



REQUEST FOR CHILD CARE PROVIDER CHANGE

Client: _____

Parent/Guardian Name: _____

Child Care Case Number: _____

Date: _____

List a telephone number where you can be reached during the day

Home: _____ Work: _____

**ONLY Complete and Return when you CHANGE or ADD another provider.
 DO NOT fill out if you have already sent in a form for your new provider.**

If you change providers or add another provider, you and your new provider must complete and SIGN the attached pages. Be sure to also complete this cover page. Return this cover page with the attached pages to the address listed below. We MUST have this information before we can make payments to your new provider.

You and your provider will be notified within 30 days after we receive the completed information. After your new provider is approved, we will send the new provider a billing form called a Child Care Certificate which must be completed monthly in order for the new provider to get paid.

If you are CHANGING providers, complete this box:

Name of NEW provider:

Mosaic Montessori Early Childhood

What was the FIRST DATE this provider began caring for your child(ren)?

Name of provider you are replacing:

What was the LAST DATE this provider cared for your child(ren)?

If you are ADDING providers, complete this box:

Name of ADDITIONAL provider:

What was the FIRST DATE this provider began caring for your child(ren)?

If your new child care provider is not willing to complete the attached pages, call _____ for a parent counselor at the Child Care Resource and Referral agency for your area. They may be able to help you find a new provider.

The Department reserves the right to require proof of all information on the attached pages.

Please return this form, **KEEP A COPY FOR YOUR RECORDS**, to:

1340 S Damen Ave #3, Chicago, IL 60608



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SECTION 1 - CHILD CARE ARRANGEMENT

Name of provider (attach a separate schedule for each provider you are requesting payment for). Mosaic Montessori Early Childhood

Provider Registration Number (Providers without a registration number should contact the CCR&R) 94328183033096

List only the children who will be cared for by THIS child care provider.
 If your children go to school, pre-k, or head start at another facility during the day, list only the hours that they are in child care with THIS provider. For school age children, list only the hours they are in child care.

Usual Schedule of Hours in Child Care

Child's Name	Age		MON	TUE	WED	THU	FRI	SAT	SUN	Daily Rate
			FROM	TO	TO	TO	TO	TO	TO	
		FROM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
		TO	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	

Does the child listed attend school? Yes No Year Round

What hours is the child in school? _____

Is the school at the same location as the provider? Yes No

Does this child care schedule vary? Yes No

If yes, please explain: _____

Does the provider offer a multi-child/family discount? Yes No

If yes, please explain: _____

Usual Schedule of Hours in Child Care

Child's Name	Age		MON	TUE	WED	THU	FRI	SAT	SUN	Daily Rate
			FROM	TO	TO	TO	TO	TO	TO	
		FROM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
		TO	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	

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Does this child care schedule vary? Yes No

If yes, please explain: _____

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If yes, please explain: _____



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		FROM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
		TO	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM

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Child's Name	Age		MON	TUE	WED	THU	FRI	SAT	SUN	
		FROM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
		TO	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM

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		FROM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
		TO	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM

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If yes, please explain: _____

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If yes, please explain: _____



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SECTION 2 - CHILD CARE PROVIDER INFORMATION

To be completed by the Applicant and the Provider **TOGETHER** (Please print clearly in blue or black ink).

**Parents or stepparents cannot be paid to provide child care for any children in the home.
 Providers must be at least 18 years of age and clear required background checks.**

Name of Child Care Provider Mosaic Montessori Early Childhood		If you are a Day Care Center, Corporate Name		
Address 4700 Oakton St.	Apartment Number	City Skokie	State IL	Zip Code 60076
Mailing Address, if different than above:			County Cook	
Phone Number (847) 213-0899	Fax Number (847) 675-3257	E-mail admin@mosaicearlychildhood.com		

Date of Birth (MM/DD/YYYY) (Not required for Centers and Licensed Providers) Month: _____ Day: _____ Year: _____

Provider Must Complete One: Note: Read the instructions included with the W-9 form for information on these options. If you have already registered as a provider for this program, list only your registration number.	Social Security Number (Individual or sole proprietor)
	FEIN (Corporation, partnership or sole proprietor) 453697685
	Gov't Unit Code (Public school or park district)
	IDHS Provider Registration Number 94328183033096

Child care providers are considered to be self-employed and taxes cannot be deducted from IDHS payments. This income is taxable and must be reported on tax documents. The Office of the Comptroller sends out a 1099 tax information form after each calendar year to all individual providers that earn \$600 or more a calendar year.

