Licensed Provider Rate Sheet

Provider: _____ SSN/Tax ID No.: _____ Lic. No.: _____
Address: _____ Phone No.: _____ Fiscal Year: _____
_____

Please list your rates below that correspond with your normal billing practice.

Category	Age	Monthly Fee	Weekly Fee	Daily Fee	Hourly Fee	Reg./Ins. Fee
Infant - Full Time (F/T)	0-2					
Infant - Part Time (P/T)	0-2					
Pre-school F/T	2-5					
Pre-school P/T	2-5					
School Age F/T	5-12					
School Age P/T	5-12					

Day and Hours of Operation: _____

Please list the 10 Holidays per Fiscal year you request payment for.

1. _____ 2. _____ 3. _____ 4. _____ 5. _____
6. _____ 7. _____ 8. _____ 9. _____ 10. _____

Provider Rates:

- Provider rates will be paid based upon information submitted on the annual Licensed Provider Rate Sheet.
- Based on State Regional Market Rates (RMR), this agency cannot pay provider rates that exceed RMR.
- Any fees in excess of the RMR, must be paid by the parent. This amount will be referred to as a parental co-payment.

I agree to adhere to the above stated prices for the entire fiscal year. I have read and understand the CalWORKs reimbursement procedure and agree to adhere to rules and regulations as listed above.

Provider Signature	Title	Date