



State of Illinois  
Department of Human Services

**REQUEST FOR A CHILD CARE PROVIDER CHANGE**

Child Care Case Number: \_\_\_\_\_ Date: \_\_\_\_\_

Client:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List a phone number where we can reach you during the day:

Hm: \_\_\_\_\_

Wk: \_\_\_\_\_

**ONLY Complete & Return WHEN you CHANGE or ADD Another Provider**

DO NOT fill this out if you have already sent in a form for your new provider.

**If you change providers or add another provider**, you and your new provider must complete and SIGN the attached pages. Be sure to also complete this cover page. Return this cover page with the attached pages to the address listed below. We MUST have this information before we can make payments to your new provider.

You and your provider will be notified within 30 days after we receive the completed information. After your new provider is approved, we will send the new provider a billing form, called a Child Care Certificate.

**If you are CHANGING providers, complete this box.**

• Name of New Provider:

• What was the FIRST DATE this provider began caring for your child(ren)?

\_\_\_\_\_

• Name of Provider you are replacing:

• What was the LAST DATE this provider cared for your child(ren)?

\_\_\_\_\_

**If you are ADDING another provider, complete this box.**

• Name of Provider:

• What was the FIRST DATE this provider began caring for your child(ren)?

\_\_\_\_\_

If your new child care provider is not willing to complete the attached pages, call \_\_\_\_\_ for a parent counselor at the Child Care Resource and Referral agency. They may be able to help you find a new provider.

The Department reserves the right to require proof of all information in the attached pages.

Illinois Action For Children  
Child Care Assistance Program  
1340 S. Damen Avenue, 3rd Floor  
Chicago, IL 60608  
Phone (312) 823-1100  
Fax (312) 823-1200

APPLICANT'S NAME:

### SECTION V - PROVIDER INFORMATION

To be completed by the Applicant and the Provider TOGETHER (Please Print In Ink)

Do you have more than one child care provider for this application?  YES  NO

If YES, list your other Child Care Provider(s): \_\_\_\_\_

If YES, you MUST photocopy pages 5 & 6 and complete a separate child care arrangement section for each provider.

Do any of your other children attend Head Start, Pre-K, or Child Care at another provider not on this application?  YES  NO

If YES, list your other Child Care Provider(s): \_\_\_\_\_

**Parents or stepparents cannot be paid to provide child care for any children in the home.  
Providers must be at least 18 years of age and clear a CANTS check every two years.**

Name of Provider \_\_\_\_\_ If you are a Day Care Center, Corporate Name \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address, if different than above: \_\_\_\_\_ County \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth (Not required for Centers and Licensed Providers) Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Must Complete One: **Social Security Number** (Individual or Sole Proprietor) \_\_\_\_\_  
**FEIN** (Corporation, Partnership or Sole Proprietor) \_\_\_\_\_  
**Gov't. Unit Code** (Public School or Park District) \_\_\_\_\_

Enter date provider recently began or will begin caring for children: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

### CHILD CARE ARRANGEMENT

List only the children who will be cared for by THIS provider (circle am or pm) If your children go to school, pre-K, or Head Start at another facility during the day, list only the hours that they are in child care with this provider. For school age children, list only the hours they are in child care.

CHILD'S NAME	AGE	TYPICAL SCHEDULE OF HOURS IN CHILD CARE								PROVIDER'S CURRENT DAILY RATE
			MON	TUE	WED	THU	FRI	SAT	SUN	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		FROM	am pm	am pm	am pm	am pm	am pm	am pm	am pm	
		TO	am pm	am pm	am pm	am pm	am pm	am pm	am pm	

Does this child care schedule vary?  YES  NO  
If yes, please explain: \_\_\_\_\_

Do you offer a multi-child/family discount?  YES  NO  
If yes, please explain: \_\_\_\_\_

### CHILD CARE COLLABORATIONS

Are you an IDHS approved Child Care Collaboration?  YES  NO  
Check all that apply:  Head Start  ISBE Pre-K

How long is your program?  9mo  12mo  other \_\_\_\_\_

APPLICANT'S NAME:

### LEGAL CARE ARRANGEMENT

Check the appropriate type of provider. If licensed, complete Day Care Licensing Information.

