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 _____

Street Address _____

TRUSTLINE ☐
RELATIVE ☐

_____ Email _____

City _____ Zip _____ Social Security # _____

Home # _____ Cell # _____ Fax # _____

Days/Hours of Operation _____ Ages of children served _____

Please initial and sign below. This document is required prior to OCDE FSS implementing any rate change.

	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 effective January 2019 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.	
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:**