CCAP 16PDCI
Rev. 02/12
10/11 Issue Obsolete

Louisiana Department of Children and Family Services
Child Care Assistance Program

PROVIDER DIRECTORY CHECKLIST
Family Child Day Care Home "R"
Initial Application

Please complete this checklist to ensure that all required information is being returned with the packet. Please return this checklist with your packet.

Provider's Name ______________________ Provider Number ______________________

Provider SSN ______________________

Food Program Participant ☐ Yes ☐ No

- ☐ Completed Application for FCDCH
- ☐ Provider Agreement (signed and dated)
- ☐ Provider Rate Agreement (CCAP 15R)
- ☐ Verification of rates charged (notice to parents such as newsletter, bulletin, memo, etc.)
- ☐ Verification of identity (must be a government issued picture ID such as a driver's license)
- ☐ Social Security Card (copy)
- ☐ W-9 (SSN, name, physical address, taxpayer reporting status, signature and date)
- ☐ Residence Verification (verification of physical address)
- ☐ Age Verification
- ☐ Copy of a current Fire Marshal Inspection Report. If obtained through the Food Program it must be good for at least six months from the date Provider Directory receives this application packet.
- ☐ Current Infant/Child/Adult CPR Verification Expires On: ______________
  If verification is not provided, indicate reason:
  - ☐ Class taken but card not yet received.
  - ☐ Class is scheduled. Date of class: ______________
  - ☐ Other: ______________
- ☐ Current verification of Pediatric First Aid Training Expires On: ______________
  - ☐ Class taken but card not yet received.
  - ☐ Class is scheduled. Date of class: ______________
  - ☐ Other: ______________
- ☐ A CCAP 16E, Criminal Background Check Authorization form, completed for **each** of the following: the provider, any adult living at the provider's residence, any adult working in the provider's home or on the provider's home property.
- ☐ A certified check or money order made payable to the Department of Children and Family Services for criminal background check(s). There is a fee for each criminal background check; however, one certified check or money order can be provided for the total amount of all required Criminal background checks.
- ☐ Direct Deposit Authorization Form, if you would like to receive CCAP payments by Direct Deposit.
  - ☐ Checking Account – A voided check imprinted with your name and address OR a statement from your financial institution showing your name, address, account number, and routing number.
  - ☐ Savings Account – Statement from bank indicating account and routing numbers.
- ☐ Louisiana CCAP Provider Time and Attendance Equipment Agreement (CCAP 14EA) (Agreement must be completed, signed and dated. All pages must be returned.)

For Office Use Only

Active LAMI Case	Record Found Tips number:
NO LAMI Case	No record found on TIPS 301/305

CCAP 16A
Rev. 03/12
02/12 Issue Obsolete

Louisiana Department of Children and Family Services
Child Care Assistance Program

Family Child Day Care Home Provider Application Letter

Date: ______________________________

Dear Child Care Provider:

To receive payments from the Child Care Assistance Program (CCAP) for providing child care in your home, you must be registered with the Department of Children and Family Services (DCFS) as a Family Child Day Care Home Provider. Your registration must be renewed at least every two years. You must complete 12-clock hours of training in job-related areas approved by DCFS each renewal. You must have your home inspected by the Office of State Fire Marshal every year to ensure that your home meets basic health and safety standards. Those standards are listed on the attached form entitled "Health and Safety Standards for Family Child Day Care Homes". **Payment will not be made prior to the date registration begins.**

DCFS uses an electronic time and attendance process called Tracking of Time Services (TOTS) which automatically transmits to DCFS the time of arrival and departure of each eligible child in your care. You must participate in TOTS to receive payments from DCFS for child care services provided. Parents or guardians, and persons they designate as Household Designees (HD), are responsible for checking children in and out of care each time care begins and ends. You cannot be a household designee for a child you provide care for. DCFS will NOT PAY for any time that a child was in care when the child was not properly checked in and out of care or on or off of an approved child care vehicle except in circumstances such as equipment failure that was timely reported. Any invoice or request for manual payment of attendance not tracked through TOTS must be accompanied by the attendance log(s).

All forms must be completed with accurate information. Failure to provide truthful information may result in denial or termination of your eligibility as a CCAP provider. You must complete all forms and sign them in the same way that your name appears on your social security card, unless you have verification that a name change has been submitted to the Social Security Administration.

Information listed in numbers 1-13 below must be returned to the Provider Directory at the address listed on this form. If you do not provide this information, you will be ineligible to receive payments through CCAP.

1. Form entitled "Application for Family Child Day Care Home Registration" (CCAP 16C) with all items completed.

2. Copy of a passed Fire Marshal inspection report that verifies that your home has passed inspection by the Office of State Fire Marshal.

   PLEASE NOTE: You must go to the Office of State Fire Marshal's website at http://sfm.dps.louisiana.gov/dc_forms.htm and print the forms for Family Day Care Home Inspection and follow the instructions on the forms. CAREFULLY READ THE INSTRUCTIONS because your eligibility as a CCAP provider will end if you do not send DCFS a copy of a required passed Fire Marshal inspection report. To assist you in getting your home inspected, a link is included on the DCFS website at the "How to become a CCAP provider" section or you may go directly to the Office of State Fire Marshal's website at http://sfm.dps.louisiana.gov/dc_forms.htm.

   NOTE: If you have a current passed Fire Marshal inspection obtained through the Food Program and it does NOT expire within six months, DCFS will accept that Fire Marshal inspection for CCAP registration; HOWEVER, your certification for CCAP will end when the Fire Marshal inspection expires. All training, including the 12 clock hours, must be met during that shortened certification period or your eligibility to receive CCAP payments will end. If you have not previously provided verification of the one-time Orientation training, that is also required in this shortened certification period. Any training obtained in this certification period will not count toward the required number of hours needed for the next certification period. If you participate in the Food Program and your Fire Marshal inspection does NOT expire prior to six months from the date of submitting this provider packet, you may send a copy of that current Fire Marshal inspection report.

   You may prefer to obtain a new Fire Marshal inspection for CCAP and have the benefit of a certification period of up to two years with a Midpoint Review. This will give you 12 months to obtain your 12 clock hours and meet any other annual requirements.

(Over)

3. Family Child Day Care Home Provider Agreement Form, with all items at the top completed, and your signature and date.

4. Provider Rate Agreement (CCAP 15R).

5. Verification of the rates you charge for care such as, a copy of the notice to parents, newsletter, bulletin, or memo to parents.

6. Copy of your social security card.

7. Verification of identity. This must be a government issued picture ID such as a driver's license.

8. Verification of current Infant/Child/Adult Cardiopulmonary Resuscitation (CPR) Certification. Both the front and back of the CPR card must be copied and must show a certification date and an end date or renewal date.

9. Verification of current certification for pediatric first aid training, which has a certification date and end date or renewal date.

10. Verification of your place of residence, such as a recent rent, mortgage, phone, or utility receipt in your name or correspondence delivered by mail and determined acceptable by Provider Directory that shows your physical address. A P.O. Box is not acceptable for verification of your residence. Neither your residential address nor your mailing address (with the exception of a P.O. Box), may be that of the child/client for whom you provide care.

