JOHNS HOPKINS UNIVERSITY

Dependent Care Voucher Program
Provider Enrollment Form

Please complete this form and return to DependentCareVoucher@jhu.edu, along with a copy of your current state license to operate a child care program.

Dependent Care Provider Information:

Name of care provider / agency:

Street address: Apt #:

City: State: Zip code: Phone: - -

License # or Federal ID # of care provider or agency:

Johns Hopkins employee/student name:

Please list the dependent for whom you are providing care and their birth date:

Name	Birth date	Cost of Care

Note to Care Provider: We can only reimburse care for one (1) dependent per family.

Date care started: (mm/dd/yyyy) / /

This cost is: Weekly Monthly Hourly and is: Full-time Part-time

Do you receive additional childcare funds from the State of Maryland?

Agency_____ Amount_____

Terms and Conditions for Care Provider:

1. The employee/student is solely responsible for contracting with you.
2. The Office of Benefits and Worklife will call to confirm with you the child or adult's enrollment, your charges, and the employee/student eligibility status for this program.
3. You will be required to provide a photocopy of your provider license to the Office of Benefits and Worklife.
4. The Dependent Care Voucher Program will not reimburse employee /student at rates higher than are charged to other individuals in your care.
5. This financial assistance is only for dependent care costs for one (1) dependent per family. If you are caring for more than one dependent for this employee/student, you agree to determine the cost for one of those dependents and to record it monthly on the Monthly Cost Verification Form.
6. This financial assistance is only for work/study-related dependent care costs. Dependent care expenses accrued when employee/student is not working at the university must be paid by the parent and should be recorded separately.
7. You will be required to provide information regarding dependent care charges and employee payments. This office will provide the forms and it will be the employee/student's responsibility to bring them to you for completion.
8. You will contact the Office of Benefits and Worklife should the client begin to receive childcare funding from the State of Maryland.
9. Care providers who abuse this program will be reported to their appropriate licensing organization.
10. It will be the employee/student's responsibility to email or hand carry completed forms to the Office of Benefits and Worklife, 1101 East 33rd St., Suite D200, Baltimore, MD 21218.

I have read and understand the above terms and conditions.

Care Provider Signature _____ Date _____

Employee/Student Signature _____ Date _____