CCS Central 2
https://provider.childcareportals.org

<Provider Name>
<Provider Address>
<Provider City, State Zip Code>

PROVIDER ID: <XXXXXX>

HELP US TO PROCESS YOUR PAPERWORK FASTER
BY COMPLETING THE FOLLOWING:

1. **On all documents submitted to CCS Central 2:**
   - **write your PROVIDER ID; AND**
   - **your first and last name.**

2. **ONLY SUBMIT WHEN YOU HAVE ALL DOCUMENTS. Submitting with all documents, allows us to process your documents much faster.**

USE YOUR POWER AS A PROVIDER TO HAVE A POSTIVE IMPACT ON CHILDREN!

ALWAYS PROVIDE THE VERY BEST QUALITY CHILD CARE TO CHILDREN IN YOUR CARE.

The love, care and educational experiences that the parent and the child care provider give daily, especially between the ages 0-8, prepare the child for school and life! If you need more information about what quality child care is, what it looks like and the questions you should ask the child care provider before enrolling your child, please contact LOCATE: Child Care at 877-261-0060 or visit the following websites:

For more information, visit:
1. **MarylandEXCELS.org**
2. **Marylandchild.org**
3. **Money4ChildCare.com**

Sincerely,

CCS Central 2
1-877-227-0125

Maryland Department of Education
Early Childhood Division, Office of Child Care, Child Care Scholarship Program
Child Care ERROR PAYMENT Adjustment Request Form

Facility Legal/License Name	Provider ID ____ ___ ____ ___ ___ ___ ___ ___
Facility Name	County
Name of Facility Owner/Operator	Phone
Facility Mailing Address	City, State, Zip
	Email

By my signature affixed below, I hereby affirm that I have not received any payment for the children listed below or I received incorrect payment for the children listed below and I assert that I am due payment.

SECTION 1: REASON FOR REQUEST

___ Was not paid for entire service period ___Pay was incorrect ___Pay incorrect for school closure day

___ Did not receive Grant/Special Payment ___Received PT payment for FT child ___Registration fee

___ Did not receive Payment ___Pay not correct for provider closure day _____Overpayment

PROVIDE SERVICE PERIOD & detail (If additional space is needed, attach) _____

SECTION 2: CHILD AND PARENT INFORMATION (download additional form if more than 5 children)

Name of Child	Child Voucher Number	Service Period Date	Name of Parent
1.			
2.			
3.			
4.			

_____ _____

Facility Owner/Operator Signature *Date*

SECTION 3: DECISION (to be completed by MSDE or MSDE Vendor)

Approved

Approved with modifications

_____

Denied

___ Child paid correctly ___Family/child not eligible

___ Past 30 day time frame

___ Adjustment paid on _____

Settlement date(s)

Other _____

MSDE Representative_____ Date _____

Comments:

MSDE Official Form ERROR PAYMENT FORM-1. This form must be complete and accurate. Failure to respond truthfully to any of the requested information may result in penalties as outlined in COMAR 13A.14.06.14. If an overpayment has been made, payment will be collected from subsequent payments or a collection arrangement will be made if the overpayment exceeds the authorized payment.