11. Verification of your age (copy of birth certificate, driver's license, etc.).

12. Request for Taxpayer Identification Number and Certification (Form W-9) with these items completed: name as it appears on the Social Security card, Social Security Number, physical address, signature, date, and Taxpayer Reporting Status (Line 3).

13. A form entitled "Criminal Background Check Authorization" (CCAP 16E) with all items completed for the provider, and a separate form for each adult residing at the same residence as the provider, and each adult employed by the provider in the provider's home or on the provider's home property. A fee of $26 for each criminal background check is required. Fees can be added together and a single certified check or money order sent for the total amount due for all criminal background checks made payable to Department of Children and Family Services.

    All certified checks or money orders submitted to the Department of Children and Family Services will not be returned or refunded.

14. If you have a checking or savings account in your name and would like to have your payments deposited directly into your account, complete the Direct Deposit Authorization Form (OFS DD2). You must also include a voided check if you would like your payments to be deposited into your checking account OR a statement from your bank or financial institution showing your savings account number and routing number if you would like your payments to be deposited into your savings account. The voided check must be imprinted with your name and address. If the voided check does not include this information, a statement from your financial institution showing your name, address, account number, and routing number must be provided. Once direct deposit has been established, this information will not be required again unless there is a change.

    If you do not complete the direct deposit form or you do not have a bank account, a Stored Value Card will be issued to you. If you were previously issued a Stored Value Card to receive CCAP payments and you still have that card, you do not need a new card. A Stored Value Card is a card with access to an account set up for providers, and any payments that you receive from the Child Care Assistance Program will be deposited into this account for your use. You can withdraw the money at an ATM machine for a small fee or use the card at businesses that accept VISA. You can also withdraw cash when making a purchase at stores that accept debit cards.

15. Completed, signed, and dated Louisiana CCAP Provider Time and Attendance Equipment Agreement (CCAP 14EA). If you receive payment by stored value card or you do not have a bank account you are not required to complete the banking information.

You may go to the DCFS website at www.dcfs.louisiana.gov/childcaretraining to find acceptable sources and approved course titles for CPR training and Pediatric First Aid training.

You must have on hand a statement of good health signed by a physician or his designee which must have been obtained within the past three years.

You must have access to a working telephone that can receive incoming calls and can make outgoing calls that is available at all times in the home in which care is being provided.

You must use only safe children's products in accordance with R.S.46:2701 (baby beds, play pens, high chairs, etc.) which have not been recalled.

For information about case status, certification/registration and licensing requirements, and maximum daily rates, you may call 1-888-LAHELPU (1-888-524-3578). You may also call this number or send an email to the Provider Directory at DSS.OFSProvider@la.gov if you have questions or need assistance in obtaining the information listed above or to report any changes.

Return to: **Provider Directory**
P.O. Box 94065
Baton Rouge, LA 70804

CCAP 16C
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Louisiana Department of Children and Family Services
Child Care Assistance Program

Case Name ______________
ID No. ______________
Worker ______________
Parish # ______________
Structure # ______________
☐ Renewal
☐ Midpoint
☐ Change

CCAP APPLICATION FOR FAMILY CHILD DAY CARE HOME REGISTRATION

(This application will not be considered complete until all information has been provided.)

Name:	
Residential Address (House Number/Apt. Number/Street/Hwy. Name):	
City, State, Zip:	Parish:
Home Telephone Number:	Contact Number:
Mailing Address (House Number/Apt. Number/Street/Hwy. Name/P.O. Box):	
City, State, Zip:	

What is the total number of children that you care for or will be caring for, including your own children under age 13 or 13 through 17 if disabled, and any other children? ______________

List all of the children that you care for, or will be caring for, including your own children under age 13 or age 13 through 17 if disabled, and any other children:

Name	Age	Relationship	Child's Address

FOR OFFICE USE ONLY

Contact Name: ______________ Phone #: ______________

See Reverse Side for Additional Questions

Are you participating in the Child and Adult Care Food Program? ☐ Yes ☐ No

I wish to apply/reapply as a registered Family Child Day Care Home Provider. **As a Family Child Day Care Home Provider, I agree to keep no more than a total of six children, whether related or unrelated to me.** This includes all children living in my home who are under age 13 and all children ages 13-17 if disabled. I will comply with all applicable state and local laws. I will possess a working telephone in my residence that can receive incoming calls and that can send outgoing calls and that is accessible at all times. I will permit parents to see and be with their children at all times. I certify that neither I nor any person living with me nor anyone employed in my home or on my home property has ever been the subject of a validated complaint of child abuse or neglect, nor been convicted of, or pled "no contest" to, a crime listed in R.S. 15:587.1 (C), or of any offense involving a juvenile victim.

I certify that I have received all appropriate immunizations and have on hand a statement of good health signed by a physician or his designee which has been obtained within the past three years.

List all household members and complete the requested information on each.			
Name	**Relationship**	**SSN**	**Date of Birth**

It is your responsibility to report if any other adults or children move into your home. Failure to report a new household member or a new employee may result in your termination as an eligible CCAP provider.

List any adults hired to work in your home or on your home property such as housekeeper, yardman, etc.		
Name	**SSN**	**Date of Birth**

YOU ARE RESPONSIBLE FOR REPORTING ANY NEW EMPLOYEES 18 YEARS OF AGE OR OLDER.

With my signature below, I certify that all information given above is true and correct to the best of my knowledge.

I understand that giving false information or violating the terms of the Provider Agreement can cause me to be terminated as an eligible provider for the Child Care Assistance Program. I understand that I must reimburse the Department of Children and Family Services for any ineligible payments received.

Signed: ______________________________ ______________________

Signature of Registrant/Applicant Date

Printed or Typed Name: ______________________________

Provider Name: ____________________
Initials of Provider: __________

CCAP 16D
Rev. 08/12
03/12 Issue Obsolete

Louisiana Department of Children and Family Services
Child Care Assistance Program

TIPS# __________
Worker Name __________
Worker # __________
Parish # __________
☐ Renewal
☐ Midpoint
☐ Change

Family Child Day Care Home Provider Agreement
(Class R)

Provider Information:

Name:		Social Security Number	Date of Birth
Street Address: City: Zip: Parish: Telephone: ( )		Mailing Address (if different from Street Address): City: Zip: Parish:	
E-mail:			
HOURS OF OPERATION:			

Monday	________	a.m./p.m. to	________	a.m./p.m.
Tuesday	________	a.m./p.m. to	________	a.m./p.m.
Wednesday	________	a.m./p.m. to	________	a.m./p.m.
Thursday	________	a.m./p.m. to	________	a.m./p.m.
Friday	________	a.m./p.m. to	________	a.m./p.m.
Saturday	________	a.m./p.m. to	________	a.m./p.m.
Sunday	________	a.m./p.m. to	________	a.m./p.m.

Agreement:
The Louisiana Department of Children and Family Services (hereinafter referred to as "Department"), and the child care provider named above (hereinafter referred to as "Provider") enter into the following agreement:

Regulations:

1. Provider will comply with all applicable state and federal laws, regulations and other standards and requirements in providing services under this agreement.

2. Provider is prohibited by regulation from keeping more than a total of 6 children, including all children living in the provider's home under age 13 or age 13 through 17 if disabled, regardless of relationship to the provider.

3. Provider must abide by all laws, rules, and regulations for any programs for which federal or state funds are received.

