



State of Montana
Department of Public Health and Human Services
Quality Assurance Division
Child Care Licensing
<http://dphhs.mt.gov/qad/Licensure/LBCCL.aspx>

Legally Certified Provider (LCP) Application Packet

This application packet includes the following items:

Background Forms (items for all adults in your home)

There are two copies of the following items in the application packet. Call 406-444-0479 if you need more than two copies and do not have access to a copier.

- ◆ Release of Information
- ◆ FBI Fingerprint Disclosure Statement
- ◆ FBI Fingerprint Card – not included in packet (including payment to the MT Department of Justice)
- ◆ Current Montana-issued photo ID and Social Security Card (copies of these are acceptable)

Application Forms – Submit to Child Care Licensing

The below application forms are needed in order to apply to be a Legally Certified Provider. The checklist that is on the Application will go into further detail regarding each form.

- ◆ Legally Certified Provider Application (*includes the application checklist*)
- ◆ Family Association Form / Health and Safety Checklist
- ◆ W-9 Tax ID Form
- ◆ Statement of Health (all adults in your home)
- ◆ Medication Administration Attestation
- ◆ Immunization Certification/Waiver

Information – For you to keep

- ◆ What is a Legally Certified Provider (LCP)?
- ◆ Dane’s Law – Medication Administration Information
- ◆ LCP Online Orientation Tips

Parent Forms – For you to keep

The below forms are forms that are to be completed with the parent(s) of the child(ren) that you are going to be approved to care for and kept at the location where care is being done.

- ◆ Medication Authorization Form
- ◆ Over the Counter Medication Authorization Form

Provider Program Forms – For you to keep

The below forms are forms that are to be used for children in care.

- ◆ Medication Administration Log
- ◆ Medication Error/Incident Report

Mail Completed Packet To:

DPHHS/QAD/Child Care Licensing
PO Box 202953
Helena, MT 59620-2953

Phone: (406) 444-0479

Families seeking child care assistance must complete the Best Beginnings Child Care Scholarship application. These applications must be obtained from and submitted to their local Child Care Resource and Referral Agency. Please see agency listings below:

HRDC District 7	Phone Numbers	Counties
7 North 31st Street Billings, MT 59103	406-247-4732 800-433-1411	Big Horn, Carbon, Stillwater Sweet Grass, Treasure, Yellowstone
Child Care Connections	Phone Numbers	Counties
1600 Ellis St, Unit 1 A Bozeman, MT 59715	406-587-7786 800-962-0418	Gallatin, Meagher, Park
Butte 4 C's	Phone Numbers	Counties
101 East Broadway Butte, MT 59701	406-723-4019 800-794-4061	Beaverhead, Deer Lodge, Granite Madison, Powell, Silver Bow
Hi-Line Home Programs, INC	Phone Numbers	Counties
605 3rd Ave So Glasgow, MT 59230	406-228-9431 800-659-3673	Daniels, Roosevelt, Phillips, Sheridan, Valley
Family Connections - MT	Phone Numbers	Counties
202 2nd Ave So Suite 201 Great Falls, MT 59405	406-761-6010 800-696-4503	Cascade, Chouteau, Glacier, Pondera, Teton, Toole
Dist IV HRDC Child Care Link	Phone Numbers	Counties
2229 5th Ave Havre, MT 59501	406-265-6743 800-640-6743	Blaine, Hill, Liberty
Child Care Partnerships	Phone Numbers	Counties
901 N. Benton Ave Helena, MT 59601	406-443-4608 800-244-5368	Broadwater, Jefferson, Lewis & Clark
The Nurturing Center	Phone Numbers	Counties
146 3rd Ave W Kalispell, MT 59901	406-756-1414 800-204-0644	Flathead, Lake, Lincoln, Sanders
HRDC Dist VI Child Care Link	Phone Numbers	Counties
300 1st Ave N, Suite 203 Lewistown, MT 59457	406-535-7488 800-766-3018	Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Wheatland
Child Care Education & Support	Phone Numbers	Counties
2200 Box Elder, Suite 151 Miles City, MT 59301	406-234-6034 800-224-6034	Carter, Custer, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Richland, Rosebud, Wibaux
Child Care Resources	Phone Numbers	Counties
105 E. Pine, Lower Level Missoula, MT 59802	406-728-6446 800-728-6446	Mineral, Missoula, Ravalli



Department of Public Health and Human Services

Early Childhood Services Bureau ♦ P.O. Box 202925 ♦ Helena, MT 59620-2925 ♦ fax: 406-444-2547

Steve Bullock, Governor

Richard H. Opper, Director

Effective October 1, 2005, Montana child-care providers will be subject to a new law under the jurisdiction of the Montana Department of Justice. *Dane's Law* makes it a felony for any employee, owner, household member, volunteer or operator of a day care facility to administer medication—either prescription or non-prescription--to a child without the **written** consent of the child's parent. The law also prohibits the inappropriate administration of medications.

The law does provide an exception for certain medical emergencies when parental consent cannot be obtained. In such cases, a provider would have to obtain the written authorization from the child's physician, or be verbally directed to administer the medication from a medical practitioner, an emergency services provider, or a 911 responder.

The penalty for giving a child medication without parental consent can be up to 20 years in jail and up to a \$50,000 fine.

