

## **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. |  |              |  |                                   |    |  |     |
|---|--|--------------|--|-----------------------------------|----|--|-----|
| Case Name:  |  | Case Number: |  |                                   |    |  |     |
|   | Family Number:   |              |  | C. L. Number:                     |    |  |     |
| PART A: Completed by the Parent   |  |              |  |                                   |    |  |     |
| Full Name of Parent:  |  |              |  | Home Phone Number:                |    |  |     |
| Home Address:   |  |              |  | Work Phone Number:                |    |  |     |
| In Case of Emergency Contact:   |  |              |  |                                   |    |  |     |
| PART B: Completed by the Provider   |  |              |  |                                   |    |  |     |
| Date Child(ren) Started:  |  |              |  |                                   |    |  |     |
| Provider Name: Business N   |  |              |  | ame (if different):               |    |  |     |
| Provider Address:   |  |              |  |                                   |    |  |     |
| Provider Phone Number: Vendor Nu  |  |              |  | mber (if available):              |    |  |     |
| Are you a registered Idaho Child Care Program (ICCP) provider?  |  |              |  |                                   |    |  |     |
| Are you related to the children listed below?   |  |              |  |                                   |    |  |     |
| If Yes, what is your relationship to the children?  |  |              |  |                                   |    |  |     |
| For how many children do you usually provide care? (Include the children listed below, including your own children.)  |  |              |  |                                   |    |  |     |
| ☐ 6 or le   | ☐ 13 or more   |              |  |                                   |    |  |     |
| Name of Each Child Receiving<br>Dependent Care  | Total Cost for<br>Each Child<br>(Anticipated<br>Monthly)     | of Ho        | Number<br>ours of<br>Anticipated<br>nthly) | Is the Chi<br>Attendin<br>School? | g  | How is the Dependent<br>Care Billed? (Hour, Day,<br>Week, or Month.) |     |
|   | \$   |              | Hours                                      | ☐ Yes ☐                           | No | \$   | Per |
|   | \$   |              | Hours                                      | ☐ Yes ☐                           | No | \$   | Per |
|   | \$   |              | Hours                                      | ☐ Yes ☐                           | No | \$   | Per |
| \$ Hours Yes N  |  |              |  |                                   | No | \$   | Per |
| *For children who attend school, what is the rate/charge for days when there is no school? \$ Per   |  |              |  |                                   |    |  | Per |
| By signing this form, we acknowledge the above terms have been agreed upon by both parties.   |  |              |  |                                   |    |  |     |
| (Provider Signature)  | (Tax Identification Number or Social Security Number) (Date) |              |  |                                   |    |  |     |
| (Parent Signature)  | (Social S  |              |  | (Date)                            |    |  |     |