4. Provider must be at least 18 years of age. Government issued picture ID such as driver's license is required.

5. Provider will comply with all applicable laws concerning the use of child safety devices (car seat belts, child restraining seats, infant carrier seats, etc.) in the transportation of a child receiving child care from a Provider under this agreement, including Louisiana R.S. 32:295. This provision applies to all types of

vehicles used for transportation as part of the child care services furnished by the Provider. Provider also agrees to use only safe children's products in accordance with R.S.46:2701 (baby beds, playpens, high chairs, etc.) which have not been recalled.

6. Provider will comply with reporting requirements with respect to suspected child abuse/neglect.

7. Provider is prohibited from the use of corporal punishment such as, but not limited to, spanking, whipping with a switch or belt, arm twisting, or washing out mouth with soap or other foul tasting substances.

8. The provider must have on hand a statement of good health signed by a physician or his designee which must have been obtained within the past three years and be obtained every three years thereafter, for review upon request.

9. Provider must furnish verification of current Infant/Child/Adult Cardiopulmonary Resuscitation (CPR) certification. Both the front and back of the CPR card must be copied and must show a certification date and the end date or renewal date.

10. Provider must furnish verification of current certification for Pediatric First Aid training at every midpoint review and renewal.

11. Provider must submit verification at every midpoint review and renewal that the provider's home has passed an inspection with the Office of State Fire Marshal to ensure that specified health and safety standards are met. Provider must contact the Office of State Fire Marshal and follow their instructions to obtain the Fire Marshal inspection.

12. Provider must have a criminal background check completed on all adults living at the provider's residence, including the provider, and any persons employed by the provider in the provider's home or on the provider's home property.

13. At midpoint review and renewal provider must furnish verification of 12-clock hours of training in job-related subject areas approved by the Department of Children and Family Services. Provider must furnish verification of one-time Orientation Training at the first midpoint review or renewal, if not previously provided. Orientation counts towards the 12-clock hour training requirement in the certification period taken. Provider orientation is only required once unless requested by the Department.

14. Provider must possess a working telephone in their residence that can receive incoming calls and that can send outgoing calls and that is accessible at all times.

15. Provider must participate in Tracking of Time Services (TOTS) to capture time and attendance and posses the minimum equipment necessary to operate the system which includes a working internet connection or landline telephone. Provider cannot be a household designee for a child he/she cares for.

16. Provider understands and agrees that he/she is entering into this agreement in an independent capacity and that this Agreement does not make Provider an employee of the state or federal government or entitle Provider to government benefits.

17. Provider must have access to email or electronic communication, and keep this information current, as the Department will now be communicating information to providers by this medium. Any action taken on your CCAP agreement will continue to be sent by original correspondence. However, in order to stay current with any changes or departmental information, the Department will now be communicating electronically. Provide a valid email address below:

    Primary email address: ____
    (PLEASE PRINT)

    Secondary email address: ____
    (PLEASE PRINT)

Services/Payments:

18. Child care will be furnished only by the Provider identified above at the Provider's home address as given above to children for whom the Department makes payment. Provider will permit parents to see and be with their children at all times.

19. Provider may not live at the same residence as the child(ren) for whom care is being provided or share the head of household's mailing address (with the exception of a P.O. Box).

20. This agreement does not guarantee the placement of any child in Provider's facility. Department does not recommend any child care provider, it is the right of parents/caretakers to make this choice from among all participating Providers in their area.

21. Provider will charge the Department no more than the maximum rate charged to any other child in care for the same service. Provider must not charge any more or any less than the amount shown on the CCAP Rate and Availability Verification Form (CCAP 7B) in order to become or remain an eligible Child Care Assistance Program Provider. Provider may not collect payment from the Child Care Assistance Program for any portion of the child care expense paid by a third party. **Provider must charge parent/guardian and collect the difference between the total charged and the Department payment.**

22. Payment to the Provider will be based on a percentage of either the Provider's actual charge or the state maximum rate for the authorized services, whichever is less.

    Payment will not be made for absences of more than two days for a child in any calendar month or for an extended closure by a provider of more than two days in any calendar month. A day of closure, on a normal operating day for the provider, is counted as an absent day for the child(ren) in the provider's care. If a child authorized for full-time care attends child care less than four hours in one day, this will be counted as a half day absent and half the daily rate will be paid to the provider. No absences will be paid for part-time care.

    Payments will not be made for any days after the last day that authorized care was provided. Days when the provider is unable to provide care will count as days of absence for the children in the provider's care.

    In cases of a federal/state/locally declared emergency situation, or other special circumstances, the Department may at the discretion of the Deputy Secretary of Programs waive the absence policy.

23. Provider agrees to notify Department promptly when Provider rates change. A new Provider Rate Agreement form and appropriate verification of the change (notice to parents of increase such as newsletter, bulletin, memo, etc.) will be required at that time. Department agrees to provide a new CCAP Rate and Availability Verification Form (CCAP 7B) for each CCAP eligible child for whom the provider's rate has changed. Provider agrees to complete and ensure return of the CCAP 7B to the Department. Department agrees to change the payable rate, subject to the state maximum rate, effective the first of the month following receipt of the new Provider Rate Agreement and verification of the new rates to Provider Directory, if the new CCAP 7B is postmarked or received timely.

24. Provider agrees to report equipment problems with a Point of Service (POS) device or finger image scanner to the ACS Provider Help Desk AND the DCFS local office within 48 hours of failure.

Ownership/Subcontracts:

25. This agreement shall not be transferred to another Provider or to another location of the same Provider, nor shall it be subcontracted to any other person. **Any transfer, change of location or subcontracting shall be grounds for immediate termination of this agreement by the Department.**

Monitoring/Record keeping:

26. Provider will keep a required daily attendance log for children, including arrival and departure time, for each child participating in the program, anytime TOTS is unavailable or not used to track the arrival and departure time of a child in care. The daily attendance log must contain the minimum required information as outlined on the CCAP 15PR (Provider Payment and Reporting Responsibilities). If transportation is provided, a daily transportation log is also required. If you do not have a daily attendance log, you may go to www.dcfs@louisiana.gov and print a copy.

    Provider will notify the Department immediately of the removal of any child from its care so that payment from the Department for that child can be discontinued.

    In the event that a manual invoice or CCAP 40 (Child Care Provider Manual Payment Request Remittance Advice) is required the provider is responsible for completing the document accurately and reporting any discrepancy in payment to the Department. Any invoice or request for manual payment of attendance not tracked through TOTS must be accompanied by the corresponding attendance log(s). Provider agrees to submit the invoice or CCAP 40 within seven (7) calendar days of receipt. Falsifying an invoice or CCAP 40 constitutes a violation of this Agreement. Payment will be made to the Provider by Department from state and federal funds by state warrant.

27. Provider will furnish Department with such reports as are required by Department in such format as is prescribed by Department.

28. Designated Department staff or representatives will make unannounced inspections of Provider's facility at any time during normal working hours. Provider will cooperate and participate fully in any such inspections, and Provider will make the home fully accessible to Department representatives.

29. Department staff representatives and Provider will carry out the requirements to monitor and conduct fiscal or program audits at reasonable times and provide consultation and technical assistance for the development of Provider's facility. Department's authority to monitor and conduct fiscal or program audits applies to Provider to the extent of the services furnished under the terms of this agreement. Provider will promptly admit representatives of all regulatory and/or funding agencies during any hours when children are in care and fully cooperate with said representatives in the performance of their duties.