In anticipation of Dane's Law and the implementation of future day care rules pertaining to medication administration, The Child Care Licensing Program has developed sample documents for providers to use. Use of these documents is voluntary at this time. The documents include:

- Medication Authorization Form
- A Medication Administration Log (with instructions for use); and
- Medication Error/Incident Report

These forms are located at www.dphhs.mt.gov/earlychildhood and are not copyright protected; they can be downloaded and used "as is", or providers may modify the documents in accordance to their program. However, if a facility chooses to modify these forms, it is critical that the same basic information contained on the above documents is used.

If you are interested in obtaining a full copy of Dane's Law, you may do so by logging onto <http://data.opi.state.mt.us/bills/2005/billhtml/HB0068.htm>

Should you have questions or concerns about Dane's Law, or the medication administration documents, please contact your local child-care licensor, or the Child Care Licensing Program Manager, Becky Fleming-Siebenaler, at 444-7770.

Orientation & Fingerprint information should not be attached to this application.

LEGALLY CERTIFIED PROVIDER (LCP) APPLICATION

What is a Legally Certified Provider?

A Legally Certified Provider (LCP), regardless of location of care, is a provider certification category that is used for state payment purposes only. LCP providers are generally matched to families on a one-to-one basis. When the LCP provides care in the child's home, the parent is considered the employer of the LCP. For additional information please see the enclosed 2-page flier entitled "What is a Legally Certified Provider (LCP)?"

What criteria must I meet to be approved as an LCP?

Applicants for status as a Legally Certified Provider [LCP], regardless of location of care, must meet all of the following conditions:

- The provider must be age 18 or older. All household members over the age of 18 must complete and pass background checks.
- The provider and all other household members over the age of 18 must be mentally and physically capable of providing child care that meets safety, health, and other basic child care requirements and standards, which may require a statement of health completed by a physician, psychologist, or psychiatrist. Based on ARM 37.80.306, prior to certification, the department may require that an applicant obtain a psychological or psychiatric evaluation at his or her own expense if there is reasonable cause to believe such a mental illness or emotional disturbance exists.
- The provider and all other household members must not have a substantiated report with Child/Adult Protective Services involving harm, physical abuse, or sexual abuse to children or adults.
 - The provider and all other household members over the age of 18 must not have a criminal conviction involving harm, drugs or alcohol, firearms, harm, physical abuse, or sexual abuse to children or adults. Based on ARM 37.80.306, prior to certification, the department may require that the provider obtain an evaluation at his or her own expense if there is reasonable cause to believe chemical dependence exists.
- The provider must not be included in the parent's Temporary Assistance for Needy Families [TANF] cash assistance payment.
- The provider must list an eligible family for whom the provider will provide care in their application.
- The provider must not provide care while home schooling.
- The provider must provide care in a home setting; either their home or the home of the parent.

Background Check Responsibilities / Costs

- The provider must pay any fees associated with the background check process for their background checks and all other household members over the age of 18. This includes, but is not limited to: CPS checks, FBI fingerprinting fees, and FBI background check fees. Although the price for CPS checks may vary, the prices for FBI checks are \$27.25. Please be advised that some

agencies charge a fee for taking the fingerprints.

- All application fees (backgrounds, notary, etc.) are not reimbursable by the Child Care Licensing Program at any time.
- There may be a cost associated with having documents notarized.
- All adults in the home must complete the background check process, regardless of location of care.

LCP Orientation / Costs

Legally Certified Providers are required to take orientation training within **60 days** of certification approval. However, orientation can be taken prior to certification approval. The online training costs \$15.00. Please make sure to check computer system requirements for completing the online orientation by calling Child Care Resources at (406) 728-6446, or online at www.childcaretraining.org. The directions for taking the online course are included in this packet and on www.childcaretraining.org. If your computer does not meet the computer system requirements, a dedicated computer is available at your local Child Care Resource and Referral Agency for your use. Please call your local Child Care Resource and Referral Agency to schedule a time to use their computer.

How do I apply?

To apply, please complete the appropriate application materials as listed on the following page and submit them to Child Care Licensing:

DPHHS/QAD/CCL
2401 Colonial Dr—2nd Floor
PO Box 202953
Helena, MT 59620-2953
406-444-0479

How long will it take?

The LCP application process may take in excess of 30 days from the date all application materials are received, especially if out-of-state background checks are needed. To help avoid possible delays or lapses in service, submit all the required documentation with your application.

***Please Note: It is recommended that the applicant not provide care until a letter of approval is received. The applicant will not be reimbursed for care if they are denied or if the parent is denied the Best Beginnings Scholarship.**

What is the payment process?

After a family is determined eligible to receive assistance and the provider is approved to provide care, invoices are mailed, to the provider, during the month in which care is provided. Invoices shall be submitted to the local Child Care Resource and Referral (CCR&R) agency immediately following the month in which care is provided. Please refer to page two of this packet to see a listing of all CCR&R agencies in the state of Montana. Invoices are processed on the fifth business day of the month and on subsequent Tuesdays. Payments generally arrive in 2 to 3 business days after processing. **Payments, when care is provided in the parent's home**, are sent to the Parent, who is to pay the Provider. Please see "Child Care Provider Rights and Responsibilities" for more information. **The in-home LCP must indicate Head of Household on the W-9 form.** Current payment rates can be found at <http://www.dphhs.mt.gov/hcsd/childcare/>.

What will my effective date for payment be?

