

Date Stamp \_\_\_\_\_

HW 0427  
Revised 3/1999

### MONTHLY DEPENDENT CARE CHARGES

Case Name:	Case Number:	
	Family Number:	C.L. Number:

Effective Date Of This Arrangement \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<b>PART A: COMPLETED BY PARENT</b>	
Full Name of Parent:	Home Phone Number:
Home Address:	Work Phone Number:
In case of Emergency Contact:	

<b>PART B: COMPLETED BY PROVIDER</b>	
Provider Name:	Business Name, if different:
Provider Address:	
Provider Phone Number:	Vendor # (if available):
Are you a registered Idaho Child Care Program (ICCP) provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you related to the children listed below? <input type="checkbox"/> YES <input type="checkbox"/> NO      If "YES", what is your relationship?	
How many children do you usually provide care for? (Include the children listed below, but not your own children.) <input type="checkbox"/> 6 or less <input type="checkbox"/> 7 - 12 <input type="checkbox"/> 13 or more	

Name of Each Child Receiving Dependent Care	Total Cost for Each Child (Anticipated Monthly)	Total Number Of Hours of Care (Anticipated Monthly)	Is the Child Attending School? *	How is the Dependent Care Billed? (Hour, Day, Week, or Month)
	\$	Hours	Y / N	\$ Per
	\$	Hours	Y / N	\$ Per
	\$	Hours	Y / N	\$ Per
	\$	Hours	Y / N	\$ Per

\*For children who attend school, what is the rate/charge for days when there is no school?       Same OR \$ Per

**IN SIGNING THIS FORM,  
WE ARE ACKNOWLEDGING THE ABOVE TERMS HAVE BEEN AGREED UPON BY BOTH PARTIES.**

Provider's Signature	Tax Identification # or SSN	Date
Parent's Signature	Social Security #	Date

**Reporting requirements are as follows:**

- The Parent must report a change in provider, a change in the parent's activity, a change in child care need, or a change in income.
- The Provider must report a change in the amount they charge.