

CHILD CARE RATE DECLARATION FORM

To comply with Federal and State requirements, the following form is required annually, or whenever you experience a change in your rates. The Division of Child Care must ensure that Federal subsidy funds do not pay more for services than is charged to the general public for the same service. In addition, the unit price billed for the child care services provided must be the provider's usual and customary charge for the same services provided on the same date to the general public per ARSD 67:47:01:15. This means that you must utilize the same rate schedule and policies for subsidy and private pay families including discounts, 'fee free allowance days', and method of charging.

Provider Name: _____ **Provider ID:** _____
(include all sites impacted by rates)

The rates that you provide will become effective either the 1st or the 16th of the month depending on the date we receive this form in our office. If your rates change, be sure to notify our office in advance to ensure we can apply them appropriately. This form is available online at: dss.sd.gov/childcare/childcareassistance

1. Attach your rate sheet to this form

If the remaining questions on this form can be answered by looking at your rate sheet, then you can simply complete question #5 and mail the form and rate sheet to our office. If you do not have a rate sheet, complete the following questions.

2. Are your rates for school-age children different between the school-year and summer? Yes No

2a. If yes, when do your school-year rates go into effect for the current school year? _____
(date)

2b. If yes, when do your summer rates go into effect? _____
(date)

3. If you offer discounts, please explain the discounts you provide: _____

4. What is the rate you charge for the following: (Circle One)

Infant/Toddler (4 weeks up to 3 years): \$ _____ per Hour Day Week Month

Pre-school age (age 3 to 5 years): \$ _____ per Hour Day Week Month

School Age (age 6 or older): \$ _____ per Hour Day Week Month

If you need to provide more detail about the rates that you charge, please provide the information below:

5. Form completed by: _____
Printed name *date* *contact phone number*

Office Use

Form complete Yes No

Provider follow-up with: _____ date: _____ incomplete clarification

Online srch cross-check for all sites

Hourly rates? Yes No

If no, pro-rating completed

Calculations/Detail documented

Provider has active certs? Yes No

Check for TANF certs

Caseworkers initial: _____

Staff review initials: _____