Child Care Alternative Payment Program
1225 Gill Ave
Madera, CA 93637
Phone (559) 661-0779 Fax (559) 661-0764

OFFICE USE ONLY

Family #: ___________________

Program #: _________________

Requested Start Date:_________

Verified Initials:______________

Verified Date:________________

Contact Information for New Child Care Provider

LIMIT TWO (2) PROVIDERS PER FAMILY

☐ **Regular Provider** *(Primary)*

☐ **Alternate Provider** *(1- An alternate is only approved when the regular provider has a paid day of non-operation and the parent has to obtain an alternate provider to meet the certified need for child care.* ***Limited to ten days per child per fiscal year****. 2- Time that child care services are provided by an eligible alternate provider when the child is ill and the parent has to obtain care from an eligible alternate provider.* ***Limited to ten days per child per fiscal year. It can exceed ten days with a physician verification****.) 5 CCR 18076.2*

☐ **Multiple Provider** *(Contractors may reimburse more than one provider per child when the hours of operation of the first provider cannot accommodate the certified need for child care.) 5 CCR 18076.3*

Parent Name: ____**Parent Phone #:** ______________________________

Provider Name: ______________________________________**Provider Phone #:**_____________________________

Provider Address: ____________________________________**City:** ____________________**Zip**: _______________

Does provider have a child care license? (please circle one): **No / Yes (If yes, skip 1-5 & a-g)**

For unlicensed (exempt) child care providers:

1. Provider's relationship to child/children:____
2. What language does provider prefer to speak (please circle one): **English / Spanish / Other** ______________
3. Is the provider currently employed or enrolled in school / training program (please circle one): **Yes / No**
   If yes, please indicate if employment or training / school schedule is (please circle one): **Full-time / Part-time**
4. Please indicate during what part of the day services will be provided (please circle one or both): **AM / PM**
5. I understand that child care services cannot be provided in parent & child's home: **Yes / No**

Please note that unlicensed (exempt) child care providers will also need to submit the following verification at their scheduled enrollment appointment:

a) Photo ID with current address
b) Proof of residence with a utility bill in their name and with current address
c) Copy of Social Security card
d) Verification of training or employment if in school or working
e) Must complete a CPR/First Aid Class within 30 days of enrollment (cost $65-$100)
f) Non-relative and other relative providers (other than aunts/uncles or grandparents by blood or marriage) are required to complete a fingerprint and criminal background clearance (cost $8-$25) ***and be registered on TrustLine within 30 days***
g) Maximum Exempt Provider child care reimbursement rates are from $2.40-$3.05 per hour up to $424.84 to $549.09 monthly maximum per child (based on the age of the child, eff. 1/1/18)

Please indicate the names and ages of all children who will be using services with this provider:

Name	Age		Name	Age
1.			4.	
2.			5.	
3.			6.	

***IMPORTANT: Parents must give a minimum two (2) week notice to CAPMC/APP & the provider if they terminate from the program or want to change providers. If a two week notice is not given, and the parent stops bringing the child or children, parents are responsible for paying the provider. The contract with a new provider will not become effective until after the end of the two week notice. *Families shall not change providers more than once in a contract year* unless the change is due to serious and compelling reasons. Requests for more than one change per year shall be considered on a case by case basis by the program manager.**

Note: Your request must be *reviewed & approved* by your Family Service Associate (FSA) prior to the use of any services.

Parent/Guardian Signature: ____ **Date:** __________________________