



**Child Care Payment Questionnaire**  
 Department of Social Services  
 Division of Family Independence | CED & TA  
 B-3923(3/2018)

First Name	M.I.	Last Name	Case Number
Address		City	Zip Code

**Please complete this questionnaire with your child care provider and return it to the worker listed below. A separate questionnaire is required for each child care provider. A new questionnaire must be completed:**

- ❖ with each Certification and Recertification
- ❖ if there is a change in child care providers
- ❖ if there is a change in your hours of employment
- ❖ if there is a change in your household composition
- ❖ if there is a change in the cost of your child care

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**TO BE COMPLETED BY CENTER/PROVIDER**

Provider	DBA Name		
Provider SSN	OR	DBA TAX ID	
Address Where Care is Provided		City	Zip Code
Mailing Address		City	Zip Code
Contact Person			Telephone Number
License #	License Period _____ to _____		
CCFS ID #	Expiration Date	Vendor #	
Are you in Receipt of Temporary Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No		TA Case #, if applicable	
Please indicate if your business can be categorized as being owned by any of the following <input type="checkbox"/> AA-Asian American <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> AI-Native American <input type="checkbox"/> WO-Woman Owned <input type="checkbox"/> Veteran Owned			
Type of Child care			
<input type="checkbox"/> Day Care Center		<input type="checkbox"/> Legally Exempt Relative in Parent's Home	
<input type="checkbox"/> Group Family Day Care Provider		<input type="checkbox"/> Legally Exempt Non-Relative In Parent's Home	
<input type="checkbox"/> Family Day Care Provider		<input type="checkbox"/> Legally Exempt Relative in Relative's Home	
<input type="checkbox"/> School Age Child Care Program		<input type="checkbox"/> Legally Exempt Non-Relative in Non-Relative's Home	
Provider Signature		Date	

**RETURN TO:**

Caseworker/Examiner	Unit/Worker#	Phone #
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**PARENT - Complete**

Place of Employment/Training					Mode of transportation <input type="checkbox"/> Car <input type="checkbox"/> Public transportation <input type="checkbox"/> Other (specify):		
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Daily Work/Training Schedule (e.g. 9am-5pm)							
Travel time from child care provider to work/approved activity (e.g. 25 minutes):							
Travel time from work/approved activity to child care provider (e.g. 25 minutes):							

**PROVIDER – Complete for each child in care**

	Child 1	Child 2	Child 3	Child 4	Child 5
Child's Name					
Child's DOB					
Name of child's school					
Child's School schedule (e.g. 9:00 am – 3:55 pm)					
Date child started in care					
Hours in care per day					
Days in care per week	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
Hourly cost of child care					
Part day cost of child care					
Daily cost of child care					
Weekly cost of child care					

**NOTE:** Payments will be based on the actual number of hours employed, plus a reasonable travel time allowance.

**THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

Client Signature	Date	Provider Signature	Date
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