Child Care Payment Plan

Family Name: _____________________________ Center: _____________________________

In compliance with Federal Performance Standards, Umatilla Morrow Head Start will collect a co-pay amount from families enrolled in full-day programs. **Co-pays are due by the 7th of each month.**

Families are expected to apply for child care assistance prior to selection and enrollment. Families must maintain eligibility by completing periodic reviews when necessary.

Families will work with their Family Advocate to develop a plan prior to enrollment to assess their ability to pay at least 50% of the State's assessed co-pay amount but not less than the State's minimum amount, or the copay amount if the family is not eligible for a subsidy program . If a family's situation changes this co-pay plan will be revised to reflect a family's current situation.

If the family is eligible for a subsidy, check the appropriate box and indicate the DHS assessed co-pay amount.

☐ DHS – ERDC or JOBS $__________ ☐ DHS-Contract $__________
☐ Child Welfare $__________ ☐ Grants $__________
☐ Employer $__________ ☐ Teen Parent Child Care $__________
☐ Other ________________ $__________

DHS Caseworker or Branch: __________________________ DHS Case #: _________________

If the family is not eligible for a child care subsidy, the monthly co-pay will be:
Child enrolled in Early Head Start $290
Child enrolled in Head Start $225

Budget: Family Advocate will develop a budget with the family and review barriers and successes.

****

By signing this plan I agree to pay UMCHS $__________________ per child per month. Co-pays are due by the **7th** of each month. Failure to pay 2 consecutive months may result in loss of full day services and my child(ren) being placed in a part day program. I understand my responsibility in participating in and contributing to the child care costs.

________________________ _________ ____________________________ ________
Family's Signature Date Family Advocate's Signature Date

Revisions to current plan:

1. DHS co-pay amount has changed: _____________(month);
   new DHS amount: ___________; new copay amount due to UMCHS _____________

   ____________________________ _______________________________
   Parent's signature and date Family Advocate signature and date

2. DHS co-pay amount has changed: _____________(month);
   new DHS amount: ___________; new copay amount due to UMCHS _____________

   ____________________________ _______________________________
   Parent's signature and date Family Advocate signature and date