

Case Name:  
 Case Number:  
 Date:  
 DHS Office:  
 Specialist:  
 Phone:  
 Fax:  
 Specialist ID:

**STATE OF MICHIGAN**  
**Department of Human Services**

If you do not understand this, call a DHS office in your area.  
 DHS employees are prohibited by law from providing legal advice.  
 Si usted no entiende esto, llame a una oficina de DHS en su área.  
 La ley prohíbe a los empleados de DHS proporcionar asesoría legal.  
 إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.  
 يحرم القانون على موظفي DHS إعطاء النصيحة القانونية.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

**AUTHORITY:** Public Act 280 of 1939.

**COMPLETION:** Mandatory.

**CONSEQUENCE FOR NONCOMPLETION:** Child care subsidy payments will not be authorized.

**CHILD DEVELOPMENT AND CARE PROVIDER VERIFICATION**

**INSTRUCTIONS:**

**Due Date:**

- Complete the form below.
- Read and certify that you agree to the statements on page 2. **Both the parent and provider MUST sign and date the form on page 2.**
- Return the completed form to your specialist in the local DHS office.
- You will be sent notification if care is authorized.
- The parent is responsible for child care expenses that are not paid by DHS, including expenses incurred while a parent's or provider's eligibility is being determined.

**TO BE COMPLETED BY PROVIDER:**

Child Care Provider or Child Care Center Director Name	Child Care Center Name (Centers Only)	County
Address (Number and Street)	City	State <b>MI</b>
Provider ID Number	Zip Code	Telephone Number (      )
Do you receive any other reimbursement for caring for any of the children listed below? <input type="checkbox"/> NO <input type="checkbox"/> YES → If yes, for whom?      From whom?		
Where do you provide the child care? (Check one box only.) <i>If you are an unlicensed child care provider who is not related to the children in care, you MUST only provide care in the home where the child lives.</i> <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> GROUP CHILD CARE HOME <input type="checkbox"/> FAMILY CHILD CARE HOME <input type="checkbox"/> HOME WHERE THE CHILD LIVES <input type="checkbox"/> MY HOME		

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List all children in the parent/substitute parent's family who are in your care.	Date of Birth	Date Care Began	Are you related to this child?	If yes, what is your relationship?
			<input type="checkbox"/> NO <input type="checkbox"/> YES →	
			<input type="checkbox"/> NO <input type="checkbox"/> YES →	
			<input type="checkbox"/> NO <input type="checkbox"/> YES →	
			<input type="checkbox"/> NO <input type="checkbox"/> YES →	
			<input type="checkbox"/> NO <input type="checkbox"/> YES →	
			<input type="checkbox"/> NO <input type="checkbox"/> YES →	

**PARENT/SUBSTITUTE PARENT:**

- 1) I certify that my child(ren) are or will be in care with this provider as of the "date care began" listed above.
- 2) I understand that the agreement for child care is an arrangement between myself and the provider.
- 3) I understand that the Department may request information from me in order to verify my provider's billing information.
- 4) I understand and agree that if an overpayment is made to my provider for any reason, the extra payments received must be repaid, and future payments to my provider, can be reduced by up to 20%.
- 5) I understand that I may be prosecuted for perjury or fraud if I intentionally leave out any information or give false information which causes child care benefits to be issued that my provider or myself are not entitled to, or more benefits than what my provider or myself are entitled to.
- 6) I understand that violation of program rules may result in a sanction of 6 months, 12 months, or a lifetime.
- 7) **I understand that if I choose an unlicensed provider:**
  - a. **I am responsible for any child care charges for periods before my provider completes the Great Start to Quality Orientation.**
  - b. **CDC payments will be issued to me and I am responsible for paying my provider.**
  - c. **I am responsible for reporting child care payments to the IRS and issuing my provider a Form W-2 or Form 1099 MISC, if appropriate.**

Parent/Substitute Parent Signature

Date

**PROVIDER:** I agree to all of the following:

- 1) **I understand if I am an unlicensed provider:**
  - a. **I must complete the Child Development and Care Unlicensed Provider Application found at [www.michigan.gov/childcare](http://www.michigan.gov/childcare) in order to apply to be CDC provider.**
  - b. **I will not receive CDC payment for any care I provide in periods before I complete the Great Start to Quality Orientation training.**
  - c. **CDC payments for care I provide will be issued to the parent of the child(ren) in care and the parent is responsible for paying me, reporting my wages to the IRS and issuing me a Form W-2 or Form 1099 MISC, when appropriate.**
- 2) I understand I am not employed by the State of Michigan or the CDC Program and am not eligible for unemployment insurance.
- 3) I will maintain time and attendance records for each child served, certified by each child's parent/substitute parent on a daily basis, and I will retain these records for four years.
- 4) I may be required to return CDC payments if an audit or investigation finds that I do not have the required attendance records.
- 5) Parents of the children in care will have unlimited access to their children while in my care.
- 6) If I am overpaid for any reason, including as a result of an error made by the parent or the Department, the incorrect payments received must be repaid, and the Department may retain up to 20% of future payments and apply the retained portion to my overpayment balance until the overpayment has been repaid.
- 7) I am responsible for all use of the CDC I-Billing system by anyone using my PIN.
- 8) I will immediately contact the CDC Central Reconciliation Unit at 1-866-990-3227 to request a PIN reset if I believe that a person not authorized by me to act as my representative has obtained my PIN.
- 9) I will not bill for hours when the child is in school, to hold a spot for a child, or if the child is not expected to return to my care.
- 10) I understand that I may be prosecuted for perjury or fraud if I intentionally leave out any information or give false information which causes child care benefits to be issued that the parent/substitute parent or myself are not entitled to, or are greater than what the parent/substitute parent or myself are entitled to.
- 11) I understand that violation of program rules may result in a sanction of 6 months, 12 months, or a lifetime.

Provider Signature

Date