NH Department of Health & Human Services (DHHS)
Bureau of Family Assistance (BFA)

BFA Form 476
08/18

DEPENDENT CARE COST VERIFICATION REQUEST

(To be completed by the child care or adult care provider)

TO:

FROM: Centralized Scanning Unit
P.O. Box 181
Concord, NH 03301

Dependent Name: _____

Name(s) of the person(s) responsible for paying the dependent care cost: _____

We would appreciate information on the amount to be charged to this family for the services you are providing. The information is necessary in order to determine his/her eligibility for benefits. Please complete the following information and return to the client or the address noted above by [ ]. Thank you for your cooperation.

PLEASE COMPLETE THE FOLLOWING INFORMATION

Care Provider Name: _____

Date that care began: _____ Number of Adults: _____ Number of Children: _____

What type of dependent care is this?

☐ Licensed Center ☐ Family Child Care Home ☐ Licensed Exempt Center ☐ Adult Day Care ☐ Licensed Exempt Family Home

What is the provider's published rate to the public? _____

Does this family have an open NH Child Care Scholarship?

If Yes: What is the amount of the family's cost share? $_____

Is there an additional co-payment? If so, how much? $_____

What is the net family contribution per week? $_____

If No: What is the family's net cost per week? $_____

Your signature confirms that the family is expected to pay this amount each week

Signature and Title of Provider **Date**

Print Name of Provider

Address

Telephone

BFA SR 18-05
(6MC)

How To Complete This Form

This form is used by the NH Department of Health & Human Services to collect dependent care verification information. Households that are paying for someone to care for a dependent child or disabled/incapacitated adult should give this form to their provider. Providers should complete the entire form and return it by the date requested in the first section. Thank you.

1. Fill in:
    - the name(s) of the person(s) responsible for the dependent care costs;
    - name of care location;
    - street address, town, zip code;
    - date that care began;
    - the number of children or adults being cared for;
    - whether the family has a NH Child Care Scholarship;
    - the amount of care provider's published rate to the public;
    - the amount of the cost share (if there is a scholarship);
    - the amount of the co-payment (above the cost share); and
    - the total amount the family is expected to pay each week.

2. Sign and date the form.

3. Print your name, address and telephone number.

4. Return this form to the client or the Central Scanning Unit at the address in the first section.