



Child Care Payment Questionnaire
Department of Social Services
Division of Family Independence | CED, TA
B-3923 (2/2023)

Parent/Guardian Information

First Name	Last Name	Case Number
Address		City
		Zip Code

Please complete this questionnaire with your child care provider and return it to the worker listed below. A separate questionnaire is required for each child care provider. A new questionnaire must be completed:

- ❖ with each Certification and Recertification
- ❖ if there is a change in child care providers
- ❖ if there is a change in your hours of employment
- ❖ if there is a change in your household composition
- ❖ if there is a change in the cost of your child care

TO BE COMPLETED BY CENTER/PROVIDER

Provider	DBA Name	
Provider SSN	OR DBA TAX ID	
-	-	-
Address Where Care is Provided	City	Zip Code
Mailing Address	City	Zip Code
Contact Person	Telephone Number	
License #	License Period to	
CCFS ID #	Expiration Date	Vendor #
Are you in Receipt of Temporary Assistance ☐ Yes ☐ No	TA Case #, if applicable	
Please indicate if your business can be categorized as being owned by any of the following ☐ AA-Asian American ☐ Black ☐ Hispanic ☐ AI-Native American ☐ WO-Woman Owned ☐ Veteran Owned		
Type of Child care ☐ Day Care Center ☐ Legally Exempt Relative in Parent's Home ☐ Group Family Day Care Provider ☐ Legally Exempt Non-Relative In Parent's Home ☐ Family Day Care Provider ☐ Legally Exempt Relative in Relative's Home ☐ School Age Child Care Program ☐ Legally Exempt Non-Relative in Non-Relative's Home		
Provider Signature	Date	

RETURN TO:

Caseworker/Examiner	Unit/Worker#	Phone #
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PARENT - Complete							
Place of Employment/Training				Mode of transportation ☐ Car ☐ Public transportation ☐ Other (specify):			
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Daily Work/Training Schedule (e.g. 9am-5pm)							
Travel time from child care provider to work/approved activity (e.g. 25 minutes):							
Travel time from work/approved activity to child care provider (e.g. 25 minutes):							
PROVIDER – Complete for each child in care							
	Child 1	Child 2	Child 3	Child 4	Child 5		
Child's Name							
Child's DOB							
Name of child's school							
Child's School schedule (e.g. 9:00 am – 3:55 pm)							
Date child started in care							
Hours in care per day							
Days in care per week	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday		
Part day cost of child care							
Daily cost of child care							
Weekly cost of child care							

NOTE: Payments will be based on the actual number of hours employed, plus a reasonable travel time allowance.

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Client Signature	Date	Provider Signature	Date
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