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| --- | --- | --- | --- |
| **State of Hawaii - Department of Human Services** |  | **Worker’s Name:** |       |
|  **Benefit, Employment & Support Services Division** |  | **Unit # / Tel:** |       |
|  |
|  **CHILD CARE CERTIFICATE AND PROVIDER CONFIRMATION FORM** |
|  |
| **A. FAMILY INFORMATION (To be completed by DHS Staff):**  |  | **Fingerprint By:** |       |
|  |
| **1.** | **CLIENT NAME:** |       |  | **CLIENT ID#** |       |
|  |
| **2.** | List the first and last name(s) of the child(ren) who receive care from the provider being certified: |
|  |
| **HANA Child ID #** |  | **Name(s) of Child(ren)** |  | **Date of Birth** (mm/dd/yy) |
|       |  |       |  |       |
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|       |  |       |  |        |
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|       |  |       |  |       |
|  |
| **3.** | **Certificate Start Date** (mm/dd/yy) |       |  |  |
|  |
| **B. CHILD CARE INFORMATION (To be completed by Client)** |
|  |
| **1.** | I understand that I am responsible to submit to the Department (DHS) all completed forms that require signature from my child care provider before DHS can determine if the child care payment can be authorized. |
|  |
| **2.** | If this child care provider is found to pose a risk to the health, safety, and welfare of my child, I understand that DHS will not authorize a child care payment. |
|  |
| **3.** | I agree to notify DHS if there are any changes to the information provided on this form. |
|  |
| **4.** | I understand that DHS may contact my provider to discuss or verify any information regarding the information provided on this form. |
|  |
| **5.** | I understand that if I have an **in-home** child care provider, I am responsible to follow Federal wage and income tax laws governing domestic workers. I, as an employer, am responsible for all taxes and withholding and for paying minimum wage. Internal Revenue Service (IRS) Contact information provided is:  The IRS may be contacted at www.IRS.gov or by telephone at 1-800-829-4933. |
|  |
| **6.** | Payment method: I select to have the child care payment go to (select only one option below): |
|  |
|  | *[ ]* **My Electronic Benefits Transfer (EBT) card or direct deposit to my checking or savings account** |
|  | * I understand the EBT cardholder is responsible to pay the child care provider at the beginning of the month; to report lost or stolen EBT cards immediately by calling the EBT toll-free customer service telephone number and understand that there will be no replacement of any benefits accessed with an EBT card prior to the card being reported lost or stolen.
 |
|  | * I understand that the EBT cardholder is responsible to report immediately any changes in the status of alternate payee and that there will be no replacement of any benefits accessed by alternate payees or any other individuals using an EBT card and a valid PIN.
 |
|  | * I understand that child care subsidies are included under DHS “cash assistance household” accounts, and that child care benefits not withdrawn from my EBT account within ninety (90) days will be returned to the State. Child care benefits that are returned to the State may be used to offset any outstanding over-payments owed by the household. (HAR §§17-798.3-22, 17-681-51, 17-681-52, and 17-681-56)
 |
|  | [ ]  **Designated Provider Payment (DPP) to the provider I have chosen, named on part C below on this form** |
|  | * I understand that DPP is a payment method as designated by myself that authorizes DHS to transfer my child care subsidy funds which are deposited directly to my EBT account into my provider’s bank account via an Electronic Fund Transfer.
 |
|  | * I understand that all DHS-licensed and registered child care facilities and homes can apply for DPP authorization (forms can be requested through the program’s assigned licensing worker).
 |
|  | * I understand that this is an optional payment delivery method that is designated by myself. Some child care providers require DPP to the provider as a condition of enrollment and payment received at the beginning of the month.
* I understand that any designated staff member of my DHS-licensed child care provider who is granted access to the DHS portal may view my monthly payment information, which includes my name, my DHS-assigned client number, the names(s) of the child(ren) receiving payments, and my child care payment amount(s).
* I understand that if my child care provider stops participating as a DHS-Designated Provider Payment licensed provider or waives DPP as a method of payment, I shall be responsible for making the payments directly to my child care provider.
