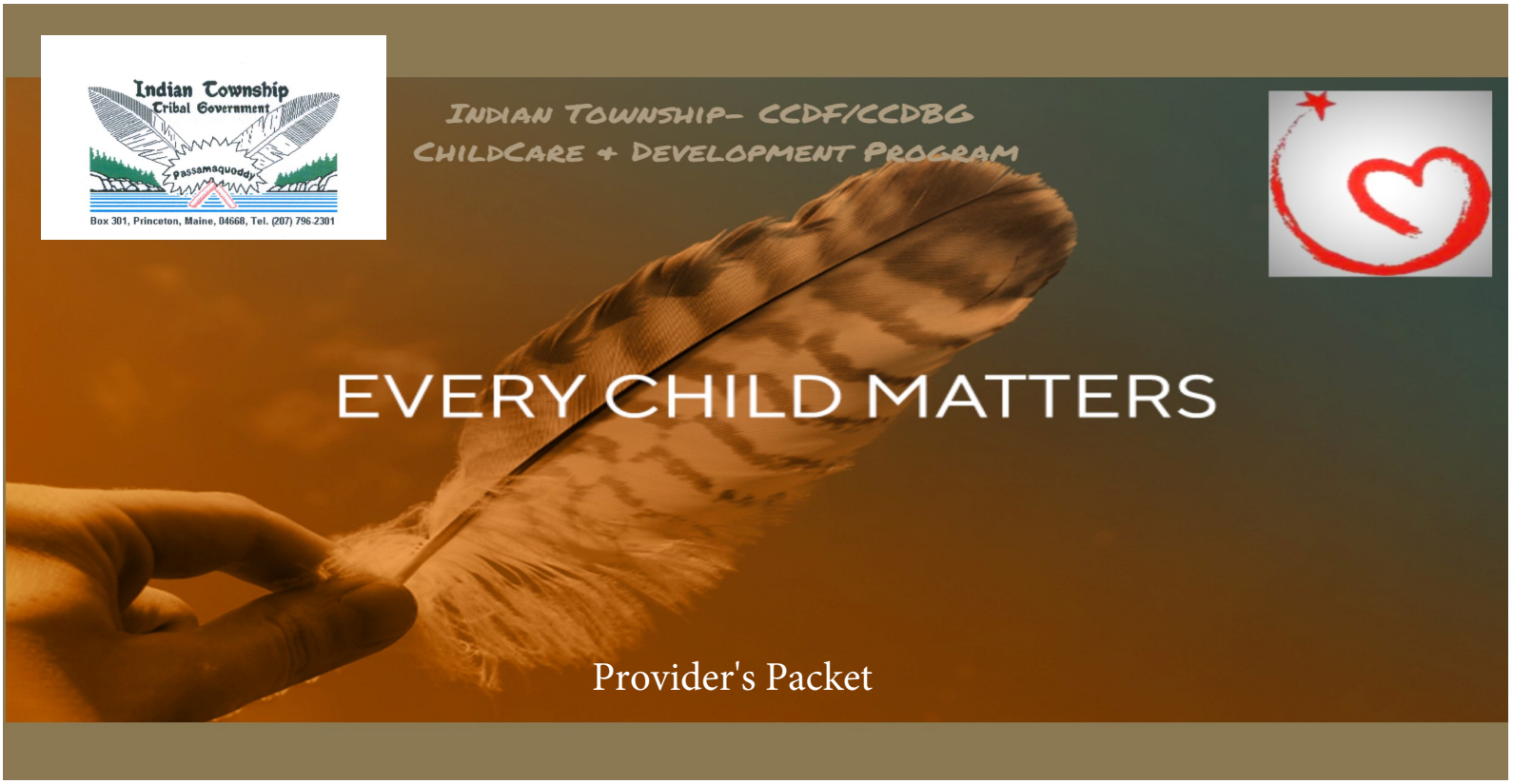

Provider types:

- In-home care- (in the parents' home only)
- Family care -(in the family home only) from a member of the child's immediate family (Adult sibling 18 and up or 16 with authorized adult supervision. aunt. uncle. grandparent or great-grandparent)
- Center-Licensed by the State of Maine.