#### CENTERS AND LICENSED PROVIDERS

- Licensed Day Care Center (760)\*
- Day Care Center Exempt from Licensing (761)
- Licensed Day Care Home (762)\*
- Licensed Group Day Care Home (763)\*

#### \* DAY CARE LICENSING INFORMATION

(DO NOT enter a Foster Care License Number)

License Number \_\_\_\_\_

License Capacity: Day \_\_\_\_\_ Night \_\_\_\_\_

License Expiration \_\_\_\_\_

Hours of Operation: From \_\_\_\_\_ To \_\_\_\_\_

#### CARE BY A RELATIVE (LICENSE NOT REQUIRED)

- In the Child Care Provider's Home (765)
- In the Child's Home (767)

My relationship to the child(ren) is:

#### CARE BY A NON-RELATIVE (LICENSE NOT REQUIRED)

- In the Child Care Provider's Home (764)
- In the Child's Home (766)

### SECTION VI - PROVIDER CERTIFICATION

After reading each of the following statements, I certify that:

- Parents will have unrestricted access to their children at all times.
- All state and local fire, health and safety codes have been followed.
- All child care providers/staff will have a physical examination no more than two years old and a TB skin test documented and on file in the facility/home within 90 days of the signature date on this form. The TB skin test is to be no earlier than the date the provider/staff began providing child care services.
- All cleaning agents, poisons and other hazardous materials are stored in an area inaccessible to the child(ren).
- There are no firearms or ammunition in the home OR any firearms or ammunition in the home are stored in a locked cabinet or locked storage at all times.
- First aid supplies are readily available.
- There will be no corporal punishment.
- The children will be provided developmentally appropriate play activities.
- The children will be supervised (indoors and outdoors) at all times.
- I have not been responsible for the abuse or neglect of children in the past five (5) years or been responsible for acts of sexual molestation or sexual exploitation of children for the past twenty (20) years. I authorize the Dept. of Children and Family Services to check the Child Abuse and Neglect Tracking System (CANTS) to confirm this information for the Department of Human Services.
- **Have you ever been convicted of anything other than a minor traffic violation?**    YES    NO  
If yes, please explain: \_\_\_\_\_

- All of the statements listed above are true.
- The information provided about myself is true, correct and complete.
- I understand the information provided will be checked using State databases.
- I understand that the information provided will be disclosed only for administrative purposes and that I may be required to verify the information.
- I understand that I cannot be paid until I complete a W-9 form and I am certified by the Office of the Comptroller.
- I understand that I am responsible for collecting a co-payment from each family.
- I understand that the rates charged to the State of Illinois do not exceed those charged to the general public for similar services and do not exceed the maximum allowed by the State.
- I certify that if I am a center provider, licensed home, or group home, I will maintain, for a minimum of 5 years from the date of payment, daily attendance records to fully document the extent of services provided and agree to make all records and supporting documentation relevant to the services billed herein available to any and all authorized Department representatives and Federal authorities. I understand that failure to maintain adequate records shall establish a presumption in favor of the State for any funds paid by the State for which adequate documentation is not available to support disbursement.
- I understand giving false information or failure to provide correct information can result in pay back of overpayments and/or referral for prosecution for fraud.
- I understand that deliberately providing an incorrect/fictitious Social Security number in order to defraud the State of Illinois will cause me to be prosecuted to the fullest extent of the law.

Child Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION VII - APPLICANT CERTIFICATION

**After reading each of the following statements, I certify that:**

- I understand that I am responsible for paying a share of my child care costs (parent co-payment) to my provider and that failure to do so may result in the loss of my child care provider.
- I understand that my eligibility will be redetermined every 6 months or as needed.
- The child(ren) is/are current on all immunizations and verification is on file with the provider.
- A review of each facility/home has been completed and I agree that it is a safe environment.
- I have given written notification to each provider if I want anyone other than myself to pick up the child(ren).
- An emergency phone number and written consent for medical care and for dispensing prescription medication has been given to each provider.
- The name of the family physician is on file with each provider.
- I am responsible for the selection of the child care providers for my child(ren).
- I will report any change in child care arrangements or employment within **5 days**. Failure to report changes in a timely manner may result in pay back of overpayments and/or loss of child care benefits.
- I understand that I must be working or attending an IDHS approved education, training, or other work related activity in order to be eligible to receive child care benefits.
- I understand the information provided will be checked using State databases, and if inconsistencies are discovered, the processing of my application may be delayed or denied.
  
- All of the statements listed above are true.
- The information provided about my case is true, correct and complete.
- I understand that I am not required to provide my Social Security Number and that if I deliberately provide an incorrect or fictitious Social Security Number I may be prosecuted for fraud.
- The information provided will be disclosed only for administrative purposes and that I may be required to verify the information that I have provided.
- I understand that I have the right to appeal and to have a fair hearing of a grievance.
- I understand that giving false information or failure to provide correct information can result in pay back of overpayments and/or referral for prosecution for fraud.
- My signature is my consent and authorization for information to be released to the Illinois Department of Human Services or its agents that may establish my eligibility or my continued eligibility for the Child Care Program.

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_