Both the parent and the Legally Certified Provider [LCP] must be determined eligible to participate in the Best Beginnings Scholarship program. The effective date for a Legally Certified Provider will be the date your completed application is received or the date the parent is determined eligible for a Best Beginnings Child Care Scholarship, whichever is later.

Application and Supporting Documentation Checklist and Instructions

✓ Check to be sure you have submitted the following documents.

<input type="checkbox"/>	LEGALLY CERTIFIED PROVIDER APPLICATION <ul style="list-style-type: none">- <i>must be completed in full, signed, and dated</i>
<input type="checkbox"/>	W-9 TAX ID FORM (See instructions on the back of the W-9 form) <ul style="list-style-type: none">- A voided check is not required for direct deposit- A missing or incomplete W-9 will cause a delay in payments- A new W-9 needs to be completed if your address changes- LCP: The top portion of the W-9 needs to be completed, including your name, address and mark individual/sole proprietor. Include your SSN and signature and date- When care is given in the parent's home, the parent must fill out the W-9 and indicated Head of Household, as the payment goes to the parent, and it is the responsibility of the parent to pay the LCP
<input type="checkbox"/>	LCP RELEASE OF INFORMATION FORM (a notary fee may apply) <ul style="list-style-type: none">- <i>must be completed in full, signed, dated, and notarized</i>- To be completed by the provider and each person over 18 living in the home
<input type="checkbox"/>	FINGERPRINT DISCLOSURE STATEMENT (must be completed in full, signed, and dated) <ul style="list-style-type: none">- To be completed by all adults living in the household over the age of 18- Must provide a photo ID and social security card for identification (<i>copies</i>)- Background checks for those who have lived outside of the United States are the applicant's responsibility and documentation concerning citizenship, a Green card or Visa, must also be supplied- <u>FBI Fingerprint Check</u> - \$27.25 fee (check or money order, made out to the Department of Justice)<ul style="list-style-type: none">• All out-of-state CPS Checks that require payment- Agencies that provide fingerprinting services may charge over and above the fee to cover their own processing fees.
<input type="checkbox"/>	STATEMENT OF HEALTH (must be completed in full, signed, and dated) <ul style="list-style-type: none">- To be completed by the provider and each person over 18 living in the home- Any associated costs related to the completion of the form are the responsibility of the applicant- If applicable, the applicant or other household member(s) may be required to complete a Doctor's visit, drug screen, or a psychological evaluation at his or her own expense if there is reasonable cause to believe it is necessary
<input type="checkbox"/>	PROVIDER RIGHTS AND RESPONSIBILITIES (to be done electronically once approved – cannot be done during the application period) http://www.dphhs.mt.gov/hcsd/childcare/bestbeginnings/index.shtml <ul style="list-style-type: none">- Two letters will be sent to the provider once they are approved and will outline the process to submit the Provider Rights and Responsibilities
<input type="checkbox"/>	FAMILY ASSOCIATION FORM / HEALTH AND SAFETY CHECKLIST <ul style="list-style-type: none">- This form indicates the family that the LCP will be providing care for- Both the parent and provider must sign this form indicating that basic health and safety considerations have been addressed
<input type="checkbox"/>	MEDICATION ADMINISTRATION ATTESTATION <ul style="list-style-type: none">- Both the parent and provider must complete the <i>Medication Administration Attestation</i>
<input type="checkbox"/>	IMMUNIZATION CERTIFICATION FORM <ul style="list-style-type: none">- One form for each child in LCP's care



(Rev 03/2014)

MONTANA LEGALLY CERTIFIED PROVIDER APPLICATION

Orientation & Fingerprint information should not be attached to this application.

LCP STAFF ONLY	
PROVIDER ID	
PROVIDER NAME	
CERTIFICATION BEGIN DATE	END DATE
LCP WORKER NAME	

1. I AM APPLYING TO BE AN LCP

<input type="checkbox"/> Care will be provided in my home	<i>ONLY SELECT ONE LOCATION OF CARE</i>
<input type="checkbox"/> Care will be provided in the child's home	
Have you ever been a Certified or Registered Child Care Provider in Montana or in any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what type of provider have you been? <input type="checkbox"/> Legally Certified Provider <input type="checkbox"/> Family Child Care Provider <input type="checkbox"/> Group Child Care Provider <input type="checkbox"/> Other	
If yes, when?	Where? (MT City) _____ (MT County) _____

2. APPLICANT

This is the person who is requesting to be the Legally Certified Provider and assumes responsibility for following the program rules and requirements, including penalties and repayment of any overpaid benefits.				
PROVIDER NAME				
LAST NAME	FIRST NAME	MIDDLE NAME		
ADDRESS (physical)				
CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION
MAILING ADDRESS (if different)				
CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION
HOME PHONE	WORK PHONE		OTHER PHONE	

LCP STAFF ONLY:

Workers Initials _____	Date _____
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3. Household Members

For Legally Certified Providers, regardless of where the care is provided (in the providers home or in the child's home)

- The provider and every adult (18 years and older) in the home must be listed below

ALL individuals listed below must complete the following forms

- Release of Information
 - *Legally Certified Provider Release of Information Criminal/Protective Service Background Checks* form must be signed by the applicant and any adult in the household. This form is used to obtain information from the Montana Department of Justice and Montana Child Protective Services and Adult Protective Services and, if applicable Tribal Law Enforcements and Child Protective Services.
- Fingerprint Disclosure Statement
 - This form is needed regardless of where the individual listed has lived
- Statement of Health
 - Applicants must meet certain personal health requirements. As the agency responsible for child care certification, the Department of Public Health and Human Services (DPHHS) must ensure that the health of all providers and family members is adequate to meet the demands of the care being provided.

