922 KAR 2:160. I agree to provide the child care provider with any requested documentation of the reason my children are absent from care. I agree to notify the cabinet or its designee and the child care provider within ten (10) days of changes relevant to this Child Care Services Agreement and Certificate. I understand that I have the right to receive fair and impartial treatment from my worker regardless of my age, sex, race, religious beliefs, political affiliation, national origin, or disability. If I am dissatisfied with the action taken, I may request a service appeal within thirty (30) days from the date of action by filing a written request with the Cabinet for Health and Family Services, Division of Administrative Hearings, Families and Children Administrative Hearings Branch, 105 Sea Hero Road, Suite 2, Frankfort, KY 40601. I may be represented by an attorney or other spokesperson. A complaint reported on the provider of services is subject to public inspection as specified in the Public Records Law KRS 61.872 to 61.884.

I agree and understand that this agreement may be terminated upon notice that the cabinet has determined that conditions or circumstances at the child care premises put children at risk of abuse, neglect or exploitation pursuant to KRS 620. I agree and understand that I must pay back benefits that are paid on my behalf to which I am not entitled to receive. I understand that benefits will not be issued if I am currently disqualified due to fraud in accordance with 922 KAR 2:020.

I have reviewed this form. I fully understand my rights and responsibilities and the terms of the agreement are understood and satisfactory.

Recipient Signature: _____ Date: _____

PROVIDER NAME: _____

The child care provider agrees to provide child care services for the children identified on this form; to charge and collect the family's co-pay as prearranged; not to subcontract child care services without prior approval of the cabinet's child care program; to provide reports to the parent and the cabinet or its designee of changes relevant to this Child Care Agreement and Certificate. The provider understands and agrees that the cabinet shall reimburse the lesser amount of: (a) the customary and usual rate that is charged to the general public, less the family co-pay, or (b) the state maximum payment rate, less the family co-pay. Days absent will be considered for payment according to 922 KAR 2:160. The provider shall not charge for days the facility is closed if the general public is not charged during that time period. The provider agrees to allow unlimited parental access to the child and to the provider during normal hours of operation.

The child care provider agrees that subject to federal regulation 45 CFR 98.32, the department maintains a records of substantiated parental complaints and makes information regarding such parental complaints available to the public on request as enumerated in the Public Records Law KRS 61.872 to 61.884. The child care provider, if licensed, shall comply with the Civil Rights Act of 1964 as amended, and Section 504 of the Rehabilitation Act of 1973 as amended.

The child care provider agrees to pay back any child care benefits to which the provider is not entitled to receive. The child care provider reports to the local DCBS/DCC 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. The child care provider agrees and understands that no payment will be made to a provider that is not in good standing with the cabinet. The child care provider understands that benefits will not be paid while a disqualification is imposed due to fraud in accordance with 922 KAR 2:020.

The child care provider agrees and understands that this agreement may be terminated upon notice that the cabinet has determined that conditions or circumstances at the child care premises put children at the risk of abuse, neglect or exploitation pursuant to KRS Chapter 620.

I have reviewed this form. I fully understand my rights and responsibilities and the terms of the agreement are understood and satisfactory.

Child Care Provider Signature: _____