### Provider Reimbursement Rates Change Form

Submit your public rate sheet for processing.

Provider Name:	
Provider Operational Hours:	
PROVIDER must mark the appropriate box below indicating the appropriate provider type PROVIDER must mark whether or not it has a Gold Seal Quality Care Designation. Finally, From the complete the table below marked "To be completed by PROVIDER." COALITION we remainder of the Exhibit.	PROVIDER mus
Does PROVIDER have a Gold Seal Designation? □Yes □No	

## PROVIDER's Private Pay Rates (To be Completed by PROVIDER)

				1 -	,			
CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	( <b>PR3</b> ) 36<48 MTH	( <b>PR4</b> ) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs
Full-Time Daily Rates								
Part-Time Daily Rates								
Before or After School Rates	N/A	N/A	N/A	N/A				

## COALITION Maximum Reimbursement Rates

(To be Completed by COALITION)

CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	(PR3) 36<48 MTH	( <b>PR4</b> ) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs
Full-Time Daily Rates					******			
Full-Time Gold Seal Daily Rates								
Part-Time Daily Rates								
Part-Time Gold Seal Daily Rates								
Before or After School Rates	N/A	N/A	N/A	N/A				
Full-Time VPK Wrap Rate	N/A	N/A	N/A	N/A		N/A	N/A	N/A
Part-Time VPK Wrap Rate	N/A	N/A	N/A	N/A		N/A	N/A	N/A

# Approved PROVIDER Reimbursement Rate\* (To be Completed by COALITION)

CARE LEVEL	(INF)	(TOD)	(2YR)	(PR3)	(PR4)	(PR5)	(SCH)	(SPCR)
	<12 MTH	12<24 MTH	24<36 MTH	36<48 MTH	48<60 MTH	60<72 MTH	In School	Special Needs
Full-Time Daily Rates								
Part-Time Daily Rates								
Before or After School Rates	N/A	N/A	N/A	N/A				
Full-Time VPK Wrap Rate	N/A	N/A	N/A	N/A		N/A	N/A	N/A
Part-Time VPK Wrap Rate	N/A	N/A	N/A	N/A		N/A	N/A	N/A

*Note: Rate PROVIDER will be paid shall not exceed PRO	VIDER's Private Pay Rates for each category.
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Effective Date of Rates Established in this exhibit	per EI	(	7
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#### **ELCFH Use ONLY**

Entered in EFS by:	Date Entered:	
Reviewed by:	Date Reviewed:	
Emailed to Provider by:	Date Emailed:	