HOUSEHOLD MEMBERS (First, Middle Last)	DATE OF BIRTH	RELATIONSHIP TO APPLICANT (you)
Provider:		SELF

4. ORIENTATION

An orientation for Legally Certified Providers is required to be completed within **60 days** of certification approval.

Have you taken Legally Certified Provider Orientation (LCP)

Yes, I completed the online LCP Orientation on _____

No, I have not completed the LCP Orientation.

LCP STAFF ONLY:

Workers Initials _____ Date _____

5. CHILD ABUSE AND NEGLECT

Have you ever had a child removed from your home? Yes No

Have you or anyone living in your home been investigated for possible abuse or neglect by the Department, a child welfare agency in another state, or law enforcement? Yes No

If "Yes,"

What is the child's name? _____

What is your relationship with the child? _____

Where and when did this happen? (please give dates)

6. CRIMINAL CHARGES / CONVICTIONS

Applicants and providers must meet certain requirements such as being free of criminal charges and convictions. As the agency responsible for child care certification, the Department of Public Health and Human Services (DPHHS) must ensure the safety of children in a child care setting. In complying with this each provider and adult persons residing in the home must complete a **"Release of Information Form,"** to be notarized and submitted with this application, along with the applicant completing the following questions. These questions apply to all persons residing in the home.

Have you or any person residing in the home lived in another state? Yes No

If "Yes," Please list the states you have lived in, and the dates:

Have you or any person living in your home been convicted of, plead guilty to, or currently charged with a crime classified as an offense against any person or family? Yes No

If "Yes," give details, including name of person, date, place and nature of the conviction and disposition:

Have you or any person living in the home ever been named as a perpetrator in a substantiated report of child or adult abuse or neglect (or exploitation of an adult)? Yes No

If "Yes," Please explain.

Have you or any person living in the home been convicted of a crime involving, child or elder abuse or neglect, including sexual abuse, physical assault, or other act of violence? Yes No

If "Yes," Please explain.

LCP STAFF ONLY:

Workers Initials _____ Date _____

7. HEALTH

Applicants and providers must meet certain personal health requirements. As the agency responsible for child care certification, the Department of Public Health and Human Services (DPHHS) must ensure that the health of all providers and family members is adequate to meet the demands of the care being provided. In complying with this each provider and adult persons residing in the home must complete a **“Statement of Health Form,”** to be submitted with this application. Further documentation at the applicant’s expense may be required at the discretion of the Child Care Licensing Program.

8. ADDITIONAL COMMENTS

9. CERTIFICATIONS - Care in Provider's Home (Do not initial if providing care in child's home)

Initial Every Line

_____ (Initials) I certify that I reside and will be providing care in my home and I agree that I am an independent contractor.

_____ (Initials) I certify that I will be the only person transporting children while in my care.

_____ (Initials) I certify that I will only provide care to the child(ren) of one family or that I will only provide care to no more than two children from separate families.

_____ (Initials) I certify that I will be providing care less than 24 hours within the day.

_____ (Initials) I certify that I will review and discuss with the parents the immunization record of the children in my care; or, review and discuss the waiver indicating parental choice not to immunize.

_____ (Initials) I certify that I will examine the home for fire and safety conditions, for the presence of working smoke detector, for placement of a family fire escape plan and discuss the conditions with the parents.

_____ (Initials) I certify that I will inform parent(s) that the state will **NOT** make payments until the provider’s and parent’s applications are approved.

_____ (Initials) I certify that I am aware it is recommended that the applicant not provide care until a letter of approval is received.

_____ (Initials) I certify that I will review the health and safety checklist for LCP providers with the parent.

_____ (Initials) I confirm that neither I nor anyone, present in the home, have been investigated for any alleged harm or physical or sexual abuse to children or adults. If this statement is false, I am providing the information required below about where the investigation occurred:

_____ City

_____ County

_____ State

_____ Date

LCP STAFF ONLY:

Workers Initials _____ Date _____

10. CERTIFICATIONS - Care in Child's Home (Do not initial if providing care in provider's home)

Initial Every Line

_____ (Initials) I certify that I will be providing care in the child's home and that the parent is considered my employer.

_____ (Initials) I certify that I will be the only person transporting children while in my care.

_____ (Initials) I certify that I will only provide care to the children of one family.

_____ (Initials) I certify that I will be providing care less than 24 hours within the day.

_____ (Initials) I certify that I will inform parent(s) that the state will **NOT** make payments until the provider's and parent's applications are approved.

_____ (Initials) I certify that I am aware it is recommended that the applicant not provide care until a letter of approval is received.

_____ (Initials) I certify that I will review the health and safety checklist for LCP providers with the parent.

_____ (Initials) I confirm that neither I nor anyone, present in the home, have been, investigated for any alleged harm, or physical or sexual abuse to children or adults. If this statement is false, I am providing the information required below about where the investigation occurred:

_____ *City*

_____ *County*

_____ *State*

_____ *Date*

11. Signature

I attest and affirm that the above statements are true and correct to the best of my knowledge and belief. I authorize a DPHHS child and adult protective services background check and a criminal records background check. I also agree to complete online orientation training within 60 calendar days of the date that I am approved to provide child care services.

