IOWA Health and Human Services

Child Care Assistance Provider Agreement

Child Care Provider Information

In order for you to receive payment under the Child Care Assistance Program, you must provide the following information about your legal name and tax ID. Please fill out either Box A or Box B.

Box A Individual

If you answer Yes to Individual, please provide your Social Security Number (SSN) as your tax ID.

Are you an Individual: *(If the answer to this question is No, complete Box B.)*

☐ Yes ☐ No

SSN: ☐☐☐-☐☐-☐☐☐☐

Provider Last Name: Provider First Name:

Address, city, state, and ZIP code where care is provided:

Address | City | State | ZIP

Mailing address, if different:

Address | City | State | ZIP

Phone number:

Box B Corporation, Government, LLC etc.

Is your business a: (Pick one)

☐ Corporation
☐ Partnership
☐ Government
☐ Sole Proprietor
☐ Limited Liability Company (LLC)

If LLC, Tax Classification (Pick one): ☐ Sole Proprietor ☐ Corporation ☐ Partnership

Please provide your Employer Identification Number.

EIN: ☐☐-☐☐☐☐☐☐☐

Provider Legal Business Name:

Doing Business As (DBA) Name:

Address, city, state, and zip code where care is provided:

Address | City | State | ZIP

Mailing address, if different:

Address | City | State | ZIP

Phone number:

Provider Rate Information

Complete the provider agreement with the usual weekly rates that you charge for a private pay family.

The weekly rate is the rate you charge for full-time care for the entire week.

	Infants or Toddlers	Preschool	School Age
Age Groups	Newborn up to 3 years old	3 years up to Kindergarten	Attending Kindergarten or older
Weekly			
Summer Weekly (if different)			

Only include one amount of each age group. Do not include any additional rate types. All amounts must be written in the above boxes, do not include an attached rate sheet.

Are you a Head Start program? ☐ Yes ☐ No

Do you charge families the difference between the CCA Program and your private pay rate? ☐ Yes ☐ No

Client Fees

I understand:

1. I am responsible for collecting all fees assessed to the client, as determined by the Iowa Department of Health and Human Services (Iowa HHS), directly from the client. Iowa HHS can't collect these fees.
2. I may bill a Child Care Assistance (CCA) participant the di erence between the CCA Program payment and the provider's private pay rate, if agreed to by the parent and the provider in writing prior to care being provided.
3. I must maintain a record of all fees collected from clients, including any charges for the di erence between the CCA payment issued by Iowa HHS and the provider's private pay rates, and this record shall be available, upon request, for audit by Iowa HHS or its representatives.
4. If I am a Head Start program in accordance with Head Start Performance Standard 1302.18 the Provider Rate Information listed above is exclusively for child care services provided outside federally funded Head Start program hours.

By signing this form, I agree to participate as a provider of child care services approved by the Iowa Department of Health and Human Services (hereafter "Iowa HHS") and/or the Promise Jobs program and assure Iowa HHS that I will comply with the provisions of this Agreement.

Submit pages 1 and 2 and keep pages 3 through 6 for your records.

Name of the Child Care Provider (please print) _____

Signature of Child Care Provider _____ **Date** _____

Keep for your records.

Eligible Provider

I must meet all federal, state, and local standards that pertain to the child care services being provided under this payment Agreement

I must not assign, transfer, or subcontract any interest in this Agreement. This means that payment for services made under this Agreement can only go to the provider named in this Agreement for care provided at the location named in this Agreement.

Billing and Payment

I understand:

1. I must provide the service as authorized on the client Notice of Decision or Certificate of Enrollment before submitting the claim for payment.
2. At the end of each billing period, I will submit a **Child Care Assistance Billing/ Attendance, form 470-4534** to the Department only for the actual hours of child care services that were provided. This form must be signed by the provider and the parent and I must keep a copy of the signed form for my records.
3. I have the option to submit attendance online through the KinderTrack web portal. If I choose to do so, I must print a **Child Care Assistance Billing/Attendance Provider Record, form 470-4535** which must be signed by the provider and the parent and kept for my records.
4. If I am not able to use form 470-4534 or 470-4535, I must keep adequate attendance records instead. To be considered adequate, attendance records must include the child's name, the dates and daily time in and time out entries for days the child was in care, and the signature of the parent or other adult designee certifying the attendance is accurate.
5. I will be paid only for the hours of care (number of half day units) that were authorized by the Department on the Notice of Decision or Certificate of Enrollment.
6. I cannot bill the Department or PROMISE JOBS more than what I charge other families for the same service.
7. If I exceed the allowed child capacity for my facility based upon the number and ages of children, this Agreement may be terminated and any payments may be recouped.
8. Failure to comply with this Agreement or other Department child care rules may result in recoupment of payments made and termination of this Agreement for up to 36 months.

