



CHILD CARE AND DEVELOPMENT FUND (CCDF)/ON MY WAY PRE-K (OMW) PROVIDER INFORMATION

State Form 57222 (R3 / 7-24)

FAMILY AND SOCIAL SERVICES ADMINISTRATION

INSTRUCTIONS: Your provider must complete this information in its entirety and sign the form.

Applicant/Co-Applicant. Please upload this document to your online application or submit this document to assist in prompt completion of your child care/OMW vouchers. If you wish to make a provider change, you must submit this form to the eligibility office by noon on Thursday, to be effective the following week or payment for care may become your responsibility. Your provider must allow unscheduled visits by a parent or legal guardian to their child care program during the hours the child care program is in operation. If you have any questions, please contact your local eligibility office.

Name of applicant		Applicant phone number		Applicant email address	
Name of program			License / registration / exemption number	Provider's current Paths to QUALITY (PTQ) Level <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
Address where care is provided (number and street, city, state, and ZIP code)			Program County	Program Telephone number ()	
What date will the child begin care? (month, day, year) / /		Is this a provider change? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this for a child who is reauthorizing their case? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Type of provider
 Licensed Home Licensed Center Registered Ministry License Exempt Home License Exempt Facility Providing Care in Child's Home Public, Private or Charter School

Hours of operation (i.e. 7 AM to 6 PM) _____ Days of operation (Check all that apply.)
 Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Name of CCDF Child(ren) (First and Last)	Date of Birth (month/day/year)	Charge for Current Age	H -Half Day F- Full Day	Charge for Next Age Group (If child is currently Infant, list charge for Toddler)	School-Age (Before and After School)	School-Age Other (Charge for School Breaks, evening or week-end care)

FOR SCHOOL AGE CHILDREN ONLY (Please include a school calendar for ALL School Aged children.)

Date school year begins (mo/day/yr) / /	Date school year ends (mo/day/yr) / /	Does school-age child need break care vouchers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this form On My Way Pre-K wraparound or break care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will child attend this same CCDF provider for summer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Summer Begin-End date (mo/day/yr) / /
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FOR ON MY WAY PRE-K CHILDREN ONLY

Name of OMW Child (First and Last)	Date of Birth (month/day/year)	OMW Pre-K Weekly Charge	H -Half Day F- Full Day	OMW Pre-K Begin Date (month/day/year)	OMW Pre-K End Date (month/day/year) Latest possible date-first Sat. in June	If family determined eligible for Limited Eligibility providers receive
						\$147.82/week
						\$147.82/week

If you are a public, private or charter school, does the OMW child listed above need break care vouchers (care at another provider when your school is not in session)? Yes No

If yes, a school schedule must be provided

Are you related to any the child(ren) listed above? Yes No

If Yes, please list relationship.

PROVIDER AFFIRMATION Eligible providers must demonstrate compliance with CCDF Minimum Standards prior to participation in these programs

I affirm the information provided on this application form is true and correct. Further, I affirm child care will be provided at the address listed above and agree to comply with the rules and regulations of the CCDF program available on www.childcarefinder.in.gov. I also understand I must allow unscheduled visits by a parent or legal guardian to my child care program during the hours my child care program is in operation. In signing this application, I certify I am the individual listed above or the authorized designee.

Signature of provider	Printed name of provider	Date (month, day, year)
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