

STATE OF NEW HAMPSHIRE Department of Health and Human Services Division for Children, Youth and Families Child Development Bureau

CHILD CARE PROVIDER ENROLLMENT

Enrollment	t Type:						Date							
(Check 1 (Employment Related	Preventive or	Both						month	day	2	year	
		Related	Protective											
Resource Identification Number (If not yet assigned, leave blank)														
SECTION 1:														
PROVIDER'S NAME: (Please Note: If you are reporting income with a Social Security Number, use your name here not the name of your														
business. If you are reporting income with an Employer Identification Number, use your business name here.)														
	DOING BUSINESS AS (DBA): Complete this line only if you report income to the IRS under your Social Security Number and you choose to have a business name. You must also complete your name above.													
-						x x	х -	х	х	-				
Employer Identification Number (EIN) OR Last four of your Social Security Number (SSN)														
SECTION 2:														
Provider's Phy						<u> </u>								
Town:						State:		_		Zış	D:			
Billing or Mail	ing Address													
Town:			State	:	Zip:		Wo	ork Tele	ephone	e:				
Provider's E-r	Provider's E-mail Address													
NOTE: All provider payments are directed to the provider's billing or mailing address. If you are a provider who forwards payments to a separate billing address or corporate headquarters, you must indicate the correct billing address above to avoid delays in payment.														
Provider Contact Person:														
Contact Pers	on's Teleph	one:				ler's Tele								
					(ii dinei	ent than coi	liaci persi	(11)						
SECTION 3:														
Service Type Provided: Check the box for the service you provide: Child Care Licensed Center														
		ed Facility (0												
CI CI			t Family/Frier	nd/Neigh	bor									
	_	er's Home –	-	-		🗌 Cł	nild's Ho	me – F	Relativ	e (06)				
] Provid	er's Home –	Non Relative	(05)		Cł	nild's Ho	me – N	lon Re	elative	(07)			
	hild Care Lic	censed Famil	y Home											
] In-Hor	ne – Relative	(02)			□ In·	-Home -	- Non F	Relativ	e (03)				
Child Care License-Exempt Center														
	Licens	ed-Exempt F	acility (08)											
DCYF USE ONLY														
Enrollment T	ype: [Ne	w Change	Renewal	Reopen	Enrolln	nent Begin	n Date:	Prov	vider (Code:				
License-Exen		0		art Date:				End	Date:					
AW9 : Yes	· ·		1099 : 🗌 Yes		No			2.1154		uffix:				
Child Care License Number:														



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Instructions for Completion of Provider Enrollment Form

PURPOSE:

The Child Care Provider Enrollment form is used to enroll child care providers who provide child care services and request a child care scholarship payment from the Department of Health and Human Services (DHHS).

INSTRUCTIONS:

Enrolled child care providers are subject to all Department rules, regulations, policies, and procedures. No payments will be made to any provider until the enrollment process has been completed and the provider has been notified by DHHS. DHHS does not withhold tax money for child care providers receiving child care payments for services. Payment of taxes is the responsibility of the child care provider.

All child care providers will be assigned a Resource Identification (ID) Number.

Reporting Changes: Providers are required to report all changes to DHHS such as changes of address, incorporation, or provider name and if you change from using a Social Security Number (SSN) to an Employer Identification Number (EIN). Changes must be reported to DHHS by submitting them on a new Form 1862 and Alternate W-9 Form to the address listed below. These two forms must be mailed together.

FORM COMPLETION:

Enrollment Type Change – Choose only one of three enrollment options: employment related child care, preventive/protective child care, or both.

Effective Date - Enter month, day, year. This date is the date you complete this form.

Resource Identification Number - Enter your assigned Resource Identification Number from left to right leaving unused spaces blank at the end. If a Resource Identification Number is not yet assigned, leave blank.

SECTION 1

Provider Name - This line must be completed whether you report income under your Social Security Number (SSN) or Employer Identification Number (EIN).

Enter your own name here if you report income to the IRS under your Social Security Number. **Enter the name of your business** here only if you report income to the IRS with an Employer Identification Number (EIN).

Doing Business As (DBA) - Complete this line only if you report income to the IRS under your Social Security Number. If you have a business name, enter it. You must also indicate your first name, middle initial and last name on the line provided above.

Employer Identification Number or Social Security Number- Enter the number you use to report income to the IRS (Enter only one number, either the EIN# or the last four of the SSN#).

SECTION 2

Provider Address - Enter your physical, billing and/or mailing address (See **NOTE** on the front of this form) **Contact Person** - Enter the name, telephone number and email address of the person to contact for questions (if the same leave blank).

SECTION 3

Services Provided Check the box for the child care service type you provide. Return this form along with a completed Alternate W-9 Form to:

NH Department of Health and Human Services 129 Pleasant Street ATTN: DCYF - CDB, Concord, NH 03301 **For Preventive and Protective** NH Department of Health and Human Services 129 Pleasant Street ATTN: DCYF - Provider Relations, Concord, NH 03301

RETENTION:

This form is retained by the Child Development Bureau in the Provider File.