

OFFICE USE ONLY	
Provider ID#:	_____
Family Name:	_____
Family ID#:	_____
AP Staff Initials:	_____



Supportive Services
_____inc._____

AGENCY COPY
Please sign and return

Licensed-Exempt Provider Request for Rate Change

PLEASE PRINT

Provider Name: _____ Soc. Sec./Tax ID #: _____
(As stated on your Social Security Card or Tax Id)

To receive payment, indicate the rate you charge for child care below.

This rate will be applied for each child in your care.

\$ _____ per **HOOR** (hourly rate)

\$ _____ per **DAY** (daily rate)

\$ _____ per **WEEK** (weekly rate)

\$ _____ per **MONTH** (monthly rate)

1. Providers must use this rate when calculating the "billing total" on the attendance sheet each month.
2. Providers will be paid based on information submitted in their initial provider packet. Provider's may submit rate adjustments as needed. Requests for rate adjustments must be made at least 30 days in advance. Unless effective on the first (1st) day of the month, the approved rate adjustment will be effective the first day of the following month.
3. Reimbursement amounts are determined by Regional Market Rates (RMR) established by the California Department of Social Services, Child Care Development Division. Supportive Services, Inc. cannot pay any provider rates that exceed the RMR.
4. Any fees in excess of the RMR must be paid by the parent. This amount will be referred to as parental CO-PAYMENT. This amount must not be confused with Family Fees which are based on family income.

Provider Signature

Date



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Current License Exempt Reimbursement Ceilings for Fresno County (Maximum Reimbursement)

Age Group	Full-time Daily	Full-time Weekly	Full-time Monthly	Part-time Hourly	Part-time Weekly	Part-time Monthly
Birth to 24 Months	35.17	149.56	599.48	7.66	114.52	476.09
2 through 5 Years	31.77	134.47	561.78	6.75	106.40	420.84
School Age	28.39	117.77	488.77	6.72	92.70	367.84

Effective January 2022