  - Licensed- State Of Maine
  - Provisional- In the process of completing required certifications.
  - Certified- Tribal Certification

Packet-

1. Provider Checklist
2. Provider Contract W/Tribe ITCC
3. Provider Statement form
4. Provider and Parent/Guardian Agreement- Center, In-home/Family In-home
5. Independent Contractor Statement WCB-267
6. W9- can be found on our website - https://itccpass.com/
7. Sample Weekly Childcare Sheet- Weekly childcare forms are due every Monday by 10:00 am via email to ccdf@itccpass.com/t.d@itccpass.com, faxed 207-796-0822 or they can be submitted on our website. @ https://itccpass.com/contact-us. Both parent/guardian and provider must sign weekly childcare form. (form is interactive-fillable- download and save to your device)

PROVIDER'S CHECK LIST

PROVIDER'S Name:_____ **DATE:**_____

The following documents must be submitted during the application process.

All information/documents listed are mandatory and must be submitted before any payments are authorized.

We recommend you keep copies for your records.

*** Independent contractor response letters for In-home/Family Providers must be submitted not later than two weeks after signed Provider Agreement. Confirmation via fax or mail receipt will be accepted until we receive your response letter.**

[ ] Center [ ] In-Home [ ] Family In-Home

☐ W9- SUBMITTED (REQUIRED ANNUALLY)
(Center/In-Home/Family In-home)

☐ SIGNED AGREEMENT BETWEEN PROVIDER AND PARENT/GUARDIAN (ANNUALLY)
(Center/In-Home/Family In-home)

☐ COPY OF CURRENT STATE LICENSE- (ANNUALLY)
(Center)

☐ INDEPENDENT CONTRACTOR STATEMENT & EMAIL RESPONSE. (ANNUALLY)
(In-Home/Family In-Home)

☐ COPY OF ALL CERTIFICATIONS - MUST BE CURRENT!
(Mandated reporter, CPR & First Aid, Health & Safety standards)
(All Providers)

☐ CURRENT BACKGROUND CHECKS (SBI-& Fingerprint background checks are required)
(All Providers) (Including anyone in the household who is 18 and older for In-Home & Family In-Home)

☐ PROVIDER CONTRACT WITH TRIBE & Provider statement form (ANNUALLY)(All Provider)

☐ SAFETY INSPECTION * We will contact the providers and schedule the inspections.*

REVIEWED BY:_____ DATE:_____

(staff use) [ ] IN- REVIEW [ ] New [ ] Renewal ☐ Provisional

Passamaquoddy Tribe- Indian Township
Indian Township Child Care - CCDF/CCDBG

Provider Contract

Provider Name:_____

Address_____

Email: _____ Phone_____

SS#_____ or EIN#_____

Child Care License #_____

Certificates: _____ _____ _____ _____

Please list any current certifications- and provide copies to **ITCC ASAP**

This agreement made and entered into by and between the ***Passamaquoddy Tribe at Indian Township/ ITCC***, herein after referred to as the ***"Tribe"*** of ***Indian Township 8 Kennebasis RD PO. Box 301 Princeton, ME 04668*** and _____

☐ An individual,- In-Home (Family/Relative)- Authorized by the "**Tribe**"/ITCC

☐ A center licensed by the State Of (ME), -Center/ Family

☐ Other: _____

Herein after referred to as "**Provider**".

The ***Tribe*** wishes to enter into an agreement to provide Child Care Services and [_____] affirms and verifies that they are a Licensed Child Care business and/or a Certified Provider with the State and/or the ***Passamaquoddy tribe/ITCC*** and is willing, and able to perform the services herein described.

TERMS OF AGREEMENT

THE TERMS OF THIS AGREEMENT shall be in place from _____ to_____ and may be extended or renewed only upon prior written mutual consent of the parties.

IT IS AGREED AND UNDERSTOOD that child care services provided under this contract will be available from date of _____ to_____ and that said services will be provided in the following location:

_____

In the event the "***Provider's***" facilities become uninhabitable by sudden catastrophe and the "**Provider**" cannot obtain a suitable alternative facility within five days, this Contract shall become null and void without notice.

