Parent

Child Care Services Provider

- When you are working with TANF/ASPIRE you may get help paying for child care.
- Finding child care now will help you prepare for working with ASPIRE's case managers at Fedcap.
- You should find a provider and have a back-up plan.
- Your case manager at Fedcap will help coordinate your child care needs with the Support Services Team.

You decide who takes care of your children. One way to find a child care provider is by searching this link*: www.childcarechoices.me

When you find a provider, work with them to complete the attached forms and send the original papers to the Support Services Team.

A child care provider who is not licensed must pass a background check. The Support Services team will contact you if the provider is denied.

The Department will pay for childcare when your case manager at Fedcap tells us that you are working with them and need the help.

Please return this original packet by mail in the enclosed postage paid return envelope to: Support Services Team, 35 Anthony Avenue, Augusta, Maine 04333. The team will contact the provider if more information is needed.

If you have any questions about child care, please call the Support Services Team at 624-5200 or by emailing Supportservices.DHHS@maine.gov.

Roles:

- Fedcap, Breaking the Cycle team: case management and help with planning support services.
- Support Services Team: issues support services that are authorized by Fedcap and processes all ASPIRE-BTC childcare requests.

Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which office(s) should help you? Please check.

☐ Office of MaineCare Services	☐ Office of Behavioral Health
☐ Office for Family Independence and Medical Review Team	☐ Office of Child and Family Services
☐ Maine Center for Disease Control and Prevention	☐ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center	☒ Other: SUPPORT SERVICE TEAM
☐ Division of Licensing and Certification	☐ Other:

Whose information will be disclosed? Please print clearly.

Individual's Name		Date of Birth	
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		

Please check: ☐ Release/Send my information to: ☐ Obtain/Get my information from:

Name of Individual: Ryan French		Organization: Standish Parks & Rec	
Address: 175 Northeast Rd	Town/City: Standish	State: ME	Zip Code: 04084
Telephone: 207 642 2875	Email address (optional): rfrench@standish.org		

What is the purpose of the disclosure?

☐ Personal request	☐ To coordinate or manage my care
☐ For a legal matter, including testimony	☐ To see whether I qualify for insurance coverage, services, or benefits
☐ Other:	

To share the information with others by EMAIL, please initial and complete the following.

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email. INITIAL HERE ______

Please print the email address where you want your information sent:

What information should be released or obtained? Please check all that apply.

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General permission:

- ❒ **All** health information from the office(s) checked above
- ❒ Claims or encounter data (information about visits to health care providers)
- ❒ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits
- ❒ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims from 2018-2020")
- ■ Other: Information to coordinate childcare payments

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Special permission: Drug/Alcohol Treatment or Referral for Services

- ❒ Include **all** drug/alcohol information in the release
- ❒ Include only the **specific** drug/alcohol records checked:
  - ❒ Diagnosis and treatment
  - ❒ Clinical notes and discharge summaries
  - ❒ Drug/Alcohol history or summary
  - ❒ Payment or claims information
  - ❒ Living situation and social supports
  - ❒ Medication, dosages or supplies
  - ❒ Lab results
  - ❒ Other: ______________

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Special permission: Mental/Behavioral Health Services

- ❒ Include this information in the release
- ❒ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.

Please note: Maine law allows us to share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.

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Special permission: HIV/AIDS Status/Test Results

- ❒ Include this information in the release

Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.

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I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- "Information" may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: ______________
- This form permits additional releases until it expires.

Date: ____________ **Signature:** ______________________________________

Personal Representative's authority to sign: ______________________________

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Acting Commissioner

Maine Department of Health and Human Services
Office for Family Independence
19 Union Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-4168; Toll-Free: (800) 442-6003
TTY: Dial 711 (Maine Relay); Fax: (207) 287-3455

ASP032 Rev. 1/2019

Name: ______________________
Telephone # ______________________
DOB: ______________________

ASPIRE CHILD CARE STATEMENT – ACTION REQUIRED

Why Am I Getting This Letter?

ASPIRE can help pay for child care while you are doing activities that are in your Family Contract Amendment. For ASPIRE to help, you need to provide some information.

What Do I Do With This Letter?

1. The first part of this letter (Part A) is for you to fill out. You need to tell ASPIRE information about the children that need care. Fedcap will help you determine how much child care you need when you meet with them.
2. The second part of this letter (Part B) is for your child care provider to fill out.
3. You and the child care provider need to sign this and return it to ASPIRE.
4. A completed packet does not guarantee the ASPIRE will pay for child care.
5. This is not a contract between ASPIRE and the child care provider.

Part A – For You To Fill Out And Sign:

I believe that the child care provider named below:

1. Is capable of providing suitable child care, and
2. Will provide a healthy and safe location so my child(ren) will not be at risk.

The Department of Health and Human Services is not liable for the choice, or actions, of the child care provider.

I understand that any false statements made about the child care arrangements, including:

1. information about the child care provider,
2. conditions at the child care site, or
3. costs of providing child care

may result in my being referred to the state's fraud unit for investigation, and may result in my benefits being cut or ended.