Enter date the child care provider recently began or will begin caring for children: (MM/DD/YYYY) _____

Have you been approved for the Illinois Quality Counts Quality Rating System (QRS)? Yes No

Are you an employee of the Illinois Department of Human Services or any other State agency? Yes No

Have you ever been convicted of anything other than a minor traffic violation? Yes No

If yes, please explain: _____

CHILD CARE COLLABORATIONS

Are you an IDHS approved Child Care Collaboration? Yes No Check all that apply: Head Start ISBE Pre-K

Are any of the children in this family enrolled as a collaboration child? Yes No

How long is your program? 9 Mo 12 Mo Other _____



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LEGAL CARE ARRANGEMENT

Check the appropriate type of provider. If licensed, complete Day Care Licensing Information.

CENTERS AND LICENSED PROVIDERS <input checked="" type="checkbox"/> Licensed Day Care Center (760)* <input type="checkbox"/> Day Care Center Exempt from Licensing (761) <input type="checkbox"/> Licensed Day Care Home (762)* <input type="checkbox"/> Licensed Group Day Care Home (763)*	*DAY CARE	LICENSING INFORMATION (DO NOT enter a Foster Care License Number) License Number: <u>519281</u> License Capacity: <u>46</u> Day <u> </u> Night License Expiration: <u>11-8-2021</u> Hours of Operation: From <u>7 am</u> To <u>6 pm</u>
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CARE BY A RELATIVE (LICENSE NOT REQUIRED) <input type="checkbox"/> In the Child Care Provider's Home (765) <input type="checkbox"/> In the Child's Home (767)	CARE BY A NON-RELATIVE (LICENSE NOT REQUIRED) <input type="checkbox"/> In the Child Care Provider's Home (764) <input type="checkbox"/> In the Child's Home (766)
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My relationship to the child(ren): _____

Language: English Spanish Polish Chinese Other: _____

NOT REQUIRED FOR LICENSED PROVIDERS

If care is being provided in the home of the provider, list all other people living in the provider's home

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PROVIDER	SOCIAL SECURITY NUMBER



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SECTION 3 - PARENT/GUARDIAN CERTIFICATION

After reading each of the following statements, I certify that:

- * I understand that I am responsible for paying a share of my child care costs (parent co-payment) to my child care provider and that failure to do so may result in the loss of my child care provider.
- * I understand that my eligibility will be redetermined every six (6) months or as needed.
- * The child(ren) is/are current on all immunizations and verification is on file with the child care provider.
- * A review of each facility/home has been completed and I agree that it is a safe environment.
- * I have given written notification to each child care provider if I want anyone other than myself to pick up the child(ren).
- * An emergency phone number and written consent for medical care and for dispensing prescription medication has been given to each child care provider.
- * The name of the family physician is on file with each child care provider.
- * I am responsible for the selection of the child care providers for my child(ren).
- * I will report any change in child care arrangements, employment or family size, within 10 days. Failure to report changes in a timely manner may result in an overpayment which I will have to pay back and/or loss of child care benefits.
- * I understand that I must be working or attending an IDHS approved education, training, or other work related activity in order to be eligible to receive child care benefits.
- * I understand the information provided will be checked using State and other databases, and if inconsistencies are discovered, the processing of my application, redetermination, or change of information may be delayed or denied.
- * I understand that deliberately providing an incorrect/fictitious Social Security number or withholding the Social Security number information in order to defraud the State of Illinois will cause me to be prosecuted to the fullest extent of the Law.
- * The information provided will be disclosed only for administrative purposes and that I may be required to verify the information that I have provided.
- * I understand that I have the right to appeal and to have a fair hearing of a grievance.
- * I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that giving false information or failing to provide correct information can also result in an overpayment which I will have to pay back and could result in my prosecution for fraud.