30. Provider will retain supporting fiscal documents (invoices, attendance logs, and remittance advices) adequate to insure that claims for matching federal funds are in accordance with federal requirements. Provider shall retain such documents for 3 years after close of the state fiscal year in which services are provided.

31. Provider will give representatives of Department and of the U. S. Department of Health and Human Services (DHHS) access at reasonable times to all books, records and supporting documents kept by Provider for purposes of inspection, monitoring, auditing, or evaluation by Department or DHHS personnel.

Agreement Timeframes:

32. This agreement shall become effective upon execution by the parties hereto on the date listed below. Department shall incur no liability for payment for child care for any child until Provider has received from Department a notification of eligibility and payment for that child. **The number of children for whose care Department makes payment to Provider at any time cannot exceed more than a total of six children.**

33. This agreement:

    A. Shall be permanently terminated at the close of business on the first workday after the Department receives notice that the criminal background check shows that the provider has been convicted of, or

pled no contest to, a crime listed in R.S.15:587.1.C. This will result in permanent ineligibility as any type of CCAP provider.

B. Shall be terminated:

1. Immediately and without necessity of advance notice by written mutual agreement of both parties; or

2. At the close of business the first workday after receiving notification that the home has failed to pass inspection by the Fire Marshal; or

3. In thirty (30) days upon either party giving written notice to the other party of its intent to terminate; or

4. At the close of business on the license end date or closure date entered in the TIPS Provider Directory, whichever is first, which may be due to ineligibility for registration.

5. Concurrent with the date that a provider is permanently disqualified from CCAP.

6. At close of business following expiration of advance notice or the current certification end date, whichever occurs first, if the provider fails to submit any of the information requested that is necessary to process the renewal of certification of the provider.

34. All payments by Department to Provider under this agreement shall cease immediately upon termination of this agreement.

35. By executing this agreement, neither of the parties incurs an obligation, either express or implied, to renew this agreement or execute a new agreement between the parties after the termination of this one.

36. The Provider shall be disqualified from receiving CCAP payments if the Department determines that certain acts or violations have been committed. Depending upon the act or violation, the disqualification may be permanent, or it may last for a period of three months to 24 months for reasons such as, but not limited to:

A. A condition or situation exists that places the lives, safety, or physical, mental, or emotional well-being of any child entrusted to the provider's care in imminent danger, regardless if such a condition or situation results from an act or omission by the provider.

B. The provider has over six children in his/her care including all children under age 13, or age 13-17, if disabled, living in the provider's home regardless of relationship to the provider.

C. Violating the terms of the Provider Agreement and/or Provider Rate Agreement, if false information or documentation is furnished to obtain or maintain registration or certification or if specified changes are not reported as required. Specified changes are listed on form CCAP 15ICP (Invoice Completion Instructions) and form CCAP 15PR (Provider Payment and Reporting Responsibilities).

D. The provider has allowed an improper check-in and or check-out or submitted invoices for payment when the provider knew or should have known that the electronic information or information contained in such invoices was false.

E. A provider has prevented or, through the use of force, violence or threats, has attempted to prevent any DCFS officer or employee from performing any of his/her official functions.

F. A condition or situation exists that places the lives, safety, or physical, mental, or emotional well-being of any government officer or employee performing official duties involving or concerning provider in imminent danger, regardless if such a condition or situation results from an act or from omission by the provider.

37. Under no circumstances will payment be made outside of the effective dates of this agreement. Neither the federal government nor the State of Louisiana provides appeal rights for providers whose participation in the Child Care Assistance Program is refused or terminated.

    There is no right to a State contract, which is what a CCAP Provider Agreement is. The decision to deny appeal rights was made by the State Legislature and the Department does not have the authority to overrule State law. If a provider appeals denial or revocation of REGISTRATION the provider is not entitled to CCAP payments during the appeal process and winning the appeal does not restore CCAP payments or eligibility.

Recovery:

38. If the Department determines that any amounts paid to the provider exceeded the amount to which the provider was qualified, the Department shall have the right to recover or recoup those amounts.

Signatures:

39. By signing this agreement, Provider agrees to abide by the foregoing provisions stated herein.

This agreement shall commence on ______________________ and terminate on Provider's registration expiration date _____________________ or upon the revocation of the Provider's registration or termination of eligibility as a CCAP Family Child Day Care Home provider, whichever comes first.

____ ______________________
Provider Signature Date

____
Provider Name (Print)

____ ______________________
Department Signature Date

Louisiana Department of Children and Family Services
Child Care Assistance Program

Criminal Background Check Authorization

Instructions for Completing the Enclosed Criminal Background Check Authorization Form For Family Child Day Care Home Providers or In-Home Providers

For a Family Child Day Care Home Provider a separate Criminal Background Check Authorization is needed for the provider, each adult living at the provider's residence, and any persons employed by the provider in the provider's home or on the provider's home property.

Example:

Sarah Brown is a Family Child Day Care Home Provider. She lives with her husband, Bobby. She also has an employee, Jimmy Smith, who does the yard work. Ms. Brown would need to submit 3 completed forms.

EACH person needing a criminal background check must complete the "Applicant" information at the bottom of page 1 and the middle of page 2. Please print in ink. THE APPLICANT IS THE PERSON WHOSE CRIMINAL RECORD IS BEING CHECKED. PAGES 1 AND 2 SHOULD HAVE THE SAME APPLICANT NAME.

APPLICANTS FULL NAME – The applicant will print their last name, first name and middle name in the spaces provided. Include maiden name and previous married names, if applicable.

APPLICANTS SIGNATURE – The applicant will sign their name.

DATE OF BIRTH – The applicant will print their date of birth.

DRIVERS LICENSE # and STATE – The applicant will print their drivers license number and the state in which they received their drivers license.

RACE and SEX – The applicant will print their race and their sex.

POSITION OR LICENSE APPLIED FOR – The applicant will complete this section with the appropriate position. The position applied for can be listed as "watching children in home", "child care provider", "spouse or husband of child care provider", "employee of child care provider", or other applicable statement.

Example:

APPLICANT'S FULL NAME: Brown Bobby Ray
POSITION OR LICENSE APPLIED FOR: Husband of child care provider

A certified check or money order must be made payable to Department of Children and Family Services to cover the cost of the criminal background check. The cost is $26.00 per person. One certified check or money order can be sent for the total amount due.

