



Child Care in Your Home Fee Assistance Program Provider Rate Verification Form Instructions

The Department of Defense (DoD) Child Care in Your Home (CCYH) Fee Assistance Program Provider Cost Verification Form collects all required information about the provider child care rates your family will be charged by the CCYH provider. This includes effective dates, rate changes, rate frequency, and the schedule of care. This form will be used to process your initial fee assistance application. If there is any unlisted change to the rate or schedule, a new form will need to be completed and submitted, but no more than one change per application year.

You will be required to submit this form to complete your family application after you have selected your provider to participate in the CCYH Fee Assistance Program. To review the provider eligibility requirements, visit <https://www.childcareaware.org/fee-assistancerespice/dod-families/dod-fee-assistance/>. You may also send questions to be addressed by a specialist at CCYH@usa.childcareaware.org. Please see the guidelines below for completing the form.

Instructions:

1. You should **VERIFY** that the provider is eligible to participate in the CCYH Fee Assistance program before hiring and completing the form.
2. Your CCYH Provider should **COMPLETE** the form.
 - a. All rate changes should be included on the form, including new rates for age changes.
 - b. Rates should be listed as the weekly, monthly or annual rate. **Fee assistance will not be calculated at an hourly rate.**
 - c. If your provider does not know the exact date of a rate change, please have them provide their best estimate as to when the rate change will occur. If it is an estimate, they should indicate that on the form. There may be only one, unannounced rate change per year. Rate changes cannot be processed unless it is provided in this form prior to the family's approval.
3. The form needs to be **SIGNED** by both the provider and the parent/guardian.
4. The form is then **SUBMITTED** by the family to complete the family application as soon as possible.
5. The information provided on this form should be consistent with the information in the CCYH provider's application.
6. Fee assistance is determined by calculating the fee a family would pay for on-installation care (based on Total Family Income (TFI), the CCYH provider's monthly rate, and the cumulative provider rate cap up to \$1,700 per child in care full-time and up to \$850 per eligible school-age child. If your provider charges weekly, CCAoA will convert your weekly fee into a monthly fee by multiplying it by 4.33 (This calculation takes into account all months within the year whether they have 4 or 5 weeks.) Please note that the rate conversion (if required) will be performed by CCAoA at the time a fee assistance approval is granted and does not need to be calculated beforehand. The Sponsor is responsible for the DoD-established parent fee based on the family's locality and Total Family Income category, and any amount over the identified provider cap for the family's locality and type of care.

**Disclaimer: Please note that failure to correctly report accurate rate information may result in removal from the fee assistance program, and if necessary, Child Care Aware® of America may notify the branch of service or agency regarding any falsifications. In the event of any overpayment, Child Care Aware® of America will request that all monies be paid back in a timely manner. Completing this form does not certify that the provider will qualify for the Child Care in Your Home Fee Assistance program.*



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CCYH Provider and Family Information

CCYH Provider Name: _____

City: _____ State: _____ Zip Code: _____

Provider Phone Number: _____ Provider Email: _____

Sponsor Name: _____ Family ID#: _____

Rate Information

Child's Name	Days of Care <small>(List all days that apply)</small> M T W Th F Sa Su	Hours of Care From To	Rate Per Child*	Effective Date
		to		
		to		
		to		

* Rates should be listed as a weekly, monthly, or annual dollar amount.

Frequency of Rate Listed Above (select one): Weekly / Monthly / Annually

State Subsidy Received? (If so, please include voucher): _____

Start of Care Date: _____ Anticipated End Date (if applicable): _____

Rate Changes within the Next 12 Months

Child's Name	Days of Care <small>(List all days that apply)</small> M T W Th F Sa Su	Hours of Care From To	Rate Per Child	Effective Date of Rate Change
		to		
		to		
		to		

I certify that all above information is correct and that I am authorized to release this rate information. I understand that I must report any changes to a child's schedule of care prior to the change being made. I understand that only consistent schedules of care are permitted. I also understand that I am responsible for any payments made in error and that in the event of overpayment, I must pay back monies to Child Care Aware® of America. Failure to comply with any of these requirements or to correctly report information will result in termination from the program. Completing this form does not certify that the provider will qualify for the fee assistance program.

CCYH Child Care Provider Name

Provider's Signature

Date

Parent/Guardian Name

Parent/Guardian Signature

Date