

CHILD CARE PROVIDER VERIFICATION

State of Michigan
Department of Human Services (DHS)

INSTRUCTIONS TO THE CHILD CARE PROVIDER:

- Complete all information requested. Read all parts of the form. Sign and date the form.
- Return the completed form to the child(ren)'s parent/substitute parent.
- You will be sent a DHS-198, Child Development and Care Certificate/Notice of Authorization, if you are authorized as the provider for this child(ren).
- The parent is responsible for child care expenses that are not paid by DHS, including expenses incurred while a parent's or provider's eligibility is being determined.

Grantee Name					
Grantee ID			Case Number		
County	District	Section	Unit	Specialist	Date
Specialist Name					
Local DHS Office				Telephone Number	
Local DHS Office Address (Street Number and Name)					
City				State	Zip Code
				MI	
Due Date:					

INSTRUCTIONS TO PARENT/SUBSTITUTE PARENT:

- Read the information completed by the provider. Read the certification statements. Sign and date the form.
- Return the completed form to your local DHS office.
- You will be sent a DHS-4690, Child Development and Care Client Certificate/Notice, if care is authorized for this provider.

Child Care Provider or Child Care Center Director Name		Child Care Center Name (Centers Only)		County		
Address (Number and Street)		City		State	Zip Code	
				MI		
Provider ID Number		Telephone Number ()				
Do you receive any other reimbursement for caring for any of the children listed below?						
<input type="checkbox"/> NO		<input type="checkbox"/> YES ▶		If yes, for whom? _____ From whom? _____		
Where do you provide the child care? (Check all that apply.)						
<input type="checkbox"/> CHILD'S HOME		<input type="checkbox"/> FAMILY CHILD CARE HOME		<input type="checkbox"/> CHILD CARE CENTER		
<input type="checkbox"/> MY HOME		<input type="checkbox"/> GROUP CHILD CARE HOME				
List all children in the parent/substitute parent's family who are in your care.		Date of Birth	Date Care Began	Are you related to this child?		If yes, what is your relationship?
				<input type="checkbox"/> NO <input type="checkbox"/> YES ▶		
				<input type="checkbox"/> NO <input type="checkbox"/> YES ▶		
				<input type="checkbox"/> NO <input type="checkbox"/> YES ▶		
				<input type="checkbox"/> NO <input type="checkbox"/> YES ▶		

PARENT/SUBSTITUTE PARENT: I certify that my child(ren) receives care from this provider as of the date care began listed above. I understand that the agreement for child care is an arrangement between myself and the provider and I am responsible for child care expenses not paid by DHS. I understand that if my provider is a day care aide, I am the employer and not DHS and I am responsible for any employer taxes that need to be paid. I understand I must report my daily activity and child care hours each pay period. I must keep the DHS-641 and supporting documentation for 4 years. I understand that I may be prosecuted for perjury or fraud if I intentionally leave out any information or give false information which causes child care benefits to be issued that my provider or myself are not entitled to, or more benefits than what my provider or myself are entitled to. I understand and agree that if I receive an overpayment for any reason, the extra payments received must be repaid, and future payments can be reduced by 20%.

PROVIDER: I agree to all of the following: (1) I will not charge the parent more than I charge the general public. (2) I will maintain records showing the time of arrival and departure of each child served, certified by each child's parent/substitute parent on a daily basis, and I will retain these records for four years. (3) I may be required to return DHS payments if an audit or investigation finds that I do not have the required attendance records. (4) Parents of the children in care will have unlimited access to their children while in my care. (5) If I am overpaid for any reason, the incorrect payments received must be repaid, and the DHS may retain 20% of future payments and apply the retained portion to my overpayment balance until the overpayment has been repaid. (6) I am responsible for all use of the DHS electronic billing systems by anyone using my PIN. (7) I will limit access to my PIN to only individuals designated by me to act as my representative. (8) I will immediately contact the DHS Customer Service Unit at (800) 444-5364 to request a PIN reset if I believe that a person not authorized by me to act as my representative has obtained my PIN. (9) I will only report child care hours for hours when a child is present and in care. (10) I will report child ill/holiday hours only for State of Michigan holidays and absences due to the child's illness (not to exceed two consecutive weeks), only if I charge the general public for such holidays and absences, and only if the child would normally have been in care those hours. (11) I may only bill for ill/holiday hours that do not exceed the 208 hour limit per child, per fiscal year. (12) I will not report hours for the following reasons: The hours a child is in school, absences for "no shows" such as when a child simply fails to attend or leaves child care without notice, vacation periods of the parent/substitute parent, child, or myself, "holding a spot" for a child, State of Michigan holidays alone when a child is not in care on any other day during the biweekly (two-week) reporting period, continuous absences due to the illness of a child that exceed two consecutive weeks. (13) I understand that I may be prosecuted for perjury or fraud if I intentionally leave out any information or give false information which causes child care benefits to be issued that the parent/substitute parent or myself are not entitled to, or are greater than what the parent/substitute parent or myself are entitled to.

Provider Signature		Date	Parent/Substitute Parent Signature		Date
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<p>AUTHORITY: Public Act 280 of 1939. COMPLETION: Mandatory CONSEQUENCE FOR NONCOMPLETION: Child care subsidy payments will not be authorized.</p>	<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>
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