CHILD CARE AND DEVELOPMENT FUND (CCDF)/ON MY WAY PRE-K (OMW) PROVIDER INFORMATION

State Form 57222 (R5 / 03-26)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF EARLY CHILDHOOD AND OUT OF SCHOOL LEARNING

INSTRUCTIONS: ***Your provider must complete this information in its entirety*** *and sign the form.*

Applicant/Co-Applicant. Please upload this document to your online application or submit this document to assist in prompt completion of your child care/OMW vouchers. If you wish to make a provider change, you must submit this form to the eligibility office by noon on Thursday, to be effective the following week or payment for care may become your responsibility. Your provider must allow unscheduled visits by a parent or legal guardian to their child care program during the hours the child care program is in operation. If you have any questions, please contact your local eligibility office.

Name of applicant	Applicant phone number	Applicant email address

Name of program	License / registration / exemption number	Provider's current Paths to QUALITY (PTQ) Level
		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Address where care is provided *(number and street, city, state, and ZIP code)*	**Program County**	**Program Telephone number** ( )

What date will the child begin care? ***(month, day, year)***	Is this a provider change?	Is this for a child who is reauthorizing their case?
/ /	☐ Yes ☐ No	☐ Yes ☐ No

Type of provider
☐ Licensed Home ☐ Licensed Center ☐ Registered Ministry ☐ License Exempt Home ☐ License Exempt Facility ☐ Providing Care in Child's Home ☐ Public, Private or Charter School

Hours of operation *(i.e. 7 AM to 6 PM)*	Days of operation *(Check all that apply.)*
	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Name of CCDF Child(ren) (*First and Last*)	**Date of Birth *(month/day/year)***	**Charge for Current Age**	***H -Half Day F- Full Day*** ***Kinder - G***	**Charge for Next Age Group** ***(For example: If child is currently Infant, list charge for Toddler)***	***School-Age (Before and After School)***	**School-Age Other *(Charge for School Break weeks, evening or weekend care)***

FOR SCHOOL AGE CHILDREN ONLY ***(Please include a school calendar for ALL School Aged children.)***

Date school year begins *(mo/day/yr)*	Date school year ends *(mo/day/yr)*	Does school-age child need break care vouchers?	Is this form On My Way Pre-K wraparound or break care?	Will child attend this same provider for summer?	Summer Program begin & end dates
/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	/ / - / /

FOR ON MY WAY PRE-K CHILDREN ONLY

All OMWPK vouchers must have a yearly monetary match component of at least five percent (5%) but not more than fifty percent (50%) of the tuition for eligible children under the Pre-K pilot program.

Name of OMW Child (*First and Last*)	**Date of Birth *(month/day/year)***	**OMW Pre-K Weekly Charge**	***H -Half Day F- Full Day***	**OMW Pre-K Start Date *(month/day/year)***	**OMW Pre-K End Date *(month/day/year)***	**Max Reimbursement for ALL Full-Time OMW providers**
						$147.82/week
						$147.82/week

If you are a public, private or charter school, does the OMW child listed need break care vouchers (weeks of care at a DIFFERENT provider when your school is closed/not in session)?
☐ **Yes** ☐ **No**

If yes, a school schedule must be provided

Are you related to any of the child(ren) listed above? ☐ Yes ☐ No	If Yes, *please list relationship.*

PROVIDER AFFIRMATION *Eligible providers must demonstrate compliance with CCDF Minimum Standards prior to participation in these programs*

I affirm the information provided on this application form is true and correct. Further, I affirm child care will be provided at the address listed above and agree to comply with the rules and regulations of the CCDF program available on www.childcarefinder.in.gov. I also understand I must allow unscheduled visits by a parent or legal guardian to my child care program during the hours my child care program is in operation. In signing this application, I certify I am the individual listed above or the authorized designee.

Signature of provider	Printed name of provider	Date *(month, day, year)*