I understand that if I provide inaccurate information or misrepresent information in writing or verbally on this application, throughout the application process, and while certified, my application may be denied.

Provider Signature

Date

LCP STAFF ONLY:

Workers Initials _____ Date _____



(Rev 12/15)

MONTANA LEGALLY CERTIFIED PROVIDER APPLICATION

LCP STAFF ONLY	
PROVIDER ID	
PROVIDER NAME	
CERTIFICATION	
BEGIN DATE	END DATE
CCR&R DATE STAMP	
LCP WORKER NAME	

FAMILY ASSOCIATION FORM

This form is to be used to associate the family that the LCP will be providing care to.

1. PROVIDER INFORMATION

This is the Legally Certified Provider who will be providing care for the family that is receiving child care assistance and who is listed below in #2.					
PROVIDER NAME					PV#
LAST NAME	FIRST NAME		MIDDLE NAME		
ADDRESS (physical)					
CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION	
HOME PHONE	WORK PHONE		OTHER PHONE		
TANF: Are you included in the Parent's TANF Financial grant? <input type="checkbox"/> Yes <input type="checkbox"/> No					

2. FAMILY INFORMATION

This is the family who care is being provided to and who is receiving child care assistance					
HEAD OF HOUSEHOLD NAME (Last, First, Middle)				CASE # / CASE EVENT #	
ADDRESS (physical)					
CITY	STATE	ZIP	COUNTY	TRIBAL RESERVATION	
NAME OF CHILDREN IN CARE (First, Middle Last)			DATE OF BIRTH	RELATIONSHIP TO LCP/LCI	

Workers Initials _____ Date _____

HEALTH AND SAFETY CHECKLIST

Health and Safety issues should be considered when arranging for child care. Here are some topics a parent and child care provider may want to discuss. For more information regarding quality child care, contact your local Child Care Resource and Referral agency.

No corporal punishment may be inflicted.

	YES	NO	<u>PLEASE ANSWER ALL QUESTIONS by Initialing either YES OR NO</u>
INITIALS			Do parents have access to their children at all times?
INITIALS			Is the provider in good health?
INITIALS			Is the provider trained about basic health and safety issues?
INITIALS			Is the provider knowledgeable about child development issues?
INITIALS			Does the provider wash hands thoroughly, before and after diapering?
INITIALS			Does the provider wash hands thoroughly, before preparing food?
INITIALS			Has the provider received guidelines on how to "child-proof" the home?
INITIALS			Does the provider talk easily with the children and respond to their needs?
INITIALS			Does the emotional climate foster happiness and trust?
INITIALS			Does the provider offer learning opportunities to the children?
INITIALS			Are children's immunizations current?
INITIALS			Are emergency telephone numbers and parent telephone numbers posted?
INITIALS			Is the provider trained in First Aid and CPR?
INITIALS			Does the provider have an emergency medical authorization form signed by the parent?
INITIALS			Is a first aid kit available?
INITIALS			Are meals and snacks nutritious?
INITIALS			Is there a quiet comfortable place for naps?
INITIALS			Is the play equipment safe?
INITIALS			Is the home clean?
INITIALS			Are the children exposed to smoking?
INITIALS			Are hazards inaccessible to children, inside and out?
INITIALS			Are electrical outlets covered?
INITIALS			Are heaters ventilated and screened?
INITIALS			Are poisonous substances out of reach of children?
INITIALS			Are smoke detectors in place and operational?
INITIALS			Is a fire extinguisher available?
INITIALS			Are firearms locked and inaccessible?
INITIALS			Are appropriate automobile restraints, such as car seats, used?

By signing below, I state that I have read, discussed and understand the above information.

 Parent Date Provider Date

State payment is dependent upon the both the parent's eligibility for child care assistance and the caregivers approval as an LCP Provider. Payments are not associated with start of care.

Workers Initials _____ Date _____

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number											
				-			-				
or											
Employer identification number											
				-							

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
Legally Certified Providers (LCP)
Criminal, Protective Services, and Motor Vehicle Background Checks

PERSONAL INFORMATION

Section A - Current Name and Residence

Ethnic Affinity: Hispanic or Latino Yes No Phone #: _____

Email Address: _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: [] Male [] Female Date of Birth: _____ Social Security # _____

Marital Status: _____ Tribal Affiliation: _____ Race: _____

Section B - Past Residences

Have you ever ...

- 1. ...lived in another state? Yes No
- 2. ...lived on or do you now live in an area designated as an Indian reservation? Yes No

If you answered yes to the any of the above questions:

- Please declare where you have lived in the table below.
- Out of state background checks or tribal background checks, will be required. There is a cost associated with these checks.

City	County	Reservation	State	Dates of Residency (From – To)

Section C - Prior Caregiver Approvals

Have you been...
 ...certified/ registered / licensed to care for children before? Yes No
 ...approved, in any capacity, to provide care in a child care facility? Yes No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

(Director / Facility Name) (Dates)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Workers Initials _____ Date _____

LCP PROVIDER HOUSEHOLD INFORMATION

Section D - LCP Provider Household Member Status

The legally Certified Provider /In-Home Provider that I live with is:

Provider #: _____

Legally Certified Providers Name: _____

Mailing Address : _____

I am: the legally certified provider [LCP] & care will be provided

in my home in the child's home **or**

I am: the spouse of the LCP applicant a member of the LCP's household

Section E - Authorization Statement and Signature

As part of the initial and subsequent annual application process, I, _____ (applicant name) do hereby authorize any law enforcement and/or protective services agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services.

