Orange County Department of Education
Business Services
FAMILY SUPPORT SERVICES
Tel. (714) 708-3860 ▪ Fax (714) 708-2916

Mailing Address
Family Support Services
P.O. Box 9050
Costa Mesa, CA 92628-9050

LICENSE EXEMPT POLICY STATEMENT

Provider Name _____

Provider Address _____

City _____ Zip _____

Parent Address _____
(In Home Care) City _____ Zip _____

TRUSTLINE	☐
RELATIVE	☐
IN HOME	☐ Yes ☐ No

Email _____ Social Security # _____

Home # _____ Cell # _____ Fax # _____

Days/Hours of Availability _____ Ages of children served _____

Please initial and sign below. This document is required prior to OCDE FSS implementing any rate change. **All signatures must be handwritten (wet) — no typed or electronic signatures will be accepted.

I certify under penalty of perjury that the information contained in this document is accurate. I agree to the following:		**INITIAL**
1.	Conditions set forth in the Agreement for Child Care Services, the Certificate for Child Care Services and Family Support Services Provider Participation Guidelines will be observed.	
2.	Provider reimbursement is limited by statutes and regulations found in Education Code and California Code of Regulations, Title 5, Subchapter 2.5: Utilization of the Regional Market Rate Ceiling.	
3.	Attendance sheets must be completed daily with exact time in and time out of child.	
4.	License exempt providers will only be paid for hours and days of care authorized by OCDE Family Support Services.	
5.	License exempt providers will not be paid for any child's absence from care. (Unless otherwise directed by CDSS CCDD)	
6.	License exempt providers must be in good health.	
7.	In writing, provider must notify the OCDE FSS changes in address and/or telephone number(s). Failure to notify OCDE FSS of these changes may result in delay in payment or non-payment for child care.	
8.	Parent(s) must have unlimited access to their child(ren) and child care provider during normal hours of provider operation and/or whenever child(ren) are in the care of the provider.	
9.	Failure to submit any requested documentation may result in termination of your contractual agreement for child care services with OCDE FSS.	

Provider Signature _____ **Print Name** _____ **Date** _____

Return the completed form to the above mailing address or fax to (714) 708-2916.	**Attn: Provider Services**

TO BE COMPLETED BY OCDE FSS

Date All Documents Received:	**Effective Date of Rates:**	
Type of Action/Change:	**Effective Date of Action/Change:**	
Authorized Signature:	**Print Name:**	**Date:**