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|       |  |  |  |       |
| **Client’s Name (Printed)**: |  | **Client’s Signature**: |  | **Date:** |
|  |
| **C. CHILD CARE PROVIDER INFORMATION (To be completed by all providers):** |
|  |
| **1.** | Provider Name: |       | Phone: |       |
|  |
| **2.** | Facility Address: |       | Mailing Address: |       |
|  |
|  |       |  |       |
| **3.** | Tax ID No. (TIN) for center-based providers |       | Service ID assigned by DHS |       |
|  |
| **4.** | Social Security No. (last 4-digits) for home-based providers | XXX-XX- |       |  |
|  |
| **5.** | Do you receive financial, SNAP, or medical assistance from the State? | [ ]  No | [ ]  Yes, specify |       |
|  |
| **6.** | Care type: **(select only one option from 6a, 6b or 6c)** |
|  | **a. Licensed or Registered Providers:** |  |
|  |
|  | [ ]  Accredited Registered Family Child Care Home  | [ ]  Licensed Group Child Care Center |
|  | [ ]  Accredited Infant/Toddler Registered Family Child Care Home | [ ]  Licensed Group Child Care Home |
|  | [ ]  Accredited Licensed Group Child Care Center | [ ]  Licensed Infant/Toddler Child Care Center  |
|  | [ ]  Hawaiian Medium Group Child Care Center  | [ ]  Licensed Intercession/Before/After School  |
|  |  | [ ]  Registered Family Child Care Home |
|  |
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| **b. Exempt Providers:** |  | **c. Exempt Providers Listed with DHS:** |
|  |
| [ ]  Exempt Family Child Care | [ ]  Exempt Center Based Care |
| [ ]  Non-Relative Care in Child’s Home | [ ]  Exempt Intercession Care |
| [ ]  Relative Care Not in Child’s Home |
| [ ]  Relative Care in Child’s Home |
|  |

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| **7.** | Date that child will begin/has begun care at this facility: |       |  |
|  |
| **8.** | Day(s) and times care is provided:  *complete one (1) week below* | *[ ]* Check this box if days and times vary |
|  |
| **[ ]  Sun** | **[ ]  Mon** | **[ ]  Tues** | **[ ]  Wed** | **[ ]  Thurs** | **[ ]  Fri** | **[ ]  Sat** |
| **Start:** | **am****pm** | **Start:** | **am****pm** | **Start:** | **am****pm** | **Start:** | **am****pm** | **Start:** | **am****pm** | **Start:** |  **am** **pm** | **Start:** | **am****pm** |
| **End:** | **am****pm** | **End:** | **am****pm** | **End:** | **am****pm** | **End:** | **am****pm** | **End:** | **am****pm** | **End:** |  **am** **pm** | **End:** | **am****pm** |
|  |
| **9.** | Child care cost (amount charged) per month/per child: **$** |       | Parent’s portion: **$** |       |  |
|  |
|  **10.** | Provider scholarships/child care assistance other than from DHS: **$** |       | Source: |       |
|  |
| **11.** | Registration and/or activity fee once per State fiscal year (July 1 – June 30): **$** |       |  |
|  |
| **12.** | I understand that the department may contact me to verify information provided on this form. |
|  |
| **Completed by (Print Name):** |       |  | **Title:** |       |
|  |
|  |
|  **Signature:** |  |  | **Date:** |       |  |
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| **D. PROVIDER SELF-CERTIFICATION: To be completed by all providers, except for DHS licensed or registered providers:** |
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| **1.** | I am at least 18 years of age: | *[ ]* Yes | *[ ]*  No |
|  |
| **2.** | I am licensed or certified to provide child care by the U.S. Dept. of Defense: | *[ ]* Yes | *[ ]* No |
|  |
| **3.** | This facility is licensed or certified by the Dept. of Education:  | *[ ]* Yes | *[ ]* No |
|  |
| **4.** | I provide care in my home/center for |       | children. | Number of subsidized children: |       |  |
| For home-based providers, complete DHS 918-B ***“Exempt Home-Based Provider’s Relationship to All Children in Care”*** form |
|  |
| **5.** | I understand I must be licensed or registered by DHS if I provide care to more than two (2) children who are not related to me unless I am licensed or certified under D.2. or D.3. above. |
|  |
| **Names of Adult Household Members, or Staff, as applicable** | **Name (Print)** |  **Birthdate (mm/dd/yy)** | **Relationship to Child in Care** |
|       |       |       |
|       |       |       |
|       |       |       |
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| **6.** | I understand the children’s parents shall be permitted access when their children are in my care. |
|  |
| **7.** | I certify that I comply with the health and safety requirements and have signed the attached DHS 919, Health and Safety Requirements for Child Care Subsidy Payments When Using Exempt Relative Home Based Providers or DHS 937, Health and Safety Requirements For Exempt Family Child Care Home-Based Providers. |
|  |
| **8.** | I understand that monies received as a child care provider are subject to taxation. |
|  |
| **9.** | Neither I nor members of my household/staff have been convicted of crimes or are known to have a history of child abuse or adult abuse which may indicate that the children’s health, safety or welfare may be endangered. |
|  |
| **10.** | Upon receipt of the appropriate instructions and forms, my household/staff and I will complete Authorization for Background Check and To Release Findings DHS 948 authorization forms to conduct the required background clearance checks, which may include but is not limited to State child abuse records check, State adult abuse records check, and national and State criminal history records checks. List names and birth dates of household members/staff above. **(Attach a separate sheet if more space is needed.)** |
|  |
| **11.** | DHS may not authorize a child care subsidy payment to the client until all household members/staff have authorized the required background clearance checks and completed fingerprinting, if applicable. Furthermore, DHS will not authorize a child care payment to the client if any household member/staff is found to pose a risk to the health, safety, and welfare of children. |
|  |
| **12.** | I understand that the department may contact me to verify information provided on this form. |
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|  |
| **Completed by (Print Name):** |       |  | **Title:** |       |
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| **Child Care Provider Signature:** |  |  | **Date:** |       |  |

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| For more information on Child Care Subsidies, visit the DHS website: [**https://humanservices.hawaii.gov/bessd/ccch-subsidies/**](https://humanservices.hawaii.gov/bessd/ccch-subsidies/) |
|  |
| or you may contact the Child Care Subsidy Office at 1-855-643-1643 or email HawaiiCCSU@dhs.hawaii.gov.  |
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