I, am aware that _____ (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with said entity.

I am aware that Child and Family Services Division and, Department of Justice records may contain information that could adversely affect my Legally Certified Provider approval. These records will relate to criminal history records, as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and **I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____

(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

PRINT Notary Public for the State of Montana

Signature Notary Public for the State of Montana

Residing at _____

My Commission Expires _____
(month/day/4 digit year)

Workers Initials _____ Date _____



DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
Legally Certified Providers (LCP)
Criminal, Protective Services, and Motor Vehicle Background Checks

PERSONAL INFORMATION

Section A - Current Name and Residence

Ethnic Affinity: Hispanic or Latino Yes No Phone #: _____

Email Address: _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: [] Male [] Female Date of Birth: _____ Social Security # _____

Marital Status: _____ Tribal Affiliation: _____ Race: _____

Section B - Past Residences

Have you ever ...

- 1. ...lived in another state? Yes No
- 2. ...lived on or do you now live in an area designated as an Indian reservation? Yes No

If you answered yes to the any of the above questions:

- Please declare where you have lived in the table below.
- Out of state background checks or tribal background checks, will be required. There is a cost associated with these checks.

City	County	Reservation	State	Dates of Residency (From – To)

Section C - Prior Caregiver Approvals

Have you been...
 ...certified/ registered / licensed to care for children before? Yes No
 ...approved, in any capacity, to provide care in a child care facility? Yes No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

(Director / Facility Name) (Dates)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Workers Initials _____ Date _____

LCP PROVIDER HOUSEHOLD INFORMATION

Section D - LCP Provider Household Member Status

The legally Certified Provider /In-Home Provider that I live with is:

Provider #: _____

Legally Certified Providers Name: _____

Mailing Address : _____

I am: the legally certified provider [LCP] & care will be provided

in my home in the child's home **or**

I am: the spouse of the LCP applicant a member of the LCP's household

Section E - Authorization Statement and Signature

As part of the initial and subsequent annual application process, I, _____ (applicant name) do hereby authorize any law enforcement and/or protective services agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services.

I, am aware that _____ (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with said entity.

I am aware that Child and Family Services Division and, Department of Justice records may contain information that could adversely affect my Legally Certified Provider approval. These records will relate to criminal history records, as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and **I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____

(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

PRINT Notary Public for the State of Montana

Signature Notary Public for the State of Montana

Residing at _____

My Commission Expires _____
(month/day/4 digit year)

Workers Initials _____ Date _____



Department of Public Health and Human Services

Child Care Licensing-QAD ♦ PO Box 202953 ♦ Helena, MT 59620-2953 ♦ phone: 444-2012 ♦ fax: 444-1742

Steve Bullock, Governor

Richard H. Opper, Director

LEGALLY CERTIFIED PROVIDER (LCP) PROGRAM STATEMENT OF HEALTH FORM

Legally Certified Provider Name:

Provider Number (PV#):

Name:

Phone Number:

Address:

City, State, Zip Code:

Social Security Number:

Date of Birth:

Please check one of the boxes below:

- I am applying to be a legally certified provider. Care will be provided in my home.
- I am applying to be a legally certified provider. Care will be provided in the child's home.
- I am the spouse of the applicant.
- I am a member of the applicant's household.

Applicants and household members must meet certain health requirements. As the agency responsible for approving LCP/LCI payment numbers, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.

In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your responses. The answer "yes" does not mean you will automatically be denied as an LCP/LCI. Your explanation, or, if necessary, your physician's or other appropriate professional's statement will be taken into consideration. The purpose of the questions is to help decide if you have any health problems that may affect your ability to safely provide care. Health information, which the LCP/LCI Worker assesses as needing follow up will be forwarded to the LCP/LCI Supervisor. If an evaluation or statement is needed, the Supervisor will send the required information to the LCP/LCI applicant. Any evaluations, tests, or visits to your physician or other professional(s) must be paid by the LCP/LCI applicant.

Please answer the following questions by checking the appropriate box for each question.

During the past 3 years, have you had any disabling chronic conditions, or physical, mental, or emotional illness requiring care from a physician, psychologist, or other professional?

Yes No

- If "Yes," please describe. Include a description of any vision or hearing problem and any limitation on mobility. Include treatment and current status (you may use additional paper if needed).

Do you suffer from any physical or mental health limitations, which might affect your ability to provide child care?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Are you currently diagnosed, receiving therapy or medication for a mental health problem, which might affect your Ability to provide care?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Have you received counseling or treatment related to chemical dependency, drugs or alcohol within the past three years?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Have you ever been addicted to drugs and/or alcohol or have you been treated for drug and/or alcohol abuse, within the past three years?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Additional Comments:

Please read, then sign and date:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or for revoking my registration/license should one have been issued to me on the basis of the statements I have made herein. I understand this information is confidential and is to be used only by the Department of Public Health and Human Services for the administration of the child care licensure program. I hereby consent to the use of this information for such purposes.