Criminal Background Check Authorization Form

Louisiana State Police
Bureau of Criminal Identification and Information
P. O. Box 66614 (Mail Slip A-6)
Baton Rouge, LA 70896

THE FEE FOR PROCESSING A STATE BACKGROUND CHECK IS $26. FOR FBI PROCESSING, WHERE AUTHORIZED OR REQUIRED, THERE IS AN ADDITIONAL $24 FEE

****FORMS MUST BE FILLED OUT IN INK AND BE REVIEWED BY SUBMITTING AGENCY/INDIVIDUAL FOR ACCURACY****

******FINGERPRINTS ARE NECESSARY FOR A POSITIVE IDENTIFICATION******

******PLEASE PRINT*****

Provider Directory FACILITY OR AGENCY	FACILITY OR AGENCY AUTHORIZED REPRESENTATIVE
P.O. Box 94065 MAILING ADDRESS	SIGNATURE OF AUTHORIZED REPRESENTATIVE
Baton Rouge — LA — 70804 CITY — STATE — ZIP CODE	FACILITY OR AGENCY PHONE NUMBER
	FACILITY E-MAIL ADDRESS

Request For: (pick one only)

- ☐ ALCOHOL AND BEVERAGE COMMISSION
- ☐ ALCOHOL BEVERAGE OUTLET
- ☐ CASA
- ☐ CONCEALED HANDGUNS
- ☐ CRIMINAL JUSTICE EMPLOYEE
- ☒ DAYCARE
- ☐ DENTISTRY BOARD
- ☐ DEPARTMENT OF LABOR
- ☐ DEPARTMENT OF PUBLIC SAFETY
- ☐ EMPLOYERS
- ☐ FIREFIGHTERS
- ☐ GAMING
- ☐ HEALTH CARE PROVIDER
- ☐ JUVENILE DETENTION CENTER
- ☐ DEPARTMENT OF INSURANCE
- ☐ MANUFACTURED HOUSING
- ☐ MEDICAL EXAMINERS
- ☐ OCS ABUSE/NEGLECT INVESTIGATION
- ☐ OCS CARETAKER
- ☐ OCS FOSTER/ADOPTIVE
- ☐ OCS PERSONNEL
- ☐ OFFICE OF FINANCIAL INSTITUTIONS
- ☐ OFFICE OF PUBLIC HEALTH
- ☐ PHARMACY BOARD
- ☐ POSTSECONDARY EDUCATION
- ☐ PRACTICAL NURSING
- ☐ PRIVATE ADOPTION
- ☐ PRIVATE INVESTIGATORS
- ☐ PRIVATE SECURITY
- ☐ PUBLIC HOUSING
- ☐ PUBLIC TAG AGENT
- ☐ REGISTERED NURSING
- ☐ RELIGIOUS ACTIVISTS
- ☐ RIVERBOAT PILOTS
- ☐ SCHOOL
- ☐ SENATE AND GOVERNMENTAL AFFAIRS
- ☐ TAXI DRIVERS
- ☐ USED MOTOR VEHICLE COMMISSION
- ☐ VENDOR
- ☐ VOLUNTEERS WITH YOUTH SERVING ORGANIZATIONS
- ☐ WORKING WITH CHILDREN

APPLICANTS FULL NAME: ______________________________
****PRINT – USE INK**** LAST FIRST MIDDLE
(INCLUDE MAIDEN NAME & PREVIOUS MARRIED NAMES IF APPLICABLE)

APPLICANTS SIGNATURE: ______________________________

APPLICANTS SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____

DRIVERS LICENSE# ______________ & STATE ________ RACE _____ SEX _____

POSITION OR LICENSE APPLIED FOR ______________________________

AUTHORIZATION TO DISCLOSE CRIMINAL HISTORY RECORDS INFORMATION

By my signature above, I hereby authorize the Louisiana State Police to release all pertinent criminal record information maintained in their files, other states files, or the FBI files (if applicable) which may confirm or deny my eligibility with the facility or agency named above.

APPLICANT PROCESSING – DISCLOSURE
BUREAU OF CRIMINAL IDENTIFICATION AND INFORMATION
P.O. BOX 66614 (MAIL SLIP A-6)
BATON ROUGE, LA 70896

LSPAPP5/R10.03

AGENCY

NOTICE

PLEASE PRINT OR TYPE INFORMATION, EXCLUDING ADMINISTRATORS OR AUTHORIZED PERSONS SIGNATURE. INCOMPLETE FORMS WILL NOT BE PROCESSED.

MAILING ADDRESS

CITY STATE ZIP CODE

NAME

/ / DATE OF BIRTH

/ RACE SEX

____ - ____ - ____
SOCIAL SECURITY NUMBER

ALL INFORMATION RELEASED MUST REMAIN STRICTLY CONFIDENTIAL AND ONLY THOSE AUTHORIZED BY LAW TO RECEIVE THIS INFORMATION MAY SUBMIT A REQUEST.

DO NOT WRITE BELOW THIS LINE: {For Bureau of Criminal Identification and Information Use Only}

NOTICE: The response to your request for a criminal history check is based on a review of the State of Louisiana's criminal history records database as is available at the time of request. This does not preclude the possible existence of conviction information not available in our database.

CRIMINAL HISTORY DETERMINATION:

☐ **RAPSHEET ATTACHED**

☐ **RESPONSE BELOW**

Louisiana Department of Children and Family Services

Information about Direct Deposit & the Stored Value Card

The Department of Children and Family Services makes payments using Direct Deposit or a Stored Value Card (SVC) for child care payments. This process will ensure that you receive your payments in a safe, easy, and effective manner.

Child care payments will be deposited directly into your checking or savings account or credited to an SVC. If you do not have a checking or savings account, an SVC will be issued to you automatically if you are a Family Child Day Care Home or In-Home Provider. Class A, Class M, and school child care providers must have Direct Deposit or they will ***not*** be eligible to receive payments from the Department of Children and Family Services.

Direct Deposit

Direct Deposit is the electronic transfer of funds to your checking or savings account. All Class A, Class M, and school child care providers must have Direct Deposit to receive payments.

You may participate in Direct Deposit if you meet the following criteria:

- Have an active checking or savings account in your name or the center's name.
- Complete and submit the Direct Deposit Authorization Form (OFS DD 2) with required documentation for the account type selected as listed below.
  - For checking accounts, submit a voided check imprinted with your name and address or a statement from your financial institution showing your name, address, account number, and routing number.
  - For savings accounts, submit a statement from your financial institution showing the account number and the routing number.

Once the completed OFS DD 2 has been received, it will be processed and your account information will be verified with your financial institution. If the account information is rejected, payments will not be issued through Direct Deposit until you provide the correct account information.

Making Changes to Direct Deposit

To change the account into which Direct Deposit is made, you must notify the Provider Directory in writing by completing a new OFS DD 2. If you cancel Direct Deposit, you will be given the choice of either providing new account information or being issued an SVC only if you are an In-Home or Family Child Day Care Home provider**. If you have any questions about making changes to Direct Deposit, contact the Provider Directory at P.O. Box 94065, Baton Rouge, LA 70804 or call 1-888-LAHELPU (1-888-524-3578).**

Stored Value Card

A Stored Value Card is a card with access to an account called Chase Direct Payment. This account is another method of direct deposit where payments are placed on a card for use at businesses that accept VISA. Cash can be withdrawn from any Chase or All Point ATM with the card free of charge. Other ATMs may be used to withdraw cash, for a small fee. You must request a replacement card from Chase Bank if your card is lost or stolen.

Availability of Funds

Once Direct Deposit or SVC has been activated, payments should be available within 48 hours after the parish/district office authorizes the payment. Despite our best efforts, delays in payment may occur. You should plan and budget for necessary expenses in the event that an unplanned and unavoidable delay in payment occurs. You may contact your financial institution to verify funds deposited into your account by direct deposit. For funds credited to your SVC account, you may contact Chase Bank.