IT IS UNDERSTOOD AND AGREED that no services authorized under this Contract will be subcontracted by "***Provider***", to any other person, or entity without prior written approval by the ***"Tribe"***.

IT IS AGREED AND UNDERSTOOD that the ***Tribe*** will pay for services rendered by ***"Provider"*** for the above time period and only (s) in accordance with written authorization from the "***Tribe***" or each client served and

(b) upon receipt from ***"Provider"*** and verification of all required documents.

By initialing below, "***Provider***" agrees to the following conditions:

_____ •Licensed centers: The Tribe requires a copy of the provider's state license, any certificates, any accreditations they may hold, a copy of the Market Rates for professional childcare services-Daycare Centers, parent handbooks, and proof of back ground checks.

_____ •In-Home/Family Care: Tribe requires all interested providers complete our provider application, a W-9, an application for predetermination of independent contractor (per our finance dept), along with the official status of application, a fingerprint background check (This includes anyone in the household who is 18 or older), mandated reporter certificate, Infant and adult CPR & First Aid, and health and safety training certificates, for all in-home and family care providers, annually.

_____ Forms provided by the "***Tribe***" will be filled out completely and submitted before any payments will be receieved.

_____ ***"Provider"*** will allow unlimited access to the child care facility/home by parent/caretaker during normal hours of operation.

_____ ***"Provider"*** invoices to the "***Tribe***" will be authorized services and will be made at the same or lower rates as the child care charges made available by ***"Provider"*** to non- "***Tribe***" participants and will be submitted weekly, every Monday no later than 10:00 am unless provider requests monthly payments. Monthly submissions are due by the first Monday of the month no later than 10:00 am.

_____ Charges will not exceed the "***Tribe***" maximum scheduled rates.

_____ In areas where child care rates average higher than the standard subsidized rate paid by "***Tribe"***, the parent will be responsible for paying the additional amount over the standard rate paid by the "***Tribe***", as well as applicable co-payment (if any).

_____ "***PROVIDER***" shall clearly post all applicable fees and rates.

_____ In the event of overpayment by the "Tribe" at it's discretion may

(1) demand immediate reimbursement by the "Provider to the "Tribe"
(2) withhold the overpayment amount from future funds due and owing
(3) accept a mutually agreeable written repayment plan; or
(4) seek collection by litigation.

_____ The "***Tribe***" will determine eligibility for all authorized client services.

_____ Any parent receiving services from the "***Provider***" will have the right to a fair hearing with the "**Tribe**" in case of denial or termination of service.

_____ "***Provider***" will have the right to fair hearing with the "Tribe" in case of denial or termination of service.

_____ "***Provider***" must meet and maintain all Tribal, State, and Federal standards applicable to the authorized services being provided pursuant to this Contract.

_____ "***Provider***" shall, prior to renewal, or approval of this Contract, disclose to the "***Tribe***" the name of any person who has an ownership or controls an interest in, or is an agent or managing employee of "***Provider***," and who has been convicted of a criminal offense related to such person's involvement in a program under Title XVIII, XIX, or XX of the Social Security Act since inception of these programs.

_____ "***Provider***" AGREES to hold the "***Tribe***" harmless from any liability claims or damages that may result from the "***Provider's***" performance of its obligations under the terms of this agreement.

_____ "***Provider***" has complied and will comply with Tribal and Federal standards and State law, regarding safeguarding of information obtained pursuant to the provision of authorized services, hereunder; with the Civil Rights Act of 1964 as amended; and with the Rehabilitation Act of 1973 as amended, all including, but not limited to, giving equal opportunity to persons seeking employment and to persons seeking services without regard to age, race, color, religion, sex, national origin, or handicap.

_____ "***Provider***" acknowledges that funds provided under grants or contract may not be expended for any sectarian purpose or activity, including sectarian worship or instruction.

_____ Develop and maintain written records sufficient to document proper fiscal and program management of "***Provider's***" responsibilities under this Contract, all records to be retained for three (3) years. If the "***Tribe***" so specifies, "***Provider***" further agrees to utilize a uniform method of record keeping.

_____ All business records will be made available and accessible to the "***Tribe***" at any time, with or without notice, for the "***Tribe's***" use in inspecting, monitoring, evaluating, and auditing "***Provider's***" compliance with the terms of this Contract.

