STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth, and Families

Form 1864
February 2017

PROTECTIVE CHILD CARE PROVIDER VERIFICATION

CHILD CARE PROVIDER NAME AND PHYSICAL ADDRESS:

Name: _____ Business Name: _____

Address: _____ Telephone Number: _____

_____ Message Number: _____

CHILD INFORMATION

Child's Full Name (First)	(Last)	Date Of Birth (mm/dd/yyyy)	Age of Child	Begin Date of Care (mm/dd/yyyy)	Care Provided: # Days per week	Care Provided: Hours per Day	Total Cost per Week**

** Please provide the rate that is charged for any child of this age for the number of hours the child attends your program each week. This is not the amount that Child Care Scholarship will reimburse; this is the weekly rate that is charged by the provider.

Child Care is provided in: ☐ Child's Home ☐ Provider's Home ☐ Child Care Center

☐ I agree that I must report any changes to the cost of care no later than 10 calendar days from the date of the change.

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

☐ I certify that the information is true and correct

I understand that the Department may release child care payment information to the above-named provider, for the purpose of verifying child care payment by the Department of Health & Human Services.

_____ _____ _____

Child Care Provider's Signature: Child Care Provider's Resource ID Number Date:

Instructions for Protective Child Care Provider Verification

PURPOSE:

The "Protective Child Care Provider Verification" is used to obtain the cost the provider charges each week for children in Protective Child Care.

INSTRUCTIONS:

The child care provider must complete a separate form for each family eligible for Protective Child care. The information on the form must be complete and legible. Changes in provider information must be reported to the Division for Children, Youth and Families Provider Relations no later than ten (10) days following the change.

FORM COMPLETION:

Provider's Name and Address: Enter the first and last names, business name if applicable, physical address and a telephone number where the provider can be reached or where a message can be left.

Child care providers must:

- Be 18 years or older to provide child care **and**
- Not be a parent of the child **and**
- Not be living in the child's home

Child Information: For each child in the family receiving child care from this provider indicate: the child's first and last name, the month/day/year when the child was born, the age of the child, the month/day/year when the child care began, the number of days per week care is provided, the number of hours per week the care is provided and the total cost per week.

If there is a change in the cost of care, the change must be reported to DHHS on a new Form 1864. This form must be completed and submitted to DHHS/DCYF Provider Relations, 129 Pleasant Street, Concord, N.H. 03301 no later than 10 calendar days from the date of the change. The Department will recover any payment made for inaccurate or fraudulent billing.

Where Child Care Is Provided: Indicate where the child care takes place by checking the box marked "Child's Home," the box marked "Provider's Home," or the box marked "Child Care Center.

Check the boxes indicating agreement to report changes in cost within timeframes, which you understand inaccurate or fraudulent billing will be recovered and that the information provided on the form is true and correct.

Signature: The child care provider must sign and date this form and indicate their Bridges Resource Identification number. If you are enrolling for the first time, leave the Resource Identification number blank.

RETENTION

This form is kept by the Division for Children, Youth and Families. Please make a copy for your records.