OFS DD 2
Rev. 12/10
06/10 Issue Obsolete

Louisiana Department of Children and Family Services
Child Care Assistance Program

DIRECT DEPOSIT AUTHORIZATION FORM

Return to:

Provider Directory
P.O. Box 94065
Baton Rouge, LA 70804

Please **TYPE** or Legibly **PRINT** all information in **INK**.

Section 1: PARTICIPANT CASE INFORMATION

Name: ______________________ Date of Birth: ______________

Mailing Address: ______________________

City/State/ZIP: ______________________

Daytime Telephone #: (   ) ______________ Home Telephone #: (   ) ______________

Social Security Number: ______________ Provider Number: ______________

Section 2: FINANCIAL INSTITUTION INFORMATION

Name of Financial Institution: ______________________

Mailing Address: ______________________

City/State/ZIP: ______________________

Telephone #: (   ) ______________

Routing Number: ______________ Account Number: ______________

Account Type (Check One): ☐ Checking* ☐ Savings*

Check One: ☐ New Request ☐ Change Account ☐ Cancel Direct Deposit

***Note**: **Be sure to include a voided check for checking accounts. For savings accounts, submit a statement from your financial institution showing the account number and routing number.**

Section 3: AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF PAYMENTS

I authorize the Department of Children and Family Services (DCFS) to deposit my payments directly into my checking account or savings account as specified above. DCFS is also authorized to adjust any over/under deposit it has made to my checking account or savings account. I understand the deposits/adjustments will be made electronically by Automated Clearing House Network (ACH) transactions and I must allow the Federal Reserve two work days from the disbursement date to have the funds available to my financial institution. I also understand the following: It is my responsibility to provide correct routing and account information for ACH transmissions by attaching a voided check for a checking account or a statement from my financial institution showing the account number and the routing number for a savings account. The voided check must be imprinted with my name and address. If my voided check does not include this information, a statement from my financial institution showing my name, address, account number and routing number must be provided. I will immediately notify DCFS if my banking information changes. I must submit a new Direct Deposit Authorization form to change or cancel my direct deposit. I must notify DCFS of any changes to my address. I must include my name and provider number on all correspondence regarding direct deposit. To verify when a payment is posted to my account and funds are available, I will have to contact my financial institution.

By signing below I signify that I have read and agree to all of the conditions listed above.

Signature: ______________________ Date Signed: ______________

Office Use Only

Date Entered: ______________ Entered By: ______________

DO NOT COMPLETE THIS FORM IF YOU WANT A STORED VALUE CARD

Direct Deposit Form Instructions

This form authorizes the Department of Children and Family Services to deposit payments directly into your account. If you choose to have your child care payments sent to your financial institution, you must complete this form to authorize this action. The financial institution may be any bank, savings and loan association, or federal or state chartered credit union or similar institution. If you do not have an account in one of these institutions contact the financial institution of your choice to establish an account.

Deposits will be made by an electronic funds transfer (EFT) from the Department of Children and Family Services to your account, provided your financial institution is a member of the Automated Clearing House (ACH) system. In the event your financial institution is not a member of the ACH System, a Stored Value Card will be issued for Family Child Day Care Home and In-Home Providers only. Class A, Class M, and School Child Care Providers must have Direct Deposit or they will not be eligible to receive payments through DCFS.

Section 1-Provider Case Information

Name: Name of the provider. This is the name of the facility, In-Home provider, or Family Child Day Care Home Provider. The name of the bank account must be in the name of the facility for Class A, Class M, and School Child Care Providers. A personal account for these facilities is not acceptable.

Date of Birth: Enter the date of birth of the Family Child Day Care Home or In-Home Provider.

Mailing Address: The complete mailing address of the provider, including an apartment number (where appropriate). This address must be kept current with the Provider Directory.

You must notify the Provider Directory when your address changes.

Telephone Numbers: Area code and daytime telephone number of the provider.

Social Security Number: Social Security number of the In-Home or Family Child Day Care Home provider. The Social Security number is used to identify the provider's records and payments.

Section 2-Financial Institution Information

Name of Financial Institution: Complete the name, address and telephone number of the financial institution to which the payment will be sent (bank, savings and loan association, credit union, etc.) and the branch designation.

Routing Number: The routing number is the bank's federal identification number.

Account Number: The account number is a group of numbers assigned to an individual at a particular financial institution for tracking purposes.

Account Type: Identify the type of account in which the payments are to be deposited. The account may be either a checking or savings account. Attach a voided personal check for a checking account or a statement from your financial institution showing the account number and routing number for a savings account.

Reason for Completing this Form: Indicate if this is a new request, if you would like to make a change in account information, or if you would like to cancel direct deposit.

Section 3- Authorization Agreement for Direct Deposit

Signature: Sign and date the form. The signature must be that of the provider.

CCAP 15R
Rev. 10/11
12/10 Issue Obsolete

Louisiana Department of Children and Family Services
Child Care Assistance Program

OFFICE USE ONLY
_____________ New Provider
_____________ Rate Change
_____________ CHOW
_____________ CHOL
_____________ New license/other

Provider Rate Agreement

Name of Provider	Tips Provider No.	License No. If Applicable
Physical Street Address	City, State	Zip Code
Mailing Address, If Different From Above	City, State	Zip Code
Phone Number	Cell Phone Number	

☐ Class A ☐ Military Provider ☐ FCDCH Provider ☐ Provider in Child's Home ☐ School Program Provider

Rate changes should be promptly reported to Provider Directory at the address below.

Please complete the following and include verification of your rates (notice to parents, such as newsletter, bulletin, memo, etc.)

A CCAP Rate and Availability Form will be sent for each child in your case and must be completed and returned in order for you to be paid.

Do you have a Class A license? ☐ Yes ☐ No Are you a Head Start Program? ☐ Yes ☐ No

Do you have special rates for more than one child in a family? ☐ Yes ☐ No Rate: ________________

Do you serve children with disabilities ages 13 - 17? ☐ Yes ☐ No

Do you serve children under age 18 who have special care needs because of a mental, physical, or emotional disability, requires specialized facilities, lower staff ratio, or specially trained staff to meet his/her developmental and physical needs?
☐ Yes ☐ No

If yes, is the rate for this child higher, lower, or the same for other children for whom you provide care?
☐ Higher ☐ Lower ☐ Same

Do you participate in the Child and Adult Care Food Program? ☐ Yes ☐ No

Rates Charged Per Child

You must complete both sections below, even if you do not currently care for a child in each age group.

Under 3 Years of Age:

Full-Time Care $ ____________ per Day

3 Years of Age and Over:

Full-Time Care $ ____________ per Day

Complete part-time care rates only if you provide part-time care.

Under 3 Years of Age: Part-Time Care $ ____________ per Hour

3 Years of Age and Over: Part-Time Care $ ____________ per Hour

_______________________________ _______________________
PROVIDER SIGNATURE AND TITLE DATE

____
PRINT NAME

_______________________________ _______________________
CAPS/TIPS REPRESENTATIVE DATE

RETURN TO:

PROVIDER DIRECTORY
P.O. Box 94065
Baton Rouge, LA 70804

CCAP 14EA
Issued: 11/10

LOUISIANA CCAP PROVIDER TIME AND ATTENDANCE EQUIPMENT AGREEMENT

FOR INTERNAL USE ONLY
Agreement Number: LADAYC-00-

CCAP Provider ID: ____________________

Effective Date: ______________________

This **Agreement** is made by and between ACS State & Local Solutions, Inc. a New York Corporation, having an office at 8260 Willow Oaks Corporate Drive, Fairfax, VA 22031 (hereinafter "**ACS**") and ______________ ____ , a ☐ ________________________ corporation,

☐ individual(s), ☐ partnership, ☐ other ________________ ; organized and existing

Under the Laws of the State of ____ , and having

a ☐ business, ☐ Residence at ____
(hereinafter **"Provider"**).

