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**

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 ☐ Yes ☐ No	TA Case #, if applicable	

Please indicate if your business can be categorized as being owned by any of the following
☐ AA-Asian American ☐ Black ☐ Hispanic ☐ AI-Native American ☐ WO-Woman Owned ☐ Veteran Owned

Type of Child care

☐ Day Care Center	☐ Legally Exempt Relative in Parent's Home
☐ Group Family Day Care Provider	☐ Legally Exempt Non-Relative In Parent's Home
☐ Family Day Care Provider	☐ Legally Exempt Relative in Relative's Home
☐ School Age Child Care Program	☐ Legally Exempt Non-Relative in Non-Relative's Home

Provider Signature	Date

RETURN TO:

Caseworker/Examiner	Unit/Worker#	Phone #

PARENT - Complete							
Place of Employment/Training				Mode of transportation ☐ Car ☐ Public transportation ☐ 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	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ 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