IDAHO DEPARTMENT OF HEALTH & WELFARE

HW0427
Rev. 02/2015

Monthly Dependent Care Charges

This form is used to determine the monthly amount for child care; it is not an application for Child Care Assistance. You must complete an application for Child Care Assistance to have your eligibility determined.

- The **parent** must report a change in provider, parent's activity, child care need, or income.
- The **provider** must report if a child stops attending and any changes in the amount charged.

For office use only:		
Case Name	*IBES Number*	*Family Number*

PART A: Completed by the Parent

Full Name of Parent:	Telephone:
Home Address:	Work Phone:

PART B: Completed by the Provider

Section 1: Enrollment Information

You must have an active ICCP Vendor Number before you are eligible for any ICCP payments.

Are you a registered **I**daho **C**hild **C**are **P**rogram (ICCP) provider? ☐ Yes, Vendor #: ☐ No

Provider Name: Business Name:

Provider Phone:

Provider Address:

Section 2: Enrollment

☐ **New Enrollment - Enrollment Date:** Is there a one-time Registration Fee? ☐No ☐Yes: $

☐ **Change in Enrollment (select one):**

☐Change will take effect on (date):_____.

☐These are the final charges. The child(ren) will no longer attend this child care as of (date):_____.

If these are final charges, this form may be submitted without the parent's signature.

Section 3: Enrollment/Change Details (If more room is needed please write on the back.)

Name of Each Child Receiving Dependent Care	Monthly Cost per Child	Total Monthly Care Hours	Month of Care	Full Month Charges	Partial Month Charges
	$			☐	☐
	$			☐	☐
	$			☐	☐
	$			☐	☐

By signing this form, we acknowledge the above terms have been agreed upon by both parties.

Provider Signature **Vendor Number** **Date**

Parent Signature **Social Security Number** **Date**