

Invest in Your Health: Child Care Health Provider Benefit Program

Child Care Aware of Kansas is excited to offer child care providers a unique opportunity to invest in their health. We understand the importance of your dedication to child care and how important taking care of your health is. We are pleased to announce the opportunity for you to apply for benefits offered through our partners Optima Benefits and Payroll. There are 3 options available:

1. Tele-medicine and tele-therapy benefit—no charge for a 12-month period.
2. Tele-medicine and tele-therapy benefit-no charge for a 12-month period plus choose additional benefits from Optima Benefits and Payroll. CCAKS will cover \$25/month for a 12-month period, additional costs will be invoiced to the user.
3. Additional benefits from Optima Benefits and Payroll. CCAKS will cover \$25/month for a 12-month period, additional costs will be invoiced to the user.

Eligibility for this one-year benefit will be determined based on the number of years you have worked *directly* with children and the necessity for health benefits.

For information about the plans [Trust Sales Sheet Employer Paid Plans v3](#).

Funds are limited so apply today!

Child Care Provider Health Benefit Program

Applicant Information:

1. First Name: _____
 2. Last Name: _____
 2. Child Care Program Name: _____
 3. Kansas Department of Health and Environment License Number: _____
 2. Contact Phone Number: _____
 3. Email Address: _____
 4. Mailing Address: _____
- City _____ State _____ Zip code _____

Employment Information:

5. How many years have you worked directly with children in an educator role or administrative position (program or assistant program director) in a Kansas licensed child care setting?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6 or more years

6. What is your current position? (priority is given to those in positions working directly with children in a classroom or in a directors/assistant director/program director role)

Applicants can apply for tele-health/tele-therapy benefits and/or the additional benefits available.

7. If you are applying for the tele-health/tele-therapy benefit (available at no charge for 12-months),

Do you currently have a health insurance plan?

- Yes

- No

- If yes, please provide a brief description: _____

8. Are you interested in receiving additional benefits?

Yes

No

***each approved applicant will receive a \$25.00/month stipend to apply towards the cost of the benefit for a 12-month period.*

If approved, an email will be sent within two weeks of receipt of the application. Included in the email will be a form that must be completed and returned to Optima Benefits & Payroll.

Attestation Statement

This document will serve as an agreement between Kansas Association of Child Care Resource and Referral Agencies DBA Child Care Aware of Kansas (hereinafter referred to as CCAKS) and [insert name of child care provider] (hereinafter referred to as provider).

For CCAKS to consider the provider as a recipient of the Child Care Provider Health Benefit Program, provider must agree to the following by initialing the following attestations, and signing at the bottom of this document:

_____ 1. I understand that by accepting this donation, I acknowledge that the guidance and consultation I receive under this program does not constitute legal advice, tax advice, investment advice, or accounting advice-

_____ 2. I understand that provider's participation under this Agreement is voluntary and agree that any information provider receives from CCAKS under this Agreement is for informational purposes only. I understand and agree that provider is responsible for engaging the services of a tax and/or legal professional before making any decisions as it relates to provider's taxes.

_____ 3. Under this Agreement, provider explicitly and unequivocally waives, releases, and forever discharges CCAKS, its successors, board of directors, officers, directors, agents, and employees from any and all actions, causes of action, claims, demands, costs, liabilities, expenses, and damages (including, but not limited to attorney fees, taxes, penalties, and interest) regarding services performed or materials prepared in connection with this Agreement.

_____ 4. The information provided in this application is true and accurate to the best of my knowledge.

_____ 5. I understand that Child Care Aware of Kansas is not responsible for any legal advice or consequences as a result of the information provided. I understand that these are best practices and informative items meant to assist and provide help in managing investments. These services do not provide legal advice.

I have read, initialed, and agree to the above statements as written

Consent to Share Information

If approved, by signing this form, I am consenting for a representative of Child Care Aware® of Kansas to communicate with representatives of Optima Benefits and Payroll to provide the contact information listed above.

Applicant's Signature: _____ Date: _____

Employer's Signature: _____ Date: _____

*****Required for employees of Group Home and Child Care Centers.***

Employment Verification

The applicant must remain employed at the location indicated on this application to continue to receive the benefits. Employers will receive a monthly contact to confirm employment verification. It is important that the employer is responsive to the request as it ensures the application can continue to receive the benefit.

Employer Contact Information

Name _____

Phone Number _____

Email Address _____

Submission Instructions:

Email address: sharedservices@ks.childcareaware.org

*****limited funds available. Applications will be accepted until funds are fully utilized.***