

**Child Care And Development Fund Scholarship  
CHILD CARE PROVIDER AGREEMENT  
License-exempt Child Care**

Name of Provider	Program Name
of	of
Street Address	City, State and Zip

agrees to participate in the New Hampshire Child Care Development Fund (CCDF) Scholarship Program and comply with all the requirements set forth in this agreement.

I understand that failure to comply with the terms of this agreement is grounds for termination of participation in the New Hampshire CCDF Scholarship Program and for possible further action by the Department of Health & Human Services (DHHS).

I agree to comply with all laws, rules, policies, and procedures, including enrollment requirements and billing directions, regarding CCDF.

I agree to bill only for child care services provided in compliance with this agreement.

I agree to bill only for the time the child was in attendance.

I understand that as a child care provider:

1. I must be 16 years of age or older;
2. I may not reside in the same home as the parent and/or child for whom I am providing care;
3. I will not be paid for providing care to my own children; and,
4. I can provide care for up to 3 children, other than my own, at any given time.

I agree to bill DHHS weekly for services provided in the previous week on the Child Care Payment Request Invoice (Form 2500) or on the automated web billing system. I agree that invoices will not be paid unless they are completed correctly and are submitted to DHHS within 90 days after the services were provided.

I agree that by submitting an invoice to DHHS for services provided, I am certifying that the bill is true and accurate.

I understand that the Department will recover any payment made for inaccurate or fraudulent billing.

I agree that I will be the only person to submit invoices to DHHS for children under my care and supervision.

I agree that if I choose to submit invoices through the automated web billing method, DHHS will assign a Personal Identification Number (PIN) to me. I understand that I am responsible for all invoices submitted to DHHS using the PIN and that this PIN is non-transferable.

I agree that I will not sign or submit the child care payment request invoices until *after* the services have been provided. I further agree that I will not have the parent sign the child care payment request invoices until *after* the services have been rendered.

I agree that at all times for children receiving CCDF Scholarship under my care and supervision, I will be present and will directly provide care for those children.

I agree to keep all information concerning children and their families confidential except as otherwise allowed under law.

I agree to keep daily attendance records, which include start and stop times and parent/guardian's signature, and other records related to billing for a period of *seven years*. I agree to provide all such records and information related to billing and/or services provided to DHHS or its agents as requested.

I agree to contact DHHS if I believe that I have received an overpayment.

I agree to be responsible for reporting funds received under this agreement as income to DHHS each calendar year as required if I am receiving any other services from DHHS.

I agree that I am responsible for the payment of all required federal and state taxes accrued. DHHS will issue a Form 1099 in January of each year if total reportable payment from all state agencies equal \$600 or more.  
\*\* *Note* Form 1099 *will not* be issued for nonprofit agencies or corporations.

I agree that signing this form does not create an employer-employee relationship.

I agree that the decision to charge or not to charge all or part of the cost share determined by DHHS is between the provider and the parent.

I agree that the decision to charge all or part of the difference between what DHHS reimburses and the actual charge is between the provider and the parent.

I understand that I may be terminated from participation in CCDF for failure to comply with this agreement or DHHS rules related to child care assistance. Additionally, I understand that either party may terminate this agreement without cause following 30 days written notification by registered mail. This agreement may be terminated without advance notice if the provider has not billed in over one year, a child's health or safety is endangered or if the provider is determined to have fraudulently billed DHHS.

Any provider that has a founded fraudulent claim against them will be disqualified from participating in the CCDF Scholarship program for a minimum period of five years.

This agreement becomes effective upon the date of your signature:

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Name of Child Care Provider

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Signature

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Date

Return this signed form to the Child Development Bureau  
129 Pleasant Street  
Concord, New Hampshire 03301  
Keep a copy for your records

## Instructions for License-Exempt Child Care Provider Agreement

### **PURPOSE:**

All license-exempt child care providers enrolled through the Department of Health and Human Services to receive payments for providing child care through Child Care and Development Fund Scholarships must date and sign the agreement upon enrollment.

### **INSTRUCTIONS:**

Form 2631 must be completed by the child care provider. The completed form must be returned to the Child Development Bureau, Division for Children, Youth and Families.

The Child Development Bureau will return forms that have missing or incomplete information.

The Child Development Bureau will retain a copy of the completed form in the provider file.

### **FORM COMPLETION:**

Enter the full legal name and physical address of the child care provider.

Read the entire document and if you have any questions contact the Child Development Bureau.

Sign and date the form.

Send original and keep a copy for your records.

### **RETENTION:**

Form 2631 is retained permanently in the provider file.