



Military Fee Assistance Department
 1515 N. Courthouse Road, 11th floor
 Arlington, VA 22201
 Phone: 1-800-424-2246

GIVE ARMY PARENTS A BREAK

CHILD CARE PROVIDER REGISTRATION FORM

Please complete this application and fax to 703-341-4169 Or email to ARMYRESPITECHILDCARE@nacarra.org

PROVIDER STATUS	
Provider/Program Name: _____ <small>(As it appears on license/registration)</small>	
Check Any That Apply:	
<input type="checkbox"/> Licensed Center	<input type="checkbox"/> Licensed <input type="checkbox"/> Regulated/Certified
<input type="checkbox"/> Licensed Family Child Care Provider	Regulatory status? <input type="checkbox"/> Licensed <input type="checkbox"/> Regulated/Certified
<input type="checkbox"/> Nationally accredited program	Accreditation Name <input type="checkbox"/> NAEYC <input type="checkbox"/> NAFCC <input type="checkbox"/> NAC <input type="checkbox"/> NECPA
<input type="checkbox"/> CDA credentialed FCC provider	

1. PROVIDER'S CONTACT INFORMATION:	
Provider/Program Mailing Address:	
Street Name and Number: _____	
_____	_____
City	State
Zip Code	
Address where care is to be provided:	
Street Name and Number: _____	
_____	_____
City	State
Zip Code	
County in which care is provided: _____	
Contact Name: _____	
Provider/Program telephone number: (____) _____ - _____	
Valid Email Address: <i>(Will be used for all communication)</i> _____	

2. PROVIDER'S PROGRAM PROFILE	
Child Care License No. /Registration No.: _____	
(COPY OF LICENSE/ REGISTRATION MUST BE ATTACHED)	
License Expiration Date: ____/____/____ Date of last Licensing Inspection ____/____/____	
Licensing Agency Contact Name _____ Licensing Agency Contact Phone: (____) _____ - _____	

ATTENTION: IN ORDER TO RECEIVE REIMBURSEMENT IN A TIMELY MANNER, DIRECT DEPOSIT IS PREFERRED.

3. PROVIDER'S DIRECT DEPOSIT INFORMATION

Attach a voided check for the account designated below

Bank Name: _____ City: _____ State: _____

Checking Account Savings Account

Account Number: _____

Automated Clearing House (ACH) Number: _____

Signature: _____

4. PROVIDER'S PROGRAM RATES/FEES

Provider Hourly charge per child: _____

Providers will be reimbursed at a maximum of \$10/hour for the first child and \$5 for each additional child, not to exceed \$20/hour per family.

Please check all boxes:

- The rates listed above are the true and correct rates that I charge *all* parents for the care of their child (ren) if providing hourly care. NOTE: Failure to adhere to this policy will result in provider/program being required to refund overpayments and in negative action including program termination and legal action.
- I understand that I must notify NACCRRA at least 15 (fifteen) days prior to any rate change in order for the new rate to be honored.
- I understand that program or policy violations will result in having to repay money to NACCRRA and/or suspension from future participation in the NACCRRA.
- I understand that NACCRRA will reimburse the provider for the amount of hours of child care per child each month for which the family is eligible. The cost of any care beyond will be the families responsibility.

I have read all of the above, I understand its content, and I certify that the information I have provided is true and correct.

Signature (Provider/Program Owner or Authorized Agent of Owner)

_____/_____/_____
Date:

MANDATORY SUPPORTING DOCUMENTS

In addition to this form I have submitted:

(Fax, or email these documents to NACCRRA.)

- W-9 Form
- Child Care License
- Copy of latest Licensing inspection
- National Accreditation certificate if applicable, and
- CDA credential **or** Early Childhood Education or Child Development degree (*if applicable in a child care home*)

5. PROVIDER'S PROGRAM RESPONSIBILITIES AND CERTIFICATION

I [the Provider/Program] understand/agree that (please check all boxes):

- Provider/program will continue to meet all minimum requirements set by the state and agrees to comply with all NACCRRA policies necessary for reimbursement.
 - Provider/program will fax or email the monthly attendance record **NO LATER THAN 30 days following** care or upon termination of care (if care stops before the end of the month).
 - NACCRRA will not pay fees for lateness, transportation, trips or any other miscellaneous fees (e.g., fieldtrips, etc.). Provider/program shall collect any such fees directly from the parent.
 - Provider/program agrees to repay NACCRRA any money received for which services were not provided.
 - The Applicant has chosen the Provider/Program to provide child care services. Prior to reimbursement, the Provider/Program must first provide all information requested on the front of this form and be determined a legal provider/program in your state. Provider agrees to provide Army Respite Child Care services **ONLY** when approved by NACCRRA.
 - I understand I will not be paid for care that was provided before I have received an approval certificate from NACCRRA. No care provided before approval will be reimbursed.**
- I have read all of the above and understand its content. I also understand that non-compliance with any of the above may result in termination of my participation in the NACCRRA.*

Signature(Provider/Program Owner or Authorized Agent of Owner)

_____/_____/_____
Date

6. NACCRRA RESPONSIBILITIES

- NACCRRA MILITARY PROGRAMS is responsible for coordination of child care payments and other related support services as necessary to the children and families served under this agreement.
- NACCRRA MILITARY PROGRAMS will not pay more than one provider/program, for the same child (ren), for the same period of care.