SIGNATURE: _____ **DATE:** _____

Please Return To:

DPHHS/QAD/CCL
2401 Colonial Dr—2nd Floor
PO Box 202953
Helena, MT 59620-2953

Worker's Initials _____ **DATE:** _____



Department of Public Health and Human Services

Child Care Licensing-QAD ♦ PO Box 202953 ♦ Helena, MT 59620-2953 ♦ phone: 444-2012 ♦ fax: 444-1742

Steve Bullock, Governor

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Name:

Phone Number:

Address:

City, State, Zip Code:

Social Security Number:

Date of Birth:

Please check one of the boxes below:

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Yes No

- If "Yes," please describe. Include a description of any vision or hearing problem and any limitation on mobility. Include treatment and current status (you may use additional paper if needed).

Do you suffer from any physical or mental health limitations, which might affect your ability to provide child care?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Are you currently diagnosed, receiving therapy or medication for a mental health problem, which might affect your Ability to provide care?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Have you received counseling or treatment related to chemical dependency, drugs or alcohol within the past three years?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Have you ever been addicted to drugs and/or alcohol or have you been treated for drug and/or alcohol abuse, within the past three years?

Yes No

- If "Yes," please explain (you may use additional paper if needed).

Additional Comments:

Please read, then sign and date:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or for revoking my registration/license should one have been issued to me on the basis of the statements I have made herein. I understand this information is confidential and is to be used only by the Department of Public Health and Human Services for the administration of the child care licensure program. I hereby consent to the use of this information for such purposes.

SIGNATURE: _____ **DATE:** _____

Please Return To:

DPHHS/QAD/CCL
2401 Colonial Dr—2nd Floor
PO Box 202953
Helena, MT 59620-2953

Worker's Initials _____ **DATE:** _____

Legally Certified Provider Medication Administration Attestation

I, _____ acknowledge that I have discussed with the parent about
(Provider)
administering medication while their child or children are in my care.

I, _____ will sign the Medication Authorization form for each
(Parent)
prescription and non-prescription medication to be given to my child or children while in
_____ care.
(Provider)

I, _____ will log the medication on the Medication Administration
(Provider)
Log as given to the child or children while in my care.

The authority for this is MCA 52-2-736.

By signing below, I state that I have read, discussed and understand the above information.

Parent

Date

Provider

Date

*Please return with your application.

****Note:** The provider must keep the Medication Authorization Form, Medication Administration Log and Medication Error/Incident Report on file for 3 years.

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name _____ Date of Birth ____/____/____
Program Name _____ Today's Date ____/____/____

To administer a prescription medication:

- The medication must be in it's original container, with a legible label from the pharmacy indicating the child's name, date, name of medicine, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's/nurse practitioners name, pharmacy name and telephone number
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label (twins and siblings can not share.)
- A separate authorization is required for *each medication* and *each episode* of illness
- Label constitutes the physicians/nurse practitioner's order
- Parent/Guardian is to give as many doses as possible at home.

Medication: _____

Reason for medication: _____

Start date ____/____/____ End date ____/____/____

Dosage: _____ Times to be given at child care: _____ AM _____ PM

First dose was given at _____ AM/PM on date ____/____/____ (Medication Log needs to reflect Parent's first dose for each day.)

Route: by mouth, skin (location) _____, eye (R/L)

Possible side effects: _____

Special handling/storage Instructions _____ Refrigeration Y/N

Parent/Guardian Signature (required) _____

Physician/Nurse Practitioners Signature _____

Non-Prescription Medication:

- Parent is required to bring these medications from home.
- Medication must be in an original container, with child's name on the container.

Medication: _____ Health Care Provider _____

"For children under 2, list the name of the health care provider who recommended this medication."

Reason for medication: _____

Start date ____/____/____ End date ____/____/____

Dosage: _____ Times to be given at child care: _____ AM _____ PM

First dose was given at _____ AM/PM on date ____/____/____ (Medication Log needs to reflect Parent's first dose for each day.)

Route: by mouth, skin (location) _____, eye (R/L)

Possible side effects: _____

Special handling/storage Instructions _____ Refrigeration Y/N

Parent/Guardian Signature (required) _____

Unused medication: Returned to Parent Y/N Date ____/____/____ or Discarded appropriately Y/N Method _____

By: _____ Date ____/____/____

***Keep in the child's file when medication is finished.**

NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name _____ Date of Birth ____/____/____
Program Name _____ Today's Date ____/____/____

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

- Diaper Rash Cream/Ointments
- Insect Repellent
- Sunscreen
- Cortisone/Anti-Itch Creams/Ointments
- Medicated Lip Treatments
- OTC Antibiotic Creams/Ointments
- Burn Creams/Sprays
- Other Non-Ingestible OTC's: (Please Specify) _____
- _____
- _____
- _____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions _____ Refrigeration Y/N

Parent/Guardian Signature (required) _____

* **This document must be updated on an annual basis.**

Unused Medication: Returned to Parent Y/N or Discarded Appropriately (circle one)

By: _____ Date ____/____/____

*Keep in the child's file when medication is finished.