_____ Keep the "***Tribe***" apprised of any changes in their State or Tribal child care license/certifications to operate as a child care provider.

_____ In the event of revocation or denial, the "***Provider***" will notify the "***Tribe***" immediately or within 24 hours of notification from the State or Tribal Licensing Unit.

_____ In the event of probation, increased, or decreased capacity, the "***Provider***" will notify the "***Tribe***" within 5 days of notification from the State or Tribal Licensing Unit.

_____**"Provider" will maintain a drug, alcohol, and smoke free environment while providing care.**

All our required documents can be found on our website **https://itccpass.com/**

Forms can be found "Packets & Forms & Provider Forms **https://itccpass.com/packets-%26-forms**

PUBLIC LAW 103-277, PART C - ENVIROMENTAL TOBACCO SMOKE (also known as the Pro-Children Act of 1994) – Requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care, and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and local governments. Federal programs included grants, cooperative agreements, loans, or loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for in-patient drug and alcohol treatment.

Signature Page

This Contract may be canceled at any time by mutual consent of the parties. Either party, with or without cause, will give up to thirty (30) days written notice of intent to cancel to the other party. The term “with cause” is defined as failure to meet the terms and conditions of the Contract.

TRIBE/ORGANIZATION:

Name: _____

Title:_____

Organization: _____

_____ _____

Signature Date

PROVIDER:

Name: _____

Title: _____

Program Name: _____

License Number: _____

_____ _____

Signature Date

(This form expires one year from the date of signatures)

Passamaquoddy Tribe- Indian Township
Indian Township Child Care - CCDF/CCDBG
8 Kennebasis RD-PO. Box 301 Princeton, ME 04668
207-796-2301 (ext 6610)
https://itccpass.com/
https://www.facebook.com/ITCCpass/

Indian Township Tribal Government
Passamaquoddy
Box 301, Princeton, Maine, 04668, Tel. (207) 796-2301

Passamaquoddy Tribe- Indian Township Indian Township Child Care - CCDF/CCDBG

Phone:207-796-6110
Fax:207-796-0822

PROVIDER'S STATEMENT

I, _____ am providing child care services for the children of _____.

_____has unlimited access to their children while in my care.
(Parent's name)

Please check one of the following statements:

_____ I am a licensed child care provider (_____)
Name of Licensing Agency

_____ I am a unlicensed child care provider, I am over 18 years old (___/___/___) and not of the same household.

_____ I am related to this family, and I am unlicensed child care provider. I do not live in the same household and I am over 18 years old. Relationship to children:_____

IF YOU ARE UNLICENSED PLEASE SUBMIT A LIST OF EVERYONE LIVING IN YOUR HOUSEHOLD (on second page)

I understand that partial to full payment of these services may be paid for by the ITCC Child Care Program under the Child Care Assistance Sliding Fee Program. It is the child care provider's responsibility to notify ITCC Child Care Program of any changes of address, telephone number or cancellation of you child care services to the family listed above.

I also understand that it is my responsibility to complete each weekly child care form thoroughly (accurate dates/time, hours, name, current address) with the appropriate signatures. The parent(s) for whom I am providing services will also sign the weekly Child Care form for verification of dates/times and hours submitted. I understand that I need to submit the completed child care hours according to the approval letter provided to me by the Child Care Program.

If I am a licensed provider, I have attached a copy of my Policy/Parent handbook, Contract, provider agreement and agree to follow the policy for all families in my care. If my Child Care Policy/handbook states that I charge for absent days, I must record the number of days that the child(ren) are not in my care, but, for which I charge on the weekly childcare form.

There are a maximum number of childcare hours allowed which is agreed upon between the agency and the client. These authorized hours are stated in the approval letter, which is sent to the parent(s) and provider. The parent(s) are responsible for ANY AND ALL UNAUTHORIZED HOURS TO THE PROVIDER.

I understand that by signing my name on the claim and accepting payment for services, I am indicating that the information provided on the claim is true to the best of my knowledge. I am aware of the importance of being accurate and responsible for the information provided.

Any questions relating to the Child Care Assistance Basic Sliding Fee Program can be directed to the Child Care Program Coordinator.