My signature is my consent and authorization for information to be released to the Illinois Department of Human Services or its agents that may establish my eligibility, or my continued eligibility for the child care.

Parent/Guardian's Signature: _____ Date: _____

Other Parent/Guardian's Signature: _____ Date: _____



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SECTION 4 - CHILD CARE PROVIDER CERTIFICATION

After reading each of the following statements regarding child care standards, I certify that:

- * Parents will have unrestricted access to their children at all times.
- * All state and local fire, health and safety codes have been followed and will be maintained.
- * All child care providers/staff will have a physical examination no more than two years old and a TB skin test documented and on file in the facility/home within 90 days of the signature date on this form. The TB skin test is to be no earlier than the date the provider/staff began providing child care services.
- * All cleaning agents, poisons and other hazardous materials are stored in an area inaccessible to the child(ren).
- * There are no firearms or ammunition in the home OR any firearms or ammunition in the home are stored in a locked cabinet or locked storage at all times.
- * First aid supplies are readily available.
- * There will be no corporal punishment.
- * The children will be provided developmentally appropriate play and physical activities daily.
- * The children will be supervised (indoors and outdoors) at all times.
- * The children will be provided nutritional meals/snacks daily based on the number of hours in care.
- * I have not been responsible, and if I am a home provider, no one living in my household age 13 and older has been responsible, for the abuse or neglect of children or any acts of sexual molestation or sexual exploitation of children. I authorize the Dept. of Children and Family Services to check the Child Abuse and Neglect Tracking System (CANTS) and the Sex Offender Registry (SOR) to confirm this information for the Department of Human Services.
- * I and members of my household may need to complete an Authorization for Background Check form. The CCR&R will mail this form and instruction if its completion is required.

After reading each of the following statements regarding child care assistance program policies, I understand:

- * That if I am a home child care provider, I will report any new person(s) living in my household within 10 days.
- * The information provided will be checked using State databases.
- * I understand the information provided will be disclosed only for administrative purposes and that I may be required to verify the information, but is also subject to release under FOIA.
- * I cannot be paid until I complete a W-9 form and I am certified by the Office of the Comptroller.
- * I am responsible for collecting a co-payment from each family and that the co-payment will be deducted from the payment I receive from IDHS.
- * The State is required to make payment deductions for all home child care providers in accordance with the Service Employees International Union (SEIU) contract.
- * The State is not liable for payment of child care services provided prior to the date of an approval notice issued by the State.
- * If I am a child care center provider, licensed home, or group home, I will maintain, for a minimum of five (5) years from the date of payment, daily attendance records to fully document the extent of services provided and agree to make all records and supporting documentation relevant to the services billed herein available to any and all authorized Department representatives and Federal authorities.
- * Failure to maintain adequate records shall establish a presumption in favor of the State for any funds paid by the State for which adequate documentation is not available to support disbursement.
- * In order to be considered exempt from DCFS licensing, I can care for no more than three children during any given day, including my own children, unless all children are from the same household.
- * If not licensed by DCFS, copies of my Social Security Card and current driver's license, State ID card, or military ID are included. In order to be current, the driver's license or ID must list my current address.
- * I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that giving false information or failing to provide correct information can also result in an overpayment which I will have to pay back and could result in my prosecution for fraud.
- * That the rates charged to the State of Illinois do not exceed the maximum allowed by the State and do not exceed those charged to the general public for similar services. This includes discounts such as multiple child discounts, staff discounts, full-week discounts, per-pay discounts, and sliding fee scales.
- * I certify that the hours of child care do not include hours the child is in school.
- * That deliberately providing an incorrect/fictitious Social Security number in order to defraud the State of Illinois will cause me to be prosecuted to the fullest extent of the law.
- * My signature is my consent and authorization for information to be released to the Illinois Department of Human Services or its agents that may establish my eligibility or my continued eligibility for the Child Care Program.

By signing and dating this document I certify that I have read and understand all the statements listed above. I certify that the statements as they are listed are true and that the information provided on this application is true, correct and complete.

Child Care Provider Signature: _____

Date: _____