Attachment A - Authorization for CCAP Sick Leave Payment to Approved Assistants

Rhode Island Department of Human Services
Office of Child Care
25 Howard Avenue, LP Bldg. 3rd Floor
Cranston, R.I. 02920
(401) 462-6877

Attachment A- Authorization for CCAP Sick Leave Payment to Approved Assistants

Licensed providers may authorize payment to Approved Assistants commencing on July 1, 2018, to reimburse providers for sick leave. Authorization may only be made in accordance with the terms of the Collective Bargaining Agreement. By completing the form below, you are authorizing DHS, pursuant to Rhode Island Gen. Laws Section 28-57-1 *et seq*. ("Healthy and Safe Families and Workplaces Act") to provide payment to your Approved Assistant during your absence for the following reasons:

1. Your own or a family member's mental or physical illness, injury or health condition;
2. Your own or a family member's need for medical diagnosis, care, or treatment of a mental or physical illness, injury or health condition;
3. Your own or a family member's need for preventive medical care;
4. Closure of your place of business by order of a public official due to a public health emergency or your need to care for a child whose school or place of care has been closed by order of a public health official due to a public health emergency;
5. Your need to care for yourself or a family member when it has been determined by the health authorities having jurisdiction or by a health care provider that you or your family member's presence in the community may jeopardize the health of others because of your exposure to a communicable disease, whether or not you or the family member has actually contracted the communicable disease; or
6. Time off need when you or a member of your family is a victim of domestic violence, sexual assault of stalking.

Approved Assistants *must* be approved RI FANS vendors in order to be reimbursed for sick leave care they provide. **(To become qualified as a RI FANS vendor, Approved Assistants must submit a W-9 to the CCAP Child Care Office at DHS.)**

Provider name:	DHS Provider Number:
Provider Email:	
Date of Sick Leave: (one form per date)	Total Hours Used: (increments of 2)
Approved Assistant Name:	RI FANS Vendor Number: (DHS Use only)
Approved Assistant E-mail (if available):	

I certify under penalty of perjury that the information reported on this form is true and accurate, that I appropriately discharged sick leave during the time indicated above, or I will be liable to the State of Rhode Island for any payments made to the Approved Assistant named above based on my representations herein.

CCAP Provider's Signature: _____ **Date:** _____

Please submit this completed and signed form to the CCAP Child Care Office at RI DHS.

Email: DHS.ChildCare@dhs.ri.gov Fax: (401) 462-6878