Administration for Children's Services
Division of Child
Care/Head Start Child Care
Support Services
109 East 16th Street
New York, NY 10003

Provider / Program Enrollment or Update Request

Dear Provider / Program:

To process your request please provide the requested information below and return with the requested document(s).

Must be completed

Provider / Program Name: _____

Address: _____

City, State, Zip Code: _____

ACCIS ID#:. _____

Directors Name: _____

Telephone Number: _____

Contact Person Name: _____

Telephone Number: _____

□ Social Security Number or Employer Identification Number: -attach copy _____

□ Weekly Rate: I agree that the amount I (the provider / program) am charging is not more than the amount I charge other children of the same age. I understand that I cannot be paid if I do not list all of my rates.

Age	Part Time (less than 30 hours/week)	Full Time (more than 30 hours/week)
Under 18 months (Infant)	**$**	$
18 months to under 3 years (Toddler)	**S**	$
3 years to under 6 years (Pre-School)	**$**	**S**
6 years to under 13 years (School-Age)	**$**	$

□ Proof of address

□ New York State Department of Health License/Registration - attach copy

□ Child Care Provider Form

Signature: _____ Date: _____
(Provider/Program Signalure)

This letter and the required information and documentation may be faxed back to (212) 835-8252

Att: _____ , or mailed to:
(Caseworker Name & telephone »)

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