# CHILD CARE PROVIDER ENROLLMENT FORM

**Enrollment Type:**  
- [ ] Employment Related  
- [ ] Preventive or Protective (DCYF)  
- [ ] Both  

**Today’s Date:**  
- [ ] Month  
- [ ] Day  
- [ ] Year

Resource Identification Number *(If not yet assigned, leave blank)*

<table>
<thead>
<tr>
<th>Resource Identification Number</th>
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## SECTION 1:

### PROVIDER NAME:  
*(Please Note: If you are reporting income with a Social Security Number, use your name here not the name of your business. If you are reporting income with an Employer Identification Number, use your business name here.)*

### DOING BUSINESS AS (DBA)  
*Complete this line only if you report income to the IRS under your Social Security Number and you choose to have a business name. You must also complete your name to the left.*

- [ ] Employer Identification Number (EIN)  
- [ ] Last four of your Social Security Number (SSN)

## SECTION 2:

### Primary Language spoken:**  

Do you need an interpreter?  
- [ ] Yes  
- [ ] No

**Provider / Program’s Physical Address:**  
- City/Town:  
- State:  
- Zip:  

**Billing or Mailing Address:**  
- City/Town:  
- State:  
- Zip:

**Providers’ Work Phone #:**  
**Provider’s Email Address:**  
**Contact Phone #:**

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**NOTE:** All provider payments are directed to the provider’s billing or mailing address. If you are a provider who forwards payments to a separate billing address or corporate headquarters, you must indicate the correct billing address above to avoid delays in payment.

## SECTION 3:

**Service Type Provided**  
Check the box for the service you provide:

- [ ] Child Care Licensed Center  
- [ ] Licensed Facility (01)

- [ ] Child Care Licensed Family Home  
  - [ ] In-Home – Relative (02)  
  - [ ] In-Home – Non Relative (03)

- [ ] Child Care License-Exempt Family/Friend/Neighbor  
  - [ ] Provider’s Home – Relative (04)  
  - [ ] Child’s Home – Relative (06)
  - [ ] Provider’s Home – Non Relative (05)  
  - [ ] Child’s Home – Non Relative (07)

**Age Range:**  
**Hours of Care:**  
**Days of Operation:**  
- [ ] Monday – Friday  
- [ ] Sunday – Sunday  
- [ ] Evenings  
- [ ] Other (Please explain):

- [ ] Child Care License-Exempt Center  
  - [ ] Licensed-Exempt Facility (08)

**Age Range:**  
**Hours of Care:**  
**Business Operation:**  
- [ ] Year Round  
- [ ] School Year  
- [ ] Summer Only
OFFICE USE ONLY

Enrollment Type: □ □ □ □ □
  New  Change  Renewal  Reopen

Enrollment Begin Date: _____

License-Exempt Background Check: Start Date: _____  End Date: _____

Child Care License Number: _____

License Begin Date: _____  End Date: _____

Suffix: __  Provider Code: __

AW9:  □ Yes  □ No

1099: □ Yes  □ No
Instructions for Completion of Provider Enrollment Form

PURPOSE:
The Child Care Provider Enrollment form is used to enroll child care providers who provide child care services and request a child care scholarship payment from the Department of Health and Human Services (DHHS).

INSTRUCTIONS:
Enrolled child care providers are subject to all Department rules, regulations, policies, and procedures. No payments will be made to any provider until the enrollment process has been completed and the provider has been notified by DHHS. DHHS does not withhold tax money for child care providers receiving child care payments for services. Payment of taxes is the responsibility of the child care provider.

All child care providers will be assigned a Resource Identification (ID) Number.

Reporting Changes: Providers are required to report all changes to DHHS such as changes of address, incorporation, or provider name and if you change from using a Social Security Number (SSN) to an Employer Identification Number (EIN). Changes must be reported to DHHS by submitting them on a new Form 1862 and Alternate W-9 Form to the address listed below. These two forms must be mailed together.

FORM COMPLETION:
- **Enrollment Type Change** – Choose only one of three enrollment options: employment related child care, preventive/protective child care (DCYF) Division for Children, Youth and Families, or both.
- **Effective Date** - Enter month, day, year. This date is the date you complete this form.
- **Resource Identification Number** - Enter your assigned Resource Identification Number from left to right leaving unused spaces blank at the end. If a Resource Identification Number is not yet assigned, leave blank.

Section 1
- **Provider Name** - This line must be completed whether you report income under your Social Security Number (SSN) or Employer Identification Number (EIN).
- Enter your own name here if you report income to the IRS under your Social Security Number. **Enter the name of your business** here only if you report income to the IRS with an Employer Identification Number (EIN).
- **Doing Business As (DBA)** - Complete this line only if you report income to the IRS under your Social Security Number. If you have a business name, enter it. You must also indicate your first name, middle initial and last name on the line provided above.
- **Employer Identification Number or Social Security Number** - Enter the number you use to report income to the IRS (Enter only one number, either the EIN# or the last four of the SSN#).
Section 2

- **Primary Language Spoken** – Indicate the primary language spoken by the child care provider.
  
  o Indicate **Yes** if an interpreter is required.

- **Provider Address** - Enter your physical, billing and/or mailing address (See **NOTE** on the front of this form).

- **Contact Person** - Enter the name, telephone number and email address of the person to contact for questions (if the same leave blank).

Section 3

- **Services Provided** - Check the box for the child care service type you provide. For License-Exempt Family/Friend/Neighbor indicate the age range of care provided, hours of care provided, and days the program operates (Monday-Friday, Sunday-Sunday, Evenings or Other). If ‘Other’ is selected, please explain. For License-Exempt Center indicate the age range of care provided, hours of care provided and whether the program operates year round, school year or summer only.

- Return this form along with a completed Alternate W-9 Form to:
  
  NH Department of Health and Human Services  
  DHES – BCDHSC  
  Attn: Enrollment Specialist  
  129 Pleasant Street  
  Concord, NH 03301

**RETENTION:**
This form is retained by the Bureau of Child Development and Head Start Collaboration in the provider file.