_____ _____
Signature of Child Care Provider Date

_____
Address City State ZIP

_____ _____
Provider's Email Address Provider's home phone number

By signing this form, I understand the responsibilities relating to both my child care provider and myself. I am also giving my permission to the Child Care Program to discuss my child care assistance with my child care provider.

_____ _____
Signature of Parent Date

(This form expires one year from the date of signatures)

Unlicensed Providers only, please list all the names of ALL children and adults in your home:

Full name	Relationship	Date of Birth
Full name	Relationship	Date of Birth
Full name	Relationship	Date of Birth
Full name	Relationship	Date of Birth
Full name	Relationship	Date of Birth
Full name	Relationship	Date of Birth

We are on the web

Check out our website and Facebook page !

https://itccpass.com/

https://www.facebook.com/ITCCpass/

Indian Township Child Care- CCDF/CCDBG

CHILD CARE PROVIDER AGREEMENT

The Child Care Certificate Program is a subsidy for eligible families to use with state licensed or approved in-home/ family child care providers who are willing to accept CCDF/CCDBG funds.

You have been selected by this family to provide services to children who have been approved for coverage by the Certificate program, in order to authorize the services, the information below is needed.

*** BEFORE/AFTER CARE: before or after school.**

Please check which type of provider: ☐ **In-Home** ☐ **Family In-Home**

Parent Name: _____

CHILD CARE PROVIDER NAME					DATE OF BIRTH:	
PHYSICAL ADDRESS					MAILING ADDRESS ☐ SAME AS PHYSICAL	
MAILING ADDRESS						
TELEPHONE #	EMAIL			*DO YOU HOLD ANY CERTIFICATIONS OR LICENSES? IF YES, WHAT TYPE?*	☐ YES ☐ NO	
NON-LICENSED PROVIDERS RATES WILL BE SET BY PROGRAM. ☐ Quarter time hrs (0-5hrs per Wk) # of kids : _____						
CHILD'S NAME	First:		Last:		AGE:	
ENROLLMENT *(Select only those that apply)*	☐FULL TIME 30+ hrs		☐PART TIME 20-29hrs		☐HALF TIME 10-19hrs	
Relation to child:	WHAT DAYS	**Drop off time**	Pick up time	HRS PER DAY	HRS PER WK	**BEFORE/AFTER CARE**
CHILD'S NAME	First:		Last:		AGE:	
ENROLLMENT *(Select only those that apply)*	☐FULL TIME 30+ hrs		☐PART TIME 20-29hrs		☐HALF TIME 10-19hrs	
Relation to child:	WHAT DAYS	**Drop off time**	Pick up time	**HRS PER DAY**	HRS PER WK	**BEFORE/AFTER CARE**
CHILD'S NAME	First:		Last:		AGE:	
ENROLLMENT *(Select only those that apply)*	☐FULL TIME 30+ hrs		☐PART TIME 20-29hrs		☐HALF TIME 10-19hrs	
Relation to child:	WHAT DAYS	**Drop off time**	Pick up time	HRS PER DAY	HRS PER WK	**BEFORE/AFTER CARE**
CHILD'S NAME	First:		Last:		AGE:	
ENROLLMENT *(Select only those that apply)*	☐FULL TIME 30+ hrs		☐PART TIME 20-29hrs		☐HALF TIME 10-19hrs	
Relation to child:	WHAT DAYS	**Drop off time**	Pick up time	**HRS PER DAY**	HRS PER WK	**BEFORE/AFTER CARE**

Please review, sign and date second page of form and send both pages along with any current certifications or licenses you may have.

NOTES:

PARENT/PROVIDER AGREEMENT: FOR IN-HOME OR FAMILY CARE SERVICES

- **In-home care (in the parents' home only)**
- **Family care (in the family home only) from a member of the child's immediate family (Adult sibling 18 and up or 16 with authorized adult supervision. aunt. uncle. grandparent or great-grandparent).**

***All providers must complete a fingerprint background check.**
***Anyone over 18 in the home must complete a fingerprint background.**

1. The Office Of ITCC, hereafter referred to as the "Tribe", has determined that the State of Maine Fair Market Rate value for childcare services for the child{ren) named above is $, _____ per (day, hour). Set by the program.