Medication Administration Log

● **Use One Sheet for Each Child**

Name: _____ Birth date: _____

Name of Facility: _____

Class: _____ From: _____ To: _____
(Start date of medication) (End date)

Name of Parent: _____

Parent Work #: _____ Parent Home #: _____

Person with Prescriptive Authority: _____
(Name of health care provider prescribing the medication)

Name of Medication: _____

Dosage: _____ **Route:** _____ **Times:** _____

Length of time medication is to be given: _____

Date Mm/dd/yy	Time	Comment	Initials	Date Mm/dd/yy	Time	Comment	Initials

Signature	Initials	Date

- If the child is absent, (designate with an “A”) or if for any reason, the medication is not given, (designate with “NG”) indicate in the “comment” column.
- If NG, document the reason for not giving medication in the “comment” column

Sample Directions for Use of a Medication Log

1. The medication log is used to document that medication has been given to a child. Because this log is a legal document you must initial and sign each entry in ink.
2. Each medication given in the child care facility will need to have the following information written on the log:
 - Child's Name
 - Child Care Facility
 - Medication Name
 - Dosage—this must be the same as on the bottle and authorization form
 - Time the medication is to be given and time span for medication (e.g., days, weeks, months)
 - For Prescription medication--Name of person with Prescriptive Authority
 - Picture of the child if child is five years of age or younger
3. Have the log with you when you are giving any medication. Remember to check the information and compare it with the medication label before you give the medication to the child. Check to see if the medication has already been given to the child for that day and at that time by any other person.
4. It is preferable to assign one person to give all medications to the child for the day to avoid double dosing or missing a dose. Identify the child by name before giving the medication to the child and/or check the attached picture of the child.
5. Immediately after giving the medication, document:
 - Name and dosage of medication
 - Time the medication was given
 - Day and date the medication was given
 - Initials of the person administering the medication
6. If the medication is dropped on the floor, the child refuses to take the medication, spits out the medication, or any other unusual occurrence happens, make note (or designate NG for not given) in the Comment area and contact the parent.
7. If the child is absent from the facility, and are not in the Comment area enter an "A" for absent.
8. When the log is discontinued, write the date of discontinuation and arrange for the parent to pick up medication container, or dispose of any left over medication.

MEDICATION ERROR/INCIDENT REPORT

Child: _____ Date of Birth: _____

Child Care Facility: _____ Classroom: _____

Medications: _____ Dosage: _____

Time Medication to be administered: _____

Date of Incident: _____

Reason for Report: Missed medication, wrong medication, etc. Give a detailed report as to how incident happened:

Action Taken/Intervention:

Describe how this incident could be avoided in the future:

Name of parent/guardian who was notified: _____

Time/date of notification: _____

Printed name of person preparing report: _____

Signature of person preparing report: _____

Follow up contact/care: _____

Child Care Facility Director/Administrator signature: _____

MEDICATION ERROR/INCIDENT REPORT

Child _____

Date of Birth ___/___/___

Child Care Facility _____

Classroom _____

Medications _____

Dosage _____

Time Medication to be administered _____

Date of Incident _____

Reason for Report: Missed medication, wrong medication, etc. Give a detailed report as to how incident happened:

Action Taken/Intervention:

Describe how this incident could be avoided in the future:

Name of parent/guardian who was notified: _____

Time/date of notification: _____

Printed name of person preparing report _____

Signature of person preparing report _____

Follow up contact/care: _____

Child Care Facility Director/Administrator signature _____

New (02/2011)

STATE OF MONTANA
Department of Public Health and Human Services
Quality Assurance Division

LCP IMMUNIZATION CERTIFICATION

I _____ (provider) certify that I am in compliance with policy 6-2 that states:

Children in Legally Certified Providers [LCP] care are required to have immunizations except:

- * If the child is being cared for by an approved relative (grandparents, great-grandparents, aunt or uncle)*
- * If the child is being cared for in their own home*
- * If the child has a medical condition that contra-indicates immunization*
- * If a medical exemption for immunizations is being claimed, a LCP/LCI Immunization Waiver form must be completed.*

I _____ (provider) certify that _____ (child's name) has all of the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

Provider's Signature _____ Date _____

HCS/CC-162
New (02/2011)

STATE OF MONTANA
Department of Public Health and Human Services
Quality Assurance Division

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I _____ (provider) certify that _____ (child's name) has all of the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

Provider's Signature _____ Date _____

Getting Started with LCP Online Orientation

- Cost: \$15.00. Pay online with a debit or credit card.
- Time: Approximately 4 hours. This course is not submitted to ECP for training credit.
- Orientation is required within 60 days of license approval
- LCPs should contact cct@childcareresources.org or call 800-728-6446 with any problems. We are happy to assist participants during our office hours, 8-5 M-F, except holidays.
- If a LCP is unable to access this course from home, the local Child Care Resource and Referral Agency or public library has access to computers and the Internet.

Accessing the course:

- Enter <http://www.childcaretraining.org/?pageid=76> in an Internet browser such as Google, Yahoo or Bing.
- You'll need **Adobe Reader to open attachments for this course, it can be downloaded free from <http://get.adobe.com/reader/>.**
- If you are new to ChildCareTraining.org you must create a user account. This information is located on the above link. Once an account is created, log in.
- Click on the LCP Orientation course at the bottom of the page to purchase and complete the course.
- Completion of the course evaluation will signal the course facilitator that you have completed the course. We'll get back to you within 3 business days.
- Download your course completion certificate. This will signal us to notify Family Connections that you have completed LCP Orientation which is necessary to receive Best Beginnings Scholarship payments.

