Exhibit 5: Provider Reimbursement Rates

Provider Name: _____

Provider Operational Hours: _____

PROVIDER must mark the appropriate box below indicating the appropriate PROVIDER type. In addition, PROVIDER must mark whether or not it has a Gold Seal Quality Care Designation. PROVIDER must mark whether it requires the parent to pay the differential between the Reimbursement Rate and Copayment and the private pay rate. Finally, PROVIDER must complete the table below marked "To be completed by PROVIDER." COALITION will complete the remainder of the Exhibit.

Does PROVIDER have a Gold Seal Designation for children ages Birth-5? ☐Yes ☐No

Does PROVIDER have a Gold Seal Designation for school aged children? ☐Yes ☐ No

PROVIDER's Private Pay Rates

(To be Completed by PROVIDER)

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

If PROVIDER charges a registration fee please check one and provide the amount: $_____

☐ One time fee upon enrollment.

☐ Annual fee. Month _____, or upon enrollment_____, or other_____

☐ Other Describe:_____

Does PROVIDER require the parent to pay the differential between the approved Reimbursement Rate and the PROVIDER'S Private Pay Rate? ☐Yes ☐No