IDAHO DEPARTMENT OF HEALTH & WELFARE

HW0427
Rev. 1/2012

Monthly Dependent Care Charges

This form is used to determine the monthly amount for child care, it is not an application for Child Care Assistance. You must complete an application for Child Care Assistance to have your eligibility determined.

Case Name:	IBES Number:
	Family Number:

PART A: Completed by the Parent

Full Name of Parent:	Day Time Phone Number:
Home Address:	Work Phone Number:
In Case of Emergency Contact:	

PART B: Completed by the Provider

Section 1: Enrollment Information

New Child(ren) Enrollment Date:	One-time Registration Fee per Child:
Provider Name:	Business Name (if different):

Provider Address:

Provider Phone Number:

Are you a registered **I**daho **C**hild **C**are **P**rogram (ICCP) provider? ☐ Yes ☐ No

For how many children do you usually provide care? (Include the children listed below, including your own children.)

☐ 6 or less ☐ 7–12 ☐ 13 or more

Section 2: Changes to Existing Dependent Care Only (not required for new enrollments)

Effective date of change:

Section 3: Enrollment/Change Information (Required)

Name of Each Child Receiving Dependent Care	Monthly Cost per Child	Monthly Care Hours	Month of Care	Full Charges	Partial Charges
	$			☐	☐
	$			☐	☐
	$			☐	☐
	$			☐	☐

By signing this form, we acknowledge the above terms have been agreed upon by both parties.

(Provider Signature) *(Vendor Number)* *(Date)*

(Parent Signature) *(Social Security Number)* *(Date)*

The **parent** must report a change in provider, parent's activity, child care need, or income. The **provider** must report a change in the amount they charge. These changes must be reported within 10 days.

White – DHW copy, Yellow – Provider copy, Pink – Customer copy