ACS is under contract with the State of Louisiana (hereinafter "**State**") to provide an automated e-Child Care system that provides timekeeping and recording of attendance of State authorized Child Care attendees. As part of that contract with the State, ACS is also required to furnish equipment for the use of Class A, R and M. child care providers and maintain that equipment.

Article 1: ACS STATE AND LOCAL SOLUTIONS RESPONSIBILITIES

1.1 ACS will furnish Provider with Point of Service (POS) and biometric finger image reader equipment (hereinafter "**Equipment**") and related services: installation, training, repair, and help desk support.

1.2 Equipment. Equipment shall be a VeriFone model VX 570 (POS) and MSO300 (Biometric reader). ACS reserves the right to change the Equipment's brand, model or features at any time without prior notification to Provider.

1.3 Equipment Ownership. Equipment shall at all times remain the property of ACS.

1.4 Equipment Usage. Equipment shall be used by Provider solely in connection with the Louisiana Child Care Assistance Program (hereinafter "**CCAP**").

1.5 Equipment Allocation. Guidelines for Equipment allocation are established under a separate contract between ACS and the State. Equipment will be allocated at a ratio of 1 unit of Equipment to 40 State authorized Child Care attendees (hereinafter "Active Participants"), with the following two exceptions: (1) Class A, R, and M Providers who provide services for 39 or less authorized Child Care attendees will receive, at a minimum, one unit of Equipment; (2) Providers will receive an additional unit of Equipment if there is a "remainder" after dividing the highest number of authorized Child Care attendees by 40. Examples: (1.) A Provider with 1-40 Active Participants would receive 1 unit of Equipment; (2.) A Provider with 41-80 Active Participants would receive 2 units of Equipment; (3.) A Provider with 85 Active Participants would receive 3 units. If a single Child Care Provider operates more than one facility, these guidelines apply to each of the facilities.

ACS reserves the right to remove Excess Equipment on demand during Provider's normal business hours. Excess Equipment is defined as any equipment that exceeds the equipment allocation pursuant to the Guidelines for Equipment allocation described above and in the contract between ACS and the State of Louisiana.

1.6 Installation. ACS shall provide for Equipment installation at a time mutually agreed to between ACS (or its designated installer) and the Provider.

1.7 Training. At the time of installation, the Provider or authorized person will be trained and provided one (1) *Quick Reference Guide* and one (1) *Louisiana Child Care Provider Operations Manual*. This reference material will be made available on the Child Care Provider Web. Amendments to the Quick Reference Guide and the Louisiana Child Care Provider Operations Manual will be provided in hard copy.

1.8 Help Desk. ACS shall provide a toll free telephone number for Provider use 24 hours per day/7 days per week. The Help Desk will be staffed by customer support representatives**.** The Help Desk will also be staffed on all major holidays except New Year's Day, Independence Day, Thanksgiving, and Christmas Day. During non-staffed time, Help Desk calls will be handled through an Interactive Voice Response Unit (IVR). Telephone calls from pay phones will not be accepted.

1.9 Equipment Repair. ACS shall be solely responsible for repair of Equipment. For Equipment repair, Provider shall promptly notify ACS using the telephone number(s) separately furnished to Provider by ACS. Repair calls will be accepted during normal help desk hours listed above or the Provider may leave a message on the IVR regarding the nature of the problem. Telephone calls from pay phones will not be accepted. At ACS discretion, Equipment may either be repaired or replaced. If the equipment issue cannot be resolved by phone with the Customer Service Representative nor NEMC, and replacement equipment is required, the equipment is replaced within 24 hours of notification of the problem and is received by the provider the following business day.

1.10 Supplies. ACS will provide the initial supply of paper. After the initial supply, Providers will be responsible for purchasing paper for the equipment. ACS will be responsible for financially reimbursing the Provider for paper used in the Equipment. The amount of reimbursement is based on an algorithm of Equipment usage, not supplies actually expended. Reimbursement shall be made monthly via electronic funds transfer only.

Article 2: PROVIDER RESPONSIBILITIES

2.1 Equipment Use and Care. The Provider agrees that it shall follow the instructions of any manuals accompanying the Equipment, as amended from time to time, in the care, use and installation requirements of the Equipment as specified by the manufacturer or ACS.

2.2 Equipment Security. Provider agrees that it shall provide reasonable security measures to protect the Equipment from damage, theft or unauthorized use.

2.3 Equipment Environmentals. Provider agrees that it shall provide suitable electric current (standard 120 volt outlets) to operate the Equipment, a suitable place for Equipment installation, a suitable environment for the Equipment and telephone service for use by the Equipment (shared or dedicated at Provider discretion). Provider agrees to be solely responsible for and bear all onetime and recurring expenses and fees, of all electrical and telephone services necessary for the operation of the Equipment.

2.4 Provider and Bank Data. Provider agrees that at all times it shall provide accurate and current data for Exhibit A (Louisiana CCAP Provider Reimbursement and Settlement Authorization Form). Provider acknowledges that failure to immediately notify ACS in writing of changes to Exhibit A data may result in delay in equipment installation and/or reimbursement for POS printer paper. Provider acknowledges and agrees that banking information can be used to credit, debit, and/or make adjustments to credits or debits, required to fulfill the terms of this agreement.

2.5 Equipment Control and Location. Provider agrees that it will at all times keep the Equipment in its sole possession and control. The Equipment shall not be moved from the Provider address(es) reflected on record with the State without prior authorization from State.

2.6 Equipment Liens. Provider agrees that it shall keep the Equipment free and clear of all liens and encumbrances.

2.7. Equipment Access. Provider agrees that ACS or its designee shall have free and clear access to the Equipment at all reasonable times for the purpose of maintenance, repair, inspection or removal.

2.8 Equipment Repair. Provider agrees that it shall not make or attempt to make any repairs to the Equipment.

2.9 Equipment Supplies. ACS will provide the initial supply of paper. After the initial supply, Providers will be responsible for purchasing paper for the equipment. ACS will be responsible for financially reimbursing the Provider for paper used in the Equipment. The amount of reimbursement is based on an algorithm of Equipment usage, not paper actually expended. Reimbursement shall be made monthly via electronic funds transfer only

Article 3: TERM AND TERMINATION

3.1 Term. The term of the Agreement shall commence on the Effective Date and continue through Provider's State determined term of agreement for CCAP participation, as well as the existence of assigned Active Participants.

3.2 Renewal Periods. Unless the Agreement is terminated or expires in accordance with the terms of this Agreement, this Agreement shall automatically renew without further action for the duration of authorization assignment and active participation.

3.3 Termination. Either party may terminate this Agreement without cause upon giving fifteen (15) days prior written notice to the other party, citing this Section 3.3.