2. The Tribe may change or terminate its subsidy upon written notice to the other Parties at the sole discretion of the Tribe. Including acting in the best interest of the protection and safety of children.

3. It is understood that the Tribe will pay the Provider on a weekly basis. All required documentation must be filled out correctly signed and dated by both parties(weekly childcare sheets/attendance sheet/etc).

4. The Provider certifies that he/she is free of communicable diseases and is physically and mentally capable of caring for children.

5. The Provider assures that the Provider will: (a) protect the child(ren) against infectious diseases, (b) protect the child(ren) from physical or mental harm or abuse, and (c) ensure the health, safety and good nutrition of the child(ren).

6. The Provider understands that the tribal payment is for childcare services for children who are members and/or a descendant of the Passamaquoddy Tribe at Indian Township, and only for childcare received while the Parent is working, going to school, or receiving job training.

7. All Parties agree to remain in compliance with all policies and procedures of the Tribe's Child Care & Development Program. Including consenting to a background check.

8. The Provider understands that the Child Care Block Grant will only pay for those days the child physically attends. Sick days, vacation or holidays that the provider charges shall be billed directly to the parent for payment.

9. The Provider and Parent agree to give all parties two (2) week notice of withdrawal from the program.

10. Provider must complete all required paperwork for Indian Township tribal government finance dept IE. Independent contractor application, and W9 annually.

11. The Parent(s) and the Provider understand that the Tribe has a procedure to assess and substantiate grievances against providers and that the Tribe keeps a file of substantiated complaints at the tribal office that is available for public review.

12. All concerned parties realize that this is a parental choice program and that the Tribe has not inspected or warranted the condition of the child(ren)'s environment or the degree or type of supervision, and that the tribe may conduct an in-home monitoring and Health & Safety check at any time. The Tribe assumes no responsibility for injury or damage arising from the performance of this contract. The Provider and parent(s) understand that the tribe is a federally recognized Indian Tribe with sovereign immunity and cannot be held liable for harm arising from this program.

13. Any other written or unwritten agreement between the Parent(s) and the Provider that is not discussed here is solely between the parent(s) and the Provider. The Tribe assumes no responsibility for such agreements.

14. The Tribe may change the requirements upon written notice at the sole discretion of the Tribe.

Parent/Guardian Signature:_____ Date:_____

Provider Print:_____

Provider Signature_____ Date:_____

(This form expires one year from the date of signatures)

State of Maine Workers' Compensation Board
Independent Contractor Statement

Pursuant to 39-A M.R.S.A. § 105, I _____,
Name

_____ of _____,
Business Name City/Town

_____, state that I perform work as an independent contractor and/or construction subcontractor.
State

I understand that filing this statement creates a rebuttable presumption that I am an independent contractor and/or construction subcontractor and that:

- This statement is only valid if I perform work consistent with the definition of independent contractor and/or construction subcontractor in the Workers' Compensation Act;
- I can still file a claim with the Workers' Compensation Board if I am injured;
- This statement is valid for one year from the date it is received by the Workers' Compensation Board;
- This statement is not binding on the Department of Labor. The Department of Labor will not accept this form as evidence an individual is an independent contractor;
- Information from this form will be posted on the Workers' Compensation Board's website.
- All printed information must be legible or the form will not be accepted for filing.
- Questions/inquiries regarding this statement must be sent to ICS.WCB@maine.gov.

_____ _____
Signature Date

_____
Printed Name

THIS FORM IS ALSO AVAILABLE FOR ONLINE SUBMISSION AT:
https://www.maine.gov/wcb/Departments/coverage/independentcontractor.html

Indian Township Tribal Government
Passamaquoddy
Box 301, Princeton, Maine, 04668, Tel. (207) 796-2301

IndianTownship ChildCare/CCDF/CCDBG
Certificate Program Billing Form- (WeeklyChildcare)

- **Weekly Childcare submissions are due Monday's 10:00 am**
- **Monthly Submission are due the 1st Monday of each month by 10:00 am.**

Week ending:_____

Name of Provider:_____

Address:_____

Phone number/ Email:_____

CHILD CARE SERVICE DATES m/d-m/d/yy

Name of Child Receiving Services (Last, First)	m/d	m/d/yy	# of Hrs	Rate	Total$

Comments

Total weekly/monthly Charges: $_____

*Total billed to ITCC is not guaranteed to match what will be paid to the provider by the Certificate

*Form must be completely filled out , signed by both parties and service dates must be provided or you risk a hold.

