|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Instructions**: Use this form to request an exception payment. Complete ***one form for each child*** requiring a childcare exception payment. Missing information could DELAY your request. | | | | | | | |
| **SECTION I** | | | | | | | |
| **Today’s Date:** | |  | |  | |  | |
| **Foster Home’s Name:** | |  | | | | | |
| **Foster Home’s E-mail:** | |  | | | | | |
| **Case Manager’s Name:** | |  | | | | | |
| **Case Manager’s E-mail:** | |  | | | | | |
| **Child’s Name:** | |  | | | | | |
|  | |  | | | | | |
| **Childcare**  **Provider’s Name** | **Date Care Started** | | **Total Hours of Care Needed** | | Mark days care is needed | |  |
| **List All** |  | |  | | **S M T W T F S** | | **Rate Charged** |
|  |  | | per day | |  | | $      per (Mark one)  hr day wk mth |
| Include a copy of your childcare contract or an e-mail from your provider of their rates. | | | | | | | |
| **SECTION II** | | | | | | | |
| **Select one:** | | | | | | | |
| **Request for Ongoing Full-Coverage** Childcare Coverage Should Begin: | | | | | | | |
| Need due to FCCC denial or provider not licensed by KDHE. | | | | | | | |
|  | | | | | | | |
| **Request for Supplement to EBT Card Benefit**   |  |  | | --- | --- | | How much are you short each month? $ |  | |  | |   **Request for Out-of-Pocket Reimbursement or Fees Due**   |  |  |  |  | | --- | --- | --- | --- | | Amount Requested: | $ |  |  | | Service Dates Involved: |  | | | | Include brief description of amount paid; if not paid yet, explain reason for fees: | | | | |  | | | | | Include copy of cashed checks, receipts, or e-mail from childcare provider  showing how much was paid and when. | | | | | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |

**Submit completed form and any documentation to:** [**DCF.FCCCEBTexception@ks.gov**](mailto:DCF.FCCCEBTexception@ks.gov)