Payment for Child Absences

I understand:

1. I may bill for up to four days of absences per month (in accordance with the units approved for that day) **only** when a child is scheduled to be in attendance that day but is absent from care.

2. I may not bill for a day of absence if this policy is not applied to private pay families.
3. Holidays may be paid as an absent day **only** when the child care facility is closed for business, the child is normally scheduled to be in attendance on that day and these days are charged to private pay families. Holidays are included in the four days maximum per month.
4. I may not bill for days of absences when I am not available to provide care (vacation, sick, or other closure reason other than a holiday).
5. If I am a backup provider, I am not allowed to bill for absent days.

Record Keeping and Auditing

I understand:

1. I am responsible for keeping accurate records that document times and dates of care provided to each individual child funded by the Department or PROMISE JOBS.
2. These records must be kept for five years.
3. If this case is selected for review or audit authorized by the Department, I will make these records immediately available, upon request, to substantiate the services I provided and received payment from Child Care Assistance funds.
4. Failure to keep accurate attendance records that have been signed by the parent, may result in termination of this Agreement and repayment of funds for time periods that I am unable to provide adequate attendance verification to support the payments I have received.

Protective Child Care

1. I understand that to provide protective child care, I must be a licensed or registered child care provider unless otherwise approved by the Department.
2. I will cooperate with all aspects of the child's/family's Departmental Case Permanency Plan.

Special Needs Child Care

1. Parents are responsible to provide the Department with written documentation that their children meet the definition of "special needs."
2. I understand that in order to receive "special needs" reimbursement rates, I must provide documentation to the Department that I am responding to a child's special needs with (but not limited to) adaptive equipment, more careful supervision, or special staff training.

Other Provider Requirements

Nondiscrimination:

I will not discriminate because of race, color, national origin, sex, religion, age, disability, or political belief against any person seeking services.

Change Reporting:

I am responsible for reporting changes in my household members, substitutes, assistants, address, phone number, criminal convictions, etc. within 10 days of any change. Failure to report these changes may result in recoupment of funds paid to me and termination of this Agreement

Abuse Reporting:

I understand that as a registered or licensed provider, I am a mandatory reporter regarding suspected child abuse of children in my care and will report any suspected incidents of child abuse to the Department of Health and Human Services immediately by phone and follow up with a written report. The number for reporting suspected child abuse is 800-362-2178.

I have a written policy stating how I will report suspected child abuse.

Confidentiality:

I will respect the privacy of the client and keep the client's relationship with the Department confidential. Personal information about the client may not be shared with anyone but the Department worker and the client. Failure to respect the client's privacy could result in cancellation of this Agreement and legal sanctions, if warranted.

Indemnity:

I understand that I have the status of an independent contractor only and shall in no sense be an agent, employee, or servant of the state of Iowa, the Iowa Department of Health and Human Services, any of its employees, or its clients. I will not hold the state of Iowa, the Iowa Department of Health and Human Services, its employees, or its clients liable, as I shall be responsible for all activity in the delivery of services.

Drug-Free Environment:

I will provide a drug-free child care environment in accordance with Executive Order Number 38.

Audits or Investigations:

I understand that when fraudulent practices are suspected, a referral may be made to an investigative unit, and that I must cooperate with the investigation. I agree to permit federal, state, and local officials to monitor and evaluate my child care facility with or without notice

Repayment:

I understand that I may have to repay money received in error or as a result of failure to comply with Department rules, failure to report changes, or fraudulent billing.

Agreement Termination

Non-compliance with any of the provisions of this Agreement may result in termination of this Agreement upon ten days written notice from the Department. Termination of this Agreement may prevent you from making application for another Agreement. The Department may also refuse to enter into subsequent agreements with you for up to 36 months.

This Agreement may also be terminated upon mutual agreement of the parties.

Both parties agree that except in case of emergencies such as illnesses, death, or fire, ten days advance notice shall be given to allow for the arrangement of alternate service provision for clients.

Agreement Renewal

This Agreement remains in effect until terminated or renewed. This Agreement may be renewed at any time by submitting a new CCA Provider Agreement, form 470-3871.