Infant means a child six (6) weeks through twelve (12) months of age
Toddler is a child thirteen (13) months through thirty-six (36) months of age.
Preschooler is a child more than 36 months of age but not yet enrolled in Kindergarten. School age is a child enrolled in Kindergarten and up.

- In-home care (in the parents' home only)
- Family care (in the family home only) from a member of the child's immediate family (Adult sibling 18 and up or 16 with authorized adult supervision. (Aunt. uncle. grandparent or great-grandparent).

Service Type

- **Center Base** ☐
- **Family Care** ☐
- **In- home** ☐
- **FT-Full** ☐
- **PT- Part** ☐
- **HT- Half time** ☐
- **QT- Quarter time** ☐

Infant/Toddler/Preschooler

Full time - 30 + hours a week

Part time- **20-29** hours a week Half time- **10-19** hours a week Quarter time- **0-9** hours a week

School Age

Full time- **30** + hours a week

Part time- **11-29** hours a week

Halftime- **6-10** hours a week

Quarter time- **0-5** hours a week

Certification: I CERTIFY that the services listed on this statement were rendered on behalf of the above named persons; "under penalty of perjury" that this claim constitutes the full and complete charge for said services described above; that I will make no further claim for payment of these services; that these services have been provided without discrimination based upon age, race, color, creed, and or national origin; that this statement is subject to Federal and State Audit or Review.

Provider's Signature | Parent/s Signature | Date

Send to: Email -ccdf@ITCCpass.com or T.D@ITCCpass.com or you can submit directly to our website @ https://itccpass.com/ or send by fax to 207-796-0822 for processing

For billing questions email: Tracy Dore:T.D@ITCCpass.com

Indian Township
Tribal Government
Passamaquoddy

Box 301, Princeton, Maine, 04668, Tel. (207) 796-2301

Indian Township ChildCare/CCDF/CCDBG Certificate Billing Form- (Weekly Childcare)

This form is interactive

- **Weekly Childcare submissions are due Monday's 10:00 am**
- **Monthly Submission are due the 1st Monday of each month by 10:00 am.**

Week ending:_____

Name of Provider: _____

Address:_____

Phone number/ Email: _____

CHILD CARE SERVICE DATES m/d-m/d/yy

Name of Child Receiving Services (Last, First)	m/d	m/d/yy	# of Hrs	Rate	Total$
					$ 0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00

Comments

Total weekly/monthly Charges: $ $0.00

*Total billed to ITCC is not guaranteed to match what will be paid to the provider by the Certificate

Service Type

- Center Base ☐
- Family Care ☐
- In- home ☐
- FT- Full ☐
- PT- Part ☐
- HT- Half time ☐
- QT- Quarter time ☐

Infant/Toddler/Preschooler

Full time - 30 + hours a week

Part time- **20-29** hours a week

Half time- **10-19** hours a week

Quarter time- **0-9** hours a week

School Age

Full time- **30 +** hours a week

Part time- **11-29** hours a week

Halftime- **6-10** hours a week

Quarter time- **0-5** hours a week

Infant means a child six (6) weeks through twelve (12) months of age
Toddler is a child thirteen (13) months through thirty-six (36) months of age.
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- In-home care (in the parents' home only)
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Certification: I CERTIFY that the services listed on this statement were rendered on behalf of the above named persons; "under penalty of perjury" that this claim constitutes the full and complete charge for said services described above; that I will make no further claim for payment of these services; that these services have been provided without discrimination based upon age, race, color, creed, and or national origin; that this statement is subject to Federal and State Audit or Review.

Provider's Signature | Parent/s Signature | Date

Send to: Email -ccdf@ITCCpass.com or T.D@ITCCpass.com or you can submit directly to our website @ https://itccpass.com/ or send by fax to 207-796-0822 for processing

For billing questions email: Tracy Dore:T.D@ITCCpass.com