NAME OF CHILD(REN)	DATE OF BIRTH	HOW MUCH WILL THE PROVIDER CHARGE FOR ¼, ½, ¾ OR FULL TIME CARE PER WEEK?			

Anticipated dates of child care From: ______________ To: ____________

______________________________ Parent/ Guardian Signature

____________________ Date

Part B – For Your Child Care Provider To Fill Out:
□ check box if you are a licensed child care provider with the State of Maine

Name: Standish Parks & Rec Phone: 207 642

(Child Care Providers licensed by the State of Maine do not need to complete the section below or the Child Care Statement Supplement)

Address: 175 Northeast Rd Standish, ME 04084 Date of Birth: ____________

Social Security Number or Vendor ID#: VC1000085899

Are you a relative of the ASPIRE participant or the children? NO

I will be providing child care services:

X in my child care center/family child care home
___ in my home
___ in the ASPIRE participant's home

By signing below, I authorize the release of confidential records or information regarding a criminal record, child protection record, and motor vehicle record to the Department of Health and Human Services, Office for Family Independence, TANF and ASPIRE Programs.

I acknowledge that if other adults live, or frequent the location, where I provide child care, they will complete and sign the attached ASPIRE Child Care Statement Supplement.

I understand that any information obtained as a result of this release of information and any future record reviews will remain confidential, as required by law, and will be used solely for the purpose of determining whether my application to provide child care services for the TANF and ASPIRE Programs will be approved. The application will not be approved if one or more of the background checks are deemed unsatisfactory according to the Department of Health and Human Services.

Provider Signature

Date

What Are the Next Steps?

- This form needs to be returned to the ASPIRE Support Services Team.
- If the child care provider has never been paid by the State's vendor system, Advantage, the Vendor (W9) form with the original signature must be returned by mail to the Support Services Team at the address below.
- ASPIRE will do any needed background checks and notify the ASPIRE parent if child care can be paid by ASPIRE.

What If I Have Questions?

Contact the Support Services Team if you have any questions. The contact information is below.

Telephone:
207-624-5200

Email:
SupportServices.dhhs@maine.gov

Mailing address:
Support Services Team
Department of Health and Human Services
35 Anthony Avenue
Augusta, Maine 04333-0011

ASPIRE CHILD CARE STATEMENT SUPPLEMENT

By signing below, I authorize the release of confidential records or information regarding a criminal record, child protection record, and/or motor vehicle record to the Department of Health and Human Services, Office for Family Independence, TANF and ASPIRE Programs.

I understand this is a requirement, as I am an adult living in, or frequenting, a location where child care may be provided for an ASPIRE participant.

Print Name:________________________________

Social Security #:________________ Date of Birth:________________

______________________ ______________________

Signature **Date**

Print Name:________________________________

Social Security #:________________ Date of Birth________________

______________________ ______________________

Signature **Date**

Print Name:____

Social Security #:________________ Date of Birth______________

______________________________ ______________________
Signature **Date**

CHILD CARE PROVIDER RESPONSIBILITIES – IMPORTANT INFORMATION

When ASPIRE is paying for child care, the provider shall report to the Department of Health and Human Services information about the following circumstances, which may have occurred either in or outside the State of Maine, regarding themselves and other persons frequenting the location that child care is provided:

1. Arrests, indictments, or convictions for sexual or violent crimes involving children or adults, or any illegal acts involving children, whether prosecuted or not. Any prior convictions for any of these crimes or illegal acts must be reported.
2. Any physical, mental health, or substance use problems, which would interfere with one's ability to perform her/his duties safely.
3. Any arrest, indictment, or conviction for Operating Under the Influence (OUI) within the last five years, or for any other activity involving substance use. Any prior convictions for OUI or other activity involving substance use within the last five years must be reported.
4. Any investigation by Child Protective Services for allegations of child abuse or neglect.
5. Any prior conditional certificate, certificate suspension, fine or revocation regarding a child or adult care certificate or approval issued to the applicant.
6. The removal of children from their care or custody by court order.
7. Any Protection from Abuse Order or any other order, which resulted from domestic abuse or family violence.
8. Any other information regarding their circumstances or treatment of children which may enable the Department to determine whether there is a present threat to the health, safety, and welfare of children.
9. Any situation that affects the payment for child care services, including, when a child has more than two (2) unexplained absences in one (1) month or if the parent removes the child from your care.

10-148 CMR Chapter 33, Section 9: Rules for Certification of Family Child Care Providers

IMPORTANT:

- This is not a contract with the Department of Health and Human Services.
- Completion of this packet does not guarantee payment.
- An authorization to release information (included in the packet) must be completed by the parent or caretaker relative and used (faxed/emailed) when contacting the ASPIRE Support Services Team with questions about payment.
- The signed (original) Vendor/W9 form completed by the child care provider must be returned to the Support Services Team if the provider wishes to be paid directly by the State of Maine.