This Agreement shall terminate immediately upon the instance of one or more of the following: Provider is no longer authorized under the State Child Care Assistance Program or Provider ceases its business operations in the State for any reason.

3.4 Effect of Termination – Equipment. Within five (5) business days of Agreement termination, Provider shall return all Equipment to ACS at ACS expense and in the manner agreed to by ACS, or make the Equipment available for ACS pickup at a mutually agreed time from 9:00 a.m. to 5:00 p.m., Monday through Friday, excluding Federal holidays. Upon termination of the Agreement pursuant to the provisions herein, Provider will immediately return the Equipment to ACS or purchase the Equipment from ACS at a price to be mutually agreed upon between ACS and Provider. Failure of the Provider to return equipment within ten (10) business days of the effective termination date will result in a debit to the Provider's financial institution account in an amount consistent with the schedule below. If the Provider does not have an account with a financial institution, the Provider will be billed in accordance with the schedule below.

	Year One	**Year Two**	**Year Three**	**Year Four**	**Year Five**
VeriFone Model VX 570 (POS)	**$338.00**	**$270.00**	**$202.80**	**$135.20**	**$67.60**
MSO300 (Biometric Reader)	**$435.00**	**$348.00**	**$261.00**	**$174.00**	**$87.00**
Complete Set	**$773.00**	**$618.00**	**$463.80**	**$309.20**	**$164.60**

Article 4: CARE OF EQUIPMENT

4.1 Provider agrees to follow the instructions of any Manuals accompanying the Equipment, as amended from time to time, in the use and care of the Equipment and agrees to advise ACS or its authorized representatives of any conditions that may require servicing. Provider will take all reasonable security measures to protect the Equipment from damage and/or unauthorized use. Provider will not make or attempt to make any repairs to the Equipment. Provider will ensure that Provider's existing insurance covers the Equipment against casualty loss. Provider agrees to bear the expense of repairing damage to the Equipment which occurs while the Equipment is in Provider's care, unless such damage is caused by Equipment malfunction which did not result from Provider's improper use of the Equipment.

Article 5: **LIMITATION OF LIABILITY**

5.1 ACS and the State will not be responsible or liable for any cost, expense or damage arising out of the use of the Equipment by Provider including, but not limited to, lost profits or damages to persons or property. Provider will bear all risks including the entire risk of loss, theft, damage or destruction of the Equipment and all liability for the use, possession, operation, storage and condition of the Equipment; provided, however, that Provider will not be liable for personal injury and/or damages to property resulting from the negligence or willful acts of ACS, its employees, subcontractors or agents.

Article 6: **INDEMNIFICATION**

6.1 Provider will indemnify and hold ACS, its parent corporations, affiliates, employees, subcontractors and agents harmless from all losses, costs, expenses and damages, including attorneys' fees, incurred because of or incident to the Equipment or the use, possession, operation, storage and condition thereof; provided, however, that Provider's obligation to indemnify and hold harmless will not apply in cases in which ACS will be found liable for personal injury and/or damage to property resulting from the negligence or willful acts of ACS, its employees, contractors or agents.

Article 7: **WARRANTIES**

7.1 ACS WARRANTS THAT SERVICES PROVIDED UNDER THIS AGREEMENT WILL BE PERFORMED IN ACCORDANCE WITH INDUSTRY STANDARDS BY QUALIFIED PERSONNEL IN A QUALITY MANNER AND WILL CONFORM TO THE SPECIFICATIONS AS DESCRIBED HEREIN.

7.2 THE EXPRESS WARRANTIES SET FORTH IN THIS SECTION ARE THE ONLY WARRANTIES GIVEN BY ACS WITH RESPECT TO THE SERVICES AND EQUIPMENT PROVIDED PURSUANT TO THIS AGREEMENT. ACS MAKES NO OTHER WARRANTIES EXPRESSED OR IMPLIED, OR ARISING BY CUSTOM OR TRADE USAGE AND SPECIFICALLY MAKES NO WARRANTY OF MERCHANTABILITY OR FITNESS FOR ANY PARTICULAR PURPOSE.

Article 8: **GOVERNING LAW**

8.1 This Agreement will be governed by and construed in accordance with the Laws of the State of Louisiana and any action commenced hereunder shall be brought in State of Louisiana. Further, Provider consents to the jurisdiction of the courts located in State of Louisiana.

Article 9: **ASSIGNMENT**

9.1 Neither this Agreement, nor any right or obligation there under, shall be assigned to third parties by the Provider without the prior written consent of ACS.

Article 10: **AMENDMENTS OR ADDENDA**

10.1 The amendments, addenda, exhibits or attachments listed below, are incorporated herein by reference:

Exhibit A: Louisiana CCAP Provider Reimbursement and Settlement Authorization Form

Article 11: **INDEPENDENT CONTRACTOR**

11.1 The parties shall, at all times, be independent contractors, and nothing contained herein shall be deemed to create any association, partnership, joint venture, or relationship of principal and agent or employer and employee between the parties.

Article 12: **ENTIRE AGREEMENT AND MODIFICATIONS**

12.1 This Agreement supersedes any and all prior representations, conditions, warranties, understandings, proposals, or previous agreements between the parties hereto, either oral or written relating to the matters of this Agreement hereunder and constitutes the sole, full and complete agreement between the parties.

12.2 Further, this Agreement shall not be modified, changed, amended, or waived except by means of a written instrument signed by an authorized representative of each party.

IN WITNESS WHEREOF, the parties hereto have through duly authorized officials, executed this Agreement.

ACS STATE & LOCAL SOLUTIONS, INC.	**CHILD CARE HOME OR CENTER**
By:	
(Signature)	(Signature)
Michael Langenohl	
(Name, type or print)	(Name, type or print)
VP, Electronic Payment Services	
(Title)	(Title)
4/26/2010	
(Date)	(Date)

The Rest of This Page Intentionally Left Blank

Exhibit A

LOUISIANA CCAP PROVIDER REIMBURSEMENT AND SETTLEMENT AUTHORIZATION FORM

CCAP Provider ID #: ______________

____

(Legal Business Name)

authorizes ACS and its designated financial institution Bank of America and the financial institution listed below to deposit reimbursement funds to and debit from (equipment) the indicated business account for activity related to the State of Louisiana's Child Care Assistance Program subject to the terms of the Provider Agreement.

***Choose (☐) One*:**

☐ **First Submission** ☐ **Change in Banking Info**

Business Information:

____
Authorized Individual Name

____
Title

____
DBA (Business Name)

____
Address

____
City/State/Zip

____
Telephone Number

____
Authorized Signature

Fill in information for the account funds will be deposited in to:

Checking Account Number:

[ ]

Savings Account Number:

[ ]

Bank Routing Number (ABA Number):

[ ]

Please return completed form to:
ACS State and Local Solutions
National Retail Management Center
P.O. Box 80469, Austin TX 78708
Contact us at: ebt.retailoperations@acs-inc.com or (866) 217-1076

Louisiana Provider
123 Main St
Louisiana City, LA 12345

2372

Date ______________

Pay to the
Order of ______________________________ $ [ ]

______________________________ Dollars

VOID

XYZ Bank of Louisiana
City, XY

For ______________ ______